Special Article

Congratulations, Family Practice Residency Graduates

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Congratulations on successfully completing your residency in family practice. Your dreams of becoming a physician, indeed a family physician, are being realized. You are now making the transition from residency to practice in your chosen community. In 1987 there were 127 medical schools with 138 campuses. The average class size was more than 100 students, of whom 12.7% chose family practice as a career. That year was the peak; never before or since has a larger proportion of a graduating class chosen family practice.[1]

There was an 82.6% fill rate for family practice programs on Match Day, 1987. Except for a 1-year peak in 1984 with 85%, 1987 was the highest year before or since. On July 1, 1987, 94.2% of the family practice slots in the country were filled.[2,3] We ignored the fact that this figure represented a gradual and steady decrease from its peak of 98.7% in 1984. Our explanation was that there were more positions being offered. With the highest percentage ever of graduates choosing family practice, this was a reasonable assumption at the time.

In 1991, 9.9% of senior medical students chose family practice as a career. The fill rate on Match Day in 1991 was 65%, having declined from 70.4% in 1990, 71.1% in 1989, 73.3% in 1988, and 82.6% in 1987. We continued to increase our offering of positions nationally from 2393 in 1990 to 2467 in 1991. In 1991, 44 fewer graduating students nationally chose family practice than in 1990. In 1990, more than 100 fewer graduating students nationally chose family practice than in 1987.[1,4]

Let us look at comparisons with our primary care colleagues based on data currently available. In 1990, family practice was the choice of 10.1% of US senior medical students, and internal medicine was the choice of 35.2%. Compared with 3 years before, 27 fewer US seniors chose pediatrics in 1990, and 274 fewer chose internal medicine. Looking a little deeper, we find that the categorical internal medicine residency programs (students choosing to eventually become internists) saw a decrease of 487 US seniors. At the same time, the number of preliminary internal medicine positions filled (students who will do 1 year of internal medicine before finishing a residency in another specialty) increased by 191.[1]

In 1991 both internal medicine–primary care tracks and combined internal medicine–pediatrics programs offer few positions nationally (343 and 250, respectively), compared with the 2467 positions offered in family practice. While one more US senior chose internal medicine–primary care and 18 more chose combined internal medicine–pediatrics programs in 1991 than in 1987, the fill rates for these programs have also declined: from 76.6% to 61.5% in primary care internal medicine, and from 61.6% to 51.5% in combined internal medicine–pediatrics. Comparable statistics for fill rates in family practice by US seniors have fallen from 61.9% in 1988 to 55.9% in 1991.[1]

We know that the Match Day fill rate is not the last word; many slots are filled after the match. The peak for family practice occurred in 1984, with 98.7% of slots filled by July 1 of that year. On July 1, 1987, 94.2% of family practice slots were filled. On July 1, 1989, 90.9% were filled, and on July 1, 1990, 89.2% were filled.[2,3]

The American Academy of Family Physicians (AAFP) has committed $1 million to a 5-year plan to make increasing student interest in family practice a priority. That influence must and will be felt at the medical school, graduate program, and practice environment levels.

A Look at Medical Schools

We know that more students choose family practice as their specialty when there is a department of family practice in the medical school.[3] In 1990 there were 20 medical schools that had no family practice presence at all. Since then, we have seen the initiation of a family practice division in one of these schools and may see

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more soon. It is the AAFP's goal to encourage each of these schools to develop a family practice presence and eventually a full department.

We know that more medical students choose family practice when they have significant undergraduate exposure to the specialty.[3,5] In 1990, Texas became the first state in the nation to mandate a third-year family practice clerkship in all of its medical schools. While it is too early to predict the ultimate impact of this decision, reverberations are already being felt. Because there is often not enough money to pay for what states may mandate, faculties of family practice are being stretched thin to implement this law. Poorly designed clerkships have discouraged students from pursuing other specialties and may do so in family practice.[1,4,6] On the other hand, it is a strong message that is being sent to the medical students of Texas, and of the nation, when familiarity with the clinical discipline of family practice is made a requirement and family practice role models are acknowledged as appropriate to teach medical students and advise them on their careers.

Departments of family practice nationally enjoy approximately the same average size faculties as departments of neurology.[7,8] Often departments of family practice in academic centers have been designed to focus and concentrate on education and service delivery to the institution and community rather than on the traditional academic currency of research. We are beginning to see successful academic departments of family medicine that are promoting and awarding tenure to family physician researchers and successfully obtaining large grants from the National Institutes of Health, the National Institute of Mental Health, and the Agency for Health Care Policy and Research.

At the same time, fewer college graduates selected medicine as a career. From 1985 to 1989, the ratio of applicants to acceptances nationally has been less than 2 to 1.[8] An emphasis of the AAFP and its state chapters will be to encourage members to interact with students in colleges, high schools, junior high schools, middle schools, and elementary schools through educational interventions in the classroom as well as by bringing students into the office to expose them to the practice of family medicine. As graduates, you will have the opportunity to convince these young people that your career is rewarding, challenging, and meaningful.

Changes in Graduate Training

Family medicine has maintained between 380 and 390 residency programs nationally for the last several years, offering enough residency positions to accommodate 17.2% of senior medical students in the United States.[2] The AAFP has set a goal that 25% of future graduating classes of senior medical students will choose family practice for their residency training. In a country that needs at least 50% of its physicians to specialize in primary care, this is not an unrealistic goal.

Our programs have matured educationally. We are operating under new, revised Residency Review Committee requirements that include educationally and humanely sound requirements for resident working hours and conditions.[9]

Our programs have been fiscally threatened, operating in an era of cost containment and prospective payment ever since the advent of payment by diagnosis-related groups through the Medicare program in 1983. Thirty-six states support the training of family physicians, and their representatives are negotiating for an increase in federal funding for family practice education.[10] The first report to Congress by the Council on Graduate Medical Education in 1988 identified a shortage of physicians in family medicine.[11] While the federal government struggles with a huge budget deficit, there is a recognition of the need to train primary care physicians: family physicians, general internists, and general pediatricians. Consideration is currently being given by the administration to preferentially supporting federal reimbursement of the education costs for training primary care physicians.

In 1987, there were no certificates of added qualification (CAQ) in family practice. Now there is such a certificate in geriatrics, and there will soon be one in sports medicine. Although the American Board of Family Practice currently has no plans for further CAQs, the implications of such certificates are still being debated among the organizations of family medicine.

Aside from these two CAQs, there are numerous faculty development fellowships available to teach family physicians the skills necessary to assume critically needed academic roles as we expand the training of future family physicians. Currently, there are approximately twice as many fellowship positions in family practice available as there are fellowship applicants to fill them.

Will we see an increase in the number of family practice residency programs and an expansion of current programs to accommodate the 25% of US seniors established as a goal by the AAFP? How much closer to the goal of 25% than our current 10.9% will we actually approach?

The Future Environment of the Practice of Family Medicine

There is an old saying: "Be careful what you wish for, you may get it." When we do not like the way things are,

we demand change; then change comes, and we are threatened by it. Let us look at some of the changes that are coming. We are experiencing and will further experience a revolution in the way health care services are paid. Hospital reimbursement, representing approximately 40% of the health care bill, has moved into an era of prospective payment. Physician services now represent approximately 20% of the health care bill, up from 19% before the era of prospective payment.

Nonetheless, there is potential revolution coming in the way that physicians will be paid. It has been proposed that the resource-based relative value scale be implemented on January 1, 1992. Estimates vary as to the impact that increasing reimbursement for cognitive services will have on family physicians. Those family physicians who perform many of the procedures that will not be reimbursed as highly may see their incomes from Medicare increase by as little as 3%. Those whose practices are predominantly in the cognitive services arena may see their incomes from Medicare increase by as much as 30%. Already in 1990, the Health Care Financing Administration has decreased reimbursement for "overvalued services" by 8% to 10%, predominantly for highly technical procedures.

Preliminary proposals anticipate the plan to include "leveling of the playing field" in the area of specialty and geographic differentials. Translated into reality, this means that a family physician may be reimbursed for a 15-minute office visit with a hypertensive patient at the same rate that an internist would be reimbursed. Furthermore, the complex issue of paying more or less for care rendered in rural or urban areas is in the process of being negotiated.

Did you train in an environment with a managed care delivery system? Sixteen percent of our population (34 million people) are currently enrolled in managed care delivery systems, and this number is growing. There are many fears and concerns about the role of family physicians in managed care. We may shun the role of gatekeeper in which we perceive we may be forced to ration services to our patients. We may be threatened by practicing in an environment in which controlled reimbursement is the rule. We may further be threatened when placed at personal financial risk for the health care delivery decisions that we make.

On the other hand, managed care offers the family physician the opportunity to manage the health care of his or her patients and practice. It provides primary care with control over the health care delivery system, including laboratory utilization, referral to specialists, and hospitalizations. Managed care emphasizes the priorities of quality care, cost-effective care, personal service, the doctor-patient relationship, and preventive services. Add these up, and it looks like the ideal role for the family physician. The bottom line is: there is a great demand for family physicians in the future of managed care. Most important, managed care brings to family medicine the challenge and opportunity for leadership in health care.

In 1987, 44% of the members of the AAFP were in solo practice. That number has been declining steadily.[12] Fewer than 9% of your colleagues graduating in 1990 entered solo practice.[2] Most entered family practice groups or partnerships, with the next largest number entering multispecialty group practices. The reasons for this trend are clear. Group practice provides an economy of scale, the opportunity to afford administrative management to attend to the business aspects of dealing with health maintenance organizations, independent practice associations, marketing, contracting, prospective payment plans, and the other changes that are happening so rapidly in our practices. Family physicians are meeting the challenge and organizing into effective delivery systems to provide quality health care in a competently managed business environment.

While there are 34 million people in the United States enrolled in managed care, there are 37 million people in the United States with no health insurance; and both of these numbers are increasing. Access to health care is the number one priority of both the AAFP and the American Medical Association, and will most likely be addressed by a partnership of government and industry during this decade. When the largest payers of health care services get together to design delivery systems, we can predict that the results will include cost containment, prospective payment, quality assurance, and managed care. While these may have been threatening terms when you started your residency, family medicine as a discipline is challenged to demonstrate leadership in successfully implementing them within the health care system.

Rural patients have preferentially been served by family physicians as long as we can remember. Rural areas contain large groups of Medicare patients, Medicaid patients, and in many areas, pregnant patients.[13,14] The surplus of subspecialists has not resulted in their relocating to rural areas or health-manpower shortage areas at the same rate as family physicians have traditionally chosen such areas.

The future practice environment needs the family physician. With only 13.7% of the physicians in the nation being family physicians, and only 9.9% of US medical school seniors choosing family practice residencies, the shortage of family physicians is not being sufficiently addressed. One third of the current members of the AAFP will be over the age of 65 years by the year 2000, and 18% will be over the age of 70 years.[12] With population growth conservatively predicted at 1% per

year, the current graduates of family practice residencies (approximately 2400 per year) will merely replace the 24,000 projected retirees from the ranks of general and family physicians at the end of this decade. Thus, we can project an even larger crisis in family physician manpower in the United States by the year 2000.

The health care delivery system that you are entering is designed more and more for family physicians. Family physicians will have choices of practice arrangement and location, will experience a growing presence in medical schools, and will be challenged with leadership opportunities in both practice and academia. Family physicians will be needed and rewarded both financially and with the satisfaction of meeting personal and social needs. Congratulations on your career choice, and the completion of your training; you are entering an era in which it will continue to be great to be a family physician.

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