Editorial

Medical Graduates Opting for Family Practice: A Reassessment

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Two papers in this issue of the *Journal* warrant comment and concern with regard to the present pattern of choice by medical students of family practice as a career option. Schmittling and his colleagues[1] report the results of an American Academy of Family Physicians (AAFP) study of the number of graduates of US medical schools enrolled in family practice residencies in December 1981. They found that about 13 percent of the prior year's 15,667 graduates of US medical schools were then in training as first-year family practice residents. As a result of the National Resident Matching Program (NRMP) and other methods of resident enrollment, 96 percent of the available 2,600 first-year family practice residency positions were filled. Of those, more than 85 percent went to graduates of US medical schools. There are major differences in graduates' choice of family practice by type of school (when compared with graduates from privately funded medical schools, almost twice as many graduates from publicly funded medical schools entered family practice residencies) and by region (eg, graduates of schools in the New England and Middle Atlantic regions select family practice at less than one half the rate as do those of schools in the West North Central region).

A companion paper by Markert[2] reviews the results of 15 studies done in US medical schools during the last 15 years concerning the stability and change of specialty choice among medical students. He found a marked decrease in family practice as a specialty choice as students progress through medical school, with only one third of students retaining an initial preference for family practice throughout medical school into graduate training. Although change in specialty choice, often several times, is common as medical students proceed through their undergraduate years (there is only a 39 percent overall likelihood that an initial preference will remain stable), the stability of choice for family practice was considerably less than for other fields (eg, surgery, psychiatry, and internal medicine).

Undoubtedly there are many factors that bear upon the instability of career choice among medical students. Some are inevitable and necessary as medical students gain exposure to the various specialties and attempt to match their own individual goals, interests, and skills with a compatible specialty. With respect to family practice, however, some introspection seems useful concerning potentially correctable problems. Although complete information is lacking on the adequacy of undergraduate programs in family medicine in US medical schools, there is cause for concern on an anecdotal basis in several respects. Perhaps most important, many university-based departments of family practice are still below a critical mass of faculty to develop and maintain vigorous teaching programs for both medical students and residents. Residency training usually takes higher priority, and many departments do not have the resources

to conduct full undergraduate teaching programs. In addition, there are not yet enough family practice residency positions available to accommodate a significantly larger proportion of graduating medical students. The total number of US residency positions in all specialties has now diminished almost to the number of US medical graduates, and for the first time many graduates are applying to residencies in more than one specialty in order to feel assured of a position. There is also some evidence to suggest that some medical students are now being attracted to procedure-oriented surgical and subspecialty fields in response to prevailing reimbursement policies and the increasingly competitive health care economy.

Almost 15 years ago, with the advent of family practice residencies, the AAFP set a reasonable long-term goal to attract about 25 percent of the nation's medical graduates into family practice residency training and subsequent practice. In view of the country's continuing need for primary care physicians and the increasing surplus in many other specialties, this goal still seems reasonable if a strong primary care base to the nation's health care system is to be established. The other primary care disciplines (general internal medicine and general pediatrics) remain torn between primary care and subspecialty practice, as shown by various graduate follow-up studies. Although excellent progress has been made in establishing family practice residency programs that have attracted residents of high caliber, existing programs cannot accommodate more than about 15 percent of the country's medical graduates.

There will be an increasing need for family physicians during the next 20 years in view of the bimodal age distribution of general/family physicians (ie, the peak ages of the AAFP membership are 58 and 33 years, respectively, with a relative dearth of family physicians in the middle years). Although recognized by many as major national problems, the developing surplus of physicians in terms of absolute number and the maldistribution of physicians by specialty have not yet been effectively addressed. Many reasons account for this, including the well-known "territorial imperative" among specialties with respect to graduate medical education. Unless significant change in the mix by specialty takes place, including the relative increase of family physicians and other primary care physicians trained and clearly committed to primary care, the United States appears headed for a weak primary care base involving fragmented primary care of uncertain quality provided by "the hidden system" approach (ie, "primary care" by physicians trained in other specialties who have neither training nor commitment to primary care).

In this context, it seems clear that there are not yet enough residency positions available in family practice, and renewed emphasis should be directed to improvement of undergraduate educational programs in family medicine and to expansion of available family practice residency positions of high quality. Several approaches seem to be called for:

1. Continued efforts at the national level by specialty organizations, academic institutions, and government to rationalize the "mix" by specialty of the nation's physicians
2. Expanded institutional responsibility for decreasing surplus residency positions and increasing needed specialty positions, which may involve substitution of staff physicians in surplus specialties for house officer roles in such fields if required to meet service needs of teaching hospitals
3. Strengthening of the medical school base for family practice, including faculty recruitment well beyond that needed to operate a residency program, with concerted efforts to develop strong undergraduate teaching programs in family medicine and related scholarly activity
4. Active involvement of practicing family physicians in well-structured preceptorship and clerkship programs, careful selection of excellent role models being essential as well as rigorous attention to curricular goals, content, and evaluation of the quality of these programs
5. Continued efforts at the national level to reduce the disparity between procedure-oriented reimbursement policies and those covering comprehensive primary care services

References

1. Schmittling G, Clinton C, Brunton S: Entry of US medical school graduates into family practice residencies: A preliminary study. J Fam Pract 17:283, 1983
2. Markert RJ: Change in specialty choice during medical school. J Fam Pract 17:295, 1983