

Why Don't Medical Students Choose Primary Care?

Only a third of all US physicians are in the primary care sector, compared with over 50% of physicians in the United Kingdom, Australia, Germany, and France, and the trend seems to be dramatically downward. In 1991, more than 40% of the available residency slots in family practice, general internal medicine, and general pediatrics were left vacant in the National Resident Matching Program,¹ and more than a third of those currently in such residencies plan to subspecialize.² The most sought-after training is in dermatology, with ophthalmology, radiology, and surgical subspecialties not far behind. A chorus of plaintive questions³ has swelled into a roar of accusations that the mix of physicians produced by our academic medical centers is incongruent with our country's most fundamental health needs.

These concerns are hardly new. Exactly 100 years ago, Sir William Osler remarked that "no more dangerous members of our profession exist than those born into it, so to speak, as specialists."⁴ But the concerns seem much more urgent now, when a lack of adequate and appropriate primary care is seen as a major contributor to the national health care crisis—creating barriers to access, fragmenting care, diminishing preventive measures and early intervention, overwhelming the resources of emergency rooms, furthering the inappropriate use of specialists and high-technology procedures, increasing the rate of hospitalization, and raising costs. Two groups are most intensely affected by lack of access to primary care: the inner-city poor (who have the greatest burdens of morbidity and mortality) and rural populations, poor and affluent alike, as rural hospitals close and health workers increasingly choose suburban and metropolitan locations.

Of course, specialists (and primary care physicians) are not "born," they are made. They are made by deliberate career choices in the course of undergraduate and graduate medical education. Most of the attempts at reform have therefore focused on academic medical centers, institutions notoriously resistant to all but technology-driven change, in the hope that reform of what might be called professional gestation will alter the disciplinary outcome.⁵

Two articles in this issue of the Journal examine aspects of the primary care problem. In the first, which is part of the

Policy Forum, Roger Rosenblatt and his colleagues⁶ assess the effectiveness of a federal funding program intended to encourage medical school graduates to choose primary care disciplines such as family practice, general internal medicine, and general pediatrics. In the second, Kevin Grumbach and his colleagues⁷ study the other end of the problem—health care delivery—by surveying access barriers and the clinical appropriateness of emergency room use by patients waiting in a San Francisco emergency room.

After tracking the proportion of all US medical school graduates entering the core primary care disciplines over several decades, Rosenblatt et al. conclude that Title VII of the 1976 Health Professions Educational Assistance Act, which distributed about 50 million dollars a year between 1977 and 1985 to support the development of undergraduate and residency programs in primary care, had little effect on career choice. A substantial increase in primary care choices occurred before the legislation took effect, but there was no further increase in the subsequent decade despite the creation of many departments and divisions of family medicine and numerous primary care residency slots. There was no discernible impact on admissions policies, faculty composition, or broad curriculum design. In fact, a dramatic decrease in primary care choices began in 1987.

The failure, they note, was hardly surprising. Title VII money was dwarfed by the billions that went to the academic medical centers in research funding from the National Institutes of Health and foundations and from Medicare educational reimbursements, which disproportionately reward tertiary care institutions with a preponderance of subspecialty training programs. While noting the effect of low primary care incomes on career choice, Rosenblatt et al. place much of the blame on the medical schools: the "mission and culture" of the medical schools influence the career choices of their graduates; "with few exceptions, large, long-established, private, urban, research-intensive medical schools have not embraced primary care as part of their mission"; "the highly focused biomedical endeavors supported by the National Institutes of Health and many private foundations tend to foster an intellectual environment . . . that is, at best, indifferent to the creation of physician generalists." A British observer of

the American scene recently put it more bluntly: "Primary care is regarded by medical students and young doctors . . . as the lowest form of medical life."⁸

A recent and exhaustive analysis by Stimmel⁹ argues that the most powerful determinants of career choice lie in the health care system, not the medical schools. Medical students and residents now carry huge debt burdens (in 1990 the mean debt was \$46 000, many students now owe more than \$75 000, and a debt of \$120 000 may soon be common). They are acutely aware of the huge difference between specialty and primary care practice incomes (the before-tax net income of gastroenterologists, for example, is \$86 000 more than that of general internists, and the annual net income of radiologists, anesthesiologists, and many surgeons averages almost \$300 000, compared with \$100 000 for many primary care practitioners). They watch primary care physicians reject Medicaid patients (because of absurdly low reimbursement rates) and struggle with multiple billing requirements and third-party challenges that more rarely afflict procedure-oriented surgeons, anesthesiologists, or radiologists. They want a "controllable" life-style, the fixed professional hours of emergency physicians, dermatologists, ophthalmologists, and other subspecialists and, increasingly, they are influenced by practice demographics and the desire to avoid AIDS patients and the inner city.

In the face of these forces, Stimmel argues, we need investment in attractive ambulatory care centers for teaching, especially in underserved areas, and incentive grants and career scholar programs for primary care teachers. A vast increase in the National Health Service Corps program, decimated during the Reagan and Bush administrations, would reduce primary care shortages in the inner city. Federal and state leverage to limit specialty residencies and fellowships would help. Most of all, primary care reimbursement must be dramatically increased, and interest-free loans or loan-forgiveness programs must be provided to establish primary care practices. In contrast, Stimmel contends, focusing on medical schools and their curricula is the least effective way to initiate change.

Editor's Note. See related articles by Rosenblatt et al. (p 322) and Grumbach et al. (p 372) in this issue.

Where, then, does the blame (and the remedy) lie—in the academic medical centers or the structure of the delivery system? It is a chicken-and-egg argument. The institutions of medical education also provide care, in particular ways and particular settings, to highly selected people. In the process, they generate a powerful “latent curriculum”¹⁰ that teaches a pre-Copernican view of the medical care universe: the tertiary care hospital, technological mastery, and molecular and subspecialty knowledge are at the center of this universe; and primary care, demographic and epidemiologic knowledge, and services in the community are at its margins. The health care system, in turn, delivers its own educational messages, couched in the language of money, status, and ease of professional life. Change in either system requires change in both. Without changes in both, a recent comparison of primary care innovations in the United States and Mexico suggests, reforms flounder.¹¹

There are, to be sure, other pathways to change. The City University of New York Medical School/Sophie Davis School of Biomedical Education, now in its 20th year, is explicitly committed to training physicians for primary care careers in underserved urban communities and to recruiting underrepresented minorities.¹² It admits students at the end of high school to a combined BS/MD program and heavily subsidizes their tuition—thus greatly expanding and changing the applicant pool. More than 30% of the school’s students are Black or Hispanic, and it is, arguably, the first working-class medical school since the Flexner report. Equally to the point, it roots the students’ early experience in community health centers and other community-based, health-related programs, and it combines a conventional basic science curriculum with extensive epidemiologic and public health training. Some 70% of its graduates have chosen primary care residencies.

Hedgecock and her colleagues¹³ describe a related effort, which involves conventional medical schools under the auspices of the American Medical Student Association Foundation in collaboration with the US Public Health Service, the American Academy of Family Physicians, the Ambulatory Pediatric Association,

and the Society of General Internal Medicine. The goal is to link medical schools with the national network of community health centers—some 580 primary care institutions serving nearly 6 million people—to combine longitudinal clinical primary care training in community-based (rather than hospital-based) settings with full-scale academic teaching and supervision. At present only 24 medical schools offer such programs. With a new administration in Washington and the promise of a substantial increase in the number of community health centers, the opportunities for expanded linkages are clear.

The study by Grumbach et al.⁷ demonstrates that primary care shortages do not merely concern medical educators; they afflict patients. Some 45% of the 700 patients waiting for emergency department care at San Francisco General Hospital cited barriers of access to primary care—in particular, lack of insurance and lack of a regular source of care—as their reason for reliance on the emergency room. Only 13% of the patients had clinical conditions that required emergency care. Would such reliance on emergency room use change if there were universal access to primary care? In a well-controlled prospective study in the United Kingdom, Green and Dale¹⁴ compared attenders at hospital emergency rooms with patients seeking care at their general practitioner’s offices. Almost half of those at emergency rooms had acute injuries, compared with only 6% of the general practitioner patients. In most cases, the emergency room patients had symptoms that were new and of recent onset, whereas the patients seeking care from their primary care physicians most often presented with chronic illness, upper respiratory infections, and ill-defined problems. In sum, in contrast to the desperate overuse of emergency rooms in the United States, the use of emergency care in the United Kingdom was modest—and clinically appropriate.

Universal health insurance coverage now seems, at last, to be a near-term certainty in the United States. However, insurance without assurance of adequate and available primary care resources is likely to be a hollow victory, especially for the poor and non-White. Adequate production of primary care physicians will require major investments to induce both

educational and structural change and much more imaginative, albeit initially costly, use of the existing resources in both systems. The meaning of these studies is that we will get what we are willing to pay for, and we will pay—in avoidable suffering, preventable illness, and premature death—for what we fail to do. □

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