Future of family medicine workforce in the United States
Leon McDougle, Lawrence L Gabel and Linda Stone


In response to the Future of Family Medicine Leadership Committee’s recommendations1 The Ohio State University Department of Family Medicine convened 10 faculty development sessions covering the following strategic objectives: (1) Promoting a Sufficient Family Medicine Workforce, (2) the Role of Family Medicine in Academic Health Centers, (3) The New Model of Family Medicine, (4) Electronic Medical Records, (5) Family Medicine Education, (6) Lifelong Learning, (7) Enhancing the Science of Medicine, (8) Quality of Care, (9) Communications, and (10) Leadership and Advocacy. The focus of this editorial is on initiatives and programs to promote a sufficient family medicine workforce. In comparison to other industrialized countries, the United States ranked lowest in primary care functions and lowest in health care outcomes, but highest in health care expenditures. Despite this fact, the trend for United States medical school graduates to select subspecialty careers continues upward. Through collaboration and advocacy, we can all ensure a continued enthusiasm for the selection and retention of family medicine as a career.

Background

In comparison to other industrialized countries, the United States ranked lowest in primary care functions and lowest in health care outcomes, but highest in health care expenditures.2–5 Despite this fact, the Physician Workforce Policy Guidelines for the United States for 2000–2020, endorsed by the Council on Graduate Medical Education, concluded that the distribution between generalists and non-generalists should reflect ongoing assessments of demand.2 In addition, the Association of American Medical Colleges believes that the nation is best served by allowing individual graduates to determine for themselves which area of medicine they wish to pursue; therefore, vacating its prior position of supporting a primary care foundation of the physician workforce.2 These recommendations were based in part on population and workforce projections.

The Council on Graduate Medical Education and Association of American Medical Colleges recommends that the number of physicians entering residency training each year be increased from about 24 000 in 2002 to 27 000 in 2015 to avoid a significant shortage of physicians over the next 10–15 years.6,7 If the actual shortage was not as significant as predicted then the modest increase of about 3000 new U.S. medical school graduates per year by 2015 would permit the U.S. to decrease its current reliance on about 5200 international medical graduates who enter residency training programs annually.6,7

In 2004, 16 648 medical students matriculated to the 125 U.S. allopathic medical schools and 50% of those schools were considering increasing their class sizes.8,9 Twenty osteopathic schools plan to admit 3280 medical students in 2005 compared with 3079 in 2002.10,11 Important demographic changes include a projected 51% increase in the number of people ≥65 years of age by 2020 according to U.S. Census Bureau.12 In addition, the aging of America is expected to impact utilization of health services including increased office-based visits (Tables 1 and 2)13 and increased requirements for invasive hospital procedures.13,14 Furthermore, the U.S. population is becoming increasingly diverse by 2030 minority Americans are expected to comprise 42.5% of the projected population of 363 584 000.15

The Institute of Medicine, through the Committee on the Future of Primary Care, has stated that primary care is not a discipline or specialty but a function as the essential foundation of a successful, sustainable health care system.16 Primary care physicians currently make up <40% of the total physicians in the U.S. and family physicians represent 40% of primary care physicians.17

Received 1 September 2005; Accepted 19 December 2005.
Administrative and Practice Office, OSU Family Practice at University Hospitals East, 1492 E Broad Street, Suite 1302, Columbus, OH 43205, USA; Email: Leon.McDougle@osumc.edu
Family physicians are most likely to practice as generalists and in rural and underserved populations. As a means to contribute to a sufficient family medicine workforce the Ohio State Department of Family Medicine has focused on three areas: (1) winning respect in academic circles, (2) making family medicine an attractive career choice for medical students, and (3) leading in implementation of science and technology in practice. Visibility of family physicians in the medical school environment has also been a priority. From Patient-Centered Medicine to Physician Diagnosis and Preceptorship experiences, the Family Medicine faculty is on the front lines in innovations in education and in teaching toward the future of medicine. The Ohio State Medical Center is currently pilot testing an electronic medical record system that will be used throughout the medical center including all physician practice sites. In addition, a web-based system allows viewing of radiological tests. Furthermore, the Ohio State Department of Family Medicine implemented teleconferencing capability to facilitate communication between the offsite residency tracks. And the Ohio State family medicine faculty serves as principal investigators of two telemedicine demonstration projects.

Departments of Family Medicine should take advantage of opportunities to positively influence the development of a sufficient workforce to support the primary care foundation of the United States. Through collaboration and advocacy initiatives, we can all ensure a continued enthusiasm for the selection and retention of family medicine as a career.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Office-based visits to all physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>25–44</td>
</tr>
<tr>
<td>Rates of visits per 100 population*</td>
<td>237.9</td>
</tr>
</tbody>
</table>

*The visit rates are calculated using as the numerator the average number of office visits over the 2 year period (2001–2002), and, as the denominator, the population averaged from two mid-year civilian non-institutionalized populations in the demographic group.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Office-based visits to all physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>25–44</td>
</tr>
<tr>
<td>Family practice</td>
<td>68.9</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>36.1</td>
</tr>
<tr>
<td>Total*</td>
<td>105</td>
</tr>
</tbody>
</table>

*The visit rates per 100 population are calculated using as the numerator the average number of office visits over the 2 year period (2001–2002), and, as the denominator, the population averaged from two mid-year civilian non-institutionalized populations in the demographic group.

Disclosure

This manuscript is exempted from IRB review because of less than minimal risk. No external funding was used to create this editorial. There are no conflicts of interest associated with this manuscript.

References