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Family Medicine and Internal Medicine: Let Our Powers Combine!

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To the Editor:

The Association of American Medical Colleges now predicts the ever-rising shortage of primary care physicians in the United States to reach up to 48,000 by 2034.[1] In recent years, leaders in the family medicine community have attempted a myriad of initiatives to address and reverse this trend, without finding success.

The unfortunate truth is that family medicine alone will be unable to close the American primary care gap. Each year we await the signs of a sea change that will begin to shrink the physician shortage, such as better Match results for the family medicine specialty, but they have yet to materialize in recent years. Despite the efforts and zeal of our specialty's leaders, forces affecting primary care–some intentional, some unintentional–mandate that we expand our stakeholder pool.

One potential source of allies are our colleagues in internal medicine. Once a significant pipeline for primary care providers, these numbers have cratered: 9.6% of internal medicine residents indicated on their 2021 In-Training Exam (ITE) that they planned to practice primary care,[2] down from 54% of third-year residents taking the ITE in 1998.[3] Numerous factors led to this shift,[4] including the rise of the hospitalist movement and pay scale differences for specialists in the context of rising medical school debt. Any reverse in this trend, however, would provide a much-needed new reservoir of primary care physicians for the American workforce.

As the leader of primary care physician training, family medicine should take the initiative in renewed collaboration efforts with internal medicine leaders to develop new strategies to reinvigorate this now-dormant primary care pipeline. During the aforementioned heyday of general internal medicine training of the late 1990s, innovative combined family medicine-internal medicine residency programs were developed to expose residents to the full potential of the breadth of primary care[5] and pursue careers as generalists. The redevelopment of such programs, utilizing initiatives such as the Accreditation Council for Graduate Medical Education' Advancing Innovation in Residency Education to build out their curriculum, would have the potential to capture medical students more likely to maintain their career focus on generalist medicine via concentrated curricula within these programs. In such an arrangement, primary care becomes a valued "specialty" within the realm of internal medicine residency training! Developing more robust collaboration strategies with similarly-motivated internal medicine groups, such as the Society of General Internal Medicine, would also be a potential starting point.

Suggesting a few potential areas of opportunity may seem a bit frivolous for an issue of such magnitude with countless layers of nuanced challenges to solve. Nonetheless, it becomes more painfully obvious with each passing year that family medicine cannot close the primary care gap alone; now more than ever is the time to

build a vigorous, interdisciplinary coalition to accomplish one of our specialty's most crucial goals. Our colleagues in internal medicine are a logical starting point, with more potential partners (pediatrics, preventative medicine, advanced nursing, etc) to further recruit. The solution to America's primary care shortage, at least in the short term, is not coming via the family medicine Match.

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