

Reflections on the Four Pillars and Our Progress Toward Increased Student Interest in Family Medicine

Amanda Weidner, MPH

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Nearly a decade ago, I had the privilege of working with and in support of a Council of Academic Family Medicine (CAFM) task force that was charged to create “a framework with consistent language to guide our efforts to increase the production of well-trained primary care physicians for our populations.” This task force developed a model, the Four Pillars for Primary Care Physician Workforce Development, that highlighted the need to create programs and interventions to address the issues of pipeline, process of medical education, practice transformation, and payment reform as the main drivers of primary care physician workforce.¹

Around the same time, the specialty launched the Family Medicine for America's Health Project (FMAHealth), designed to reevaluate the role of family medicine in our evolving health care system and create new strategic and communication plans for the discipline to create better health, better health care, and lower cost for patients and communities (ie, the triple aim).² To achieve the specific project aims, six tactic teams were created, including the Workforce Education and Development Tactic Team (WEDTT). The WEDTT used the Four Pillars as the foundation to build their change ideas and specific projects from.³ This ultimately led to the creation of a stretch goal: having 25% of US allopathic and osteopathic medical students choose family medicine as their specialty by the year 2030. When the FMAHealth project was sunsetted, the WEDTT efforts and this stretch goal morphed into a new initiative of the eight national family medicine organizations: the

America Needs More Family Doctors: 25 x 2030 Initiative.⁴ The 25 x 2030 effort initially created four working groups focused on the family medicine brand, the family medicine pipeline, creating a learning and action network, and evaluating our efforts.

Even with these time- and resource-intensive collaborative activities, built up from the framework of the Four Pillars, the number of US allopathic and osteopathic medical students choosing family medicine has changed very little in the last decade. In 2012, about 9.8%* of US allopathic seniors and osteopathic seniors and graduates (the National Residency Matching Program [NRMP] and American Osteopathic Association [AOA] did not previously separate this data) matched into family medicine residency positions^{5,6} and 11.2%** matched into family medicine residency programs in 2022.^{7,8} This is despite growing the number of residency positions offered in the family medicine Match from 2,740 to 4,916 across this time period, due both to program expansion and the Single Accreditation System.

The systematic review and its themes reported in this issue of *Family Medicine* give a window and some evidence into what might still be missing in our collective equation to achieve 25 x 2030, particularly within the pipeline and process of medical education pillars that we as medical educators and leaders in our medical schools have more ability to influence. The enormous effort of the research team

From the Association of Departments of Family Medicine, Leawood, KS.

doing this systematic review should be recognized and appreciated, as through their deep dive we can now say with confidence what we know about “Medical School Characteristics, Policies, and Practices that Support Primary Care Specialty Choice.”⁹ More specifically, we now have a reliable summary of evidence for student choice of family medicine and its relationship to some institutional features of medical schools, admissions processes, educational pathways, clerkships, mentorship and interest groups, and other curriculum, including electives.

In particular, my main takeaways from this robust investigation are:

1. We need to do better in reporting the planning and piloting phases of our interventions. We cannot expect others to follow our example if they don’t know how we got from laying the groundwork of our programs to assessing their effectiveness and impact.⁹
2. Each medical school has its own unique features, structures, and opportunities, and thus, the landscape of medical education pathways is complex; Ledford et al’s “socioecological model of medical education pathways” provides a beautiful structure to consider these interwoven layers.¹⁰
3. Students who choose to go into family medicine are positively impacted by more time in the curriculum devoted to family medicine or primary care¹¹ and more family medicine programming and offerings like family medicine interest groups.¹²
4. We have evidence of successfully increasing primary care Match rates when there are family physicians in leadership positions, organizational mission alignment, a primary care-positive culture, regional campuses, or rural training.¹³ Some curricular offerings are associated with primary care specialty choice but causation is hard to determine; students choose experiences that reflect their interests.¹⁴
5. We now know there is a major gap in the literature around the development and impact of medical school policies, especially admissions policies and procedures.^{9,15}

This last identified gap is key for future investigation. In 2013, when we developed the Four Pillars of Primary Care, we acknowledged that activities should “develop more holistic medical school admissions processes, and enhance participation of primary care physicians on admission committees, to identify students who are more inclined toward primary care.”¹¹

To get a better sense of how widespread these practices are, in 2016 the Association of Departments of Family Medicine asked its members*** whether their medical school’s admissions committee had a specific charge to seek out applicants interested in primary care careers (survey response rate was 74% with 112 of 152 chairs responding on behalf of their departments). Thirty percent (n=33) said they did, and 20% (n=22) indicated that family medicine or primary care was specifically included in the medical school mission statement.

In 2020 we asked a series of follow-up questions related to admissions to learn more about practices across the United States (this survey had a 57% response rate, with 94 of 165 chairs responding). Key findings included:

- Respondents had an average of two faculty on the admissions committee and overall their faculty comprised an average of 10% of the admissions committee.
- 72% (65) said their medical school uses a holistic review process that includes consideration of “distance traveled” (which we defined as “obstacles or hardships overcome by an individual to get to this point in their education/life challenges they’ve faced and conquered”).
- 43% (38) said their medical school uses a blinded (closed-file) interview process.
- 56% (51) said their department has input into changing the admissions policies or procedures. On a follow-up, free-text question asking what this input was, most respondents indicated their ability to give input was based on informal relationships with the people in charge of the admissions process or based on formal roles as participants in the admissions committee.

These results may be somewhat surprising, given our assumptions and current data about admissions¹³ and what we know about the somewhat stagnant rates of family medicine specialty choice. There is clearly more research to be done in this area, and I, for one, look forward to seeing what inspiration will come from the enormous effort of highlighting what we do and do not know reported in these pages, and what additional research may be inspired to similarly investigate the gaps in the practice transformation and payment reform pillars of the Four Pillars, which are also crucial to move the needle on the number of students from medical schools in the United States choosing family medicine for their career.

Footnotes:

* In the 2012 NRMP Match there were 16,527 active applicant seniors of US allopathic medical schools and 2,360 active applicant students/grads of osteopathic med schools. There were 1,322 US allopathic seniors who matched into family medicine and 324 osteopathic seniors or graduates who matched into family medicine for a total of 1,646/18,887=8.7%. Then, there were 2,373 participants in the AOA GME Match, with 432 who matched into family medicine (18.2%). Together this is 2,078/21,260=9.8%.

** In the 2022 Match there were 19,902 active applicant seniors of US allopathic medical schools and 7,303 active applicant seniors of osteopathic medical schools. There were 1,555 US allopathic seniors who matched into family medicine and 1,496 osteopathic seniors who matched into family medicine for a total of 3,051/27,205 (11.2%).

*** The ADFM membership is composed of departments of family medicine, represented by the chair and in many cases, the senior administrator. The membership includes nearly all departments of family medicine at allopathic medical schools in the United States as well as some departments in academic health systems without a medical school, a few departments in osteopathic schools of medicine, and a few departments in Canadian medical schools.

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