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Family Medicine

GUEST EDITORIAL

More Family Doctors: Good News on Career Choice—What's Next?

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> Should you find yourself in a chronically leaking boat, energy devoted to changing vessels is likely to be more productive than energy devoted to patching leaks.
>
> –*Warren Buffett*

The United States needs more primary care physicians, especially family physicians. Decades of evidence supporting the benefits of more primary care to improve population health and costs,[1–3] a growing public preference for primary care delivered by primary care practices over urgent care and retail clinics,[4] and lagging health outcomes have been insufficient motivation for the country to invest in a robust primary care physician workforce.[5–10] The specialty of family medicine is positioned to prepare the largest, most flexible supply of primary care physicians to "promote the health of the population and . . . respond to community needs," supported by revised family medicine residency standards that renew and strengthen this expectation.[10] With an unmatched breadth of scope and adaptability of practice location and style, family physicians remain predominantly dedicated to practicing primary care even as internal medicine and, to a lesser extent, pediatric graduates have abandoned primary care.[7,8]

Training enough family physicians has been an arduous goal going back to the 1966 Willard committee's report, which projected optimistically that it "may require a decade or more."[9] Years of work across four pillars of workforce development (pipeline programs, the process of medical education, practice transformation, and payment reform)[10] led to the ambitious "America Needs More Family Doctors: 25 × 2030" collaborative in which eight family medicine organizations[11] aimed to increase medical school graduates choosing family medicine to 25% by 2030. The likelihood of reaching the goal was not without its skeptics and has in fact remained elusive.[12–14]

The short, elegant study reported in this issue by Westfall, Fernald, and Kamerow[15] looks at one aspect of medical education's contribution to workforce development, providing intriguing and encouraging information while provoking a reassessment of our thinking. Long-standing conventional wisdom has touted the importance of selecting candidates for medical school with interest in and an intent for a family medicine career,[16] even asserting that it is uncommon for students to "convert" to family medicine during medical school, especially from nonprimary care fields. To evaluate that view, the authors analyzed Association of American Medical Colleges (AAMC) data of national cohorts over 4 years, comparing allopathic students' specialty choice on entering medical school expressed in the Matriculation Student Questionnaire (MSQ) to their final choice reported on the Graduation Questionnaire (GQ).

The study findings were quite the opposite of conventional wisdom. Most students—more than 70%—who reported plans on the GQ to enter family medicine after medical school had expressed intent for a different specialty on the MSQ. Large change in specialty interest was not isolated to family medicine, as some two-thirds of students could not "predict their specialty choice the summer before they enter medical school." Medical students are, after all, primarily young adults, often with limited life experience outside of school.

Fidelity to family medicine career interest at matriculation was significant. Forty-five percent who listed family medicine on the MSQ chose family medicine for residency, a fidelity rate second only to psychiatry. Still, "hundreds of medical students switched their specialty choice to family medicine during medical school," reflecting a net gain into family medicine from 12 of the 17 specialties reported, including other primary care specialties. The largest group to select family medicine on the GQ came from the "undecided" MSQ and "converted" GQ pools combined (3,040), nearly twice the size of the fidelity pool (1,719).

Effort to encourage and screen for interest in family medicine before and during admissions seems worth it, and evidence supports this, including some specific circumstances like when students apply to certain medical education pathways[17] or when the goal is to admit likely future rural physicians.[18] Still, the snapshot provided by the study highlights the impact that family medicine medical school departments, programs, experiences, and teachers, including thousands of community preceptors, have on student interest. The pattern does not, unfortunately, help us understand the evolution of career interest in osteopathic and international graduates who are not included in AAMC questionnaires. Considering their contribution to family medicine residencies and the workforce, the topic warrants study.[12,19]

One can only speculate reasons for this change from past conventional wisdom. We know that matriculating students and admissions policies are different today, given holistic admissions and more diversity of individuals entering medical school. My sense is that today's students form impressions of medicine differently, influenced heavily by social media, an abundance of medical shows (but alas not featuring family medicine), and personal or family experiences that include relative prominence of urgent care centers and nonphysician providers and less doctor/patient continuity. The change is also testimony to the excellence of student-centered experiences developed over time by family medicine departments.

Might we have possibly overinterpreted the literature in our fervor for more family physicians? A recent systematic narrative review on admissions practices and primary care career choice[20] suggested the value of admissions committees' awareness of criteria associated with an increased likelihood of entering primary care, "the most important of which is a stated interest in primary care." Still, the review noted the scarcity of multi-institutional and prospective studies, plus reliance predominately on observational data, raising concerns about the strength of the evidence. The Westfall et al study does not contradict an importance to career interest at admission but provides a better relative sense of its meaning compared to what happens during medical school.

The gratifying findings that career interests can evolve favorably toward family medicine are unfortunately overshadowed by discouraging numbers. In the 2024 Match,[12]* notwithstanding hype of "15 years of growth" and "the most family medicine positions available in history," family medicine accounted for just 13.6% of positions offered and 12.8% of positions filled among all specialties, falling well short of the 25 × 2030 campaign goal. Even including potential primary care physicians from all disciplines, the numbers fail to approach the 40% goal for a combined primary care physician workforce of general internal medicine, general pediatrics, and family physicians called for by the Council on Graduate Medical Education.[6] The study identified 21,171 of 55,635 (38%) GQ respondents who were entering one of the potentially primary care fields (3,820, family medicine; 8,648, internal medicine; 6,756, pediatrics; 808, internal medicine/pediatrics). We know that there is attrition from primary care practice, especially outside of family medicine, and that upwards of 80% of internal medicine, perhaps 40% to 50% of pediatrics and internal medicine/pediatrics, and some 10% to 15% of family medicine graduates are likely to pursue nonprimary care specialties and/or practice.[6] A back-of-the-envelope calculation using these attrition rates suggests that closer to 15% to 20% of the study cohort—not 38%—will practice primary care, well below the 25% target for family medicine alone and unlikely to add net growth to the primary care workforce, certainly without accounting for osteopathic and international graduates.

This crisis is real while next steps of a cohesive plan are not apparent. We all agree to the value of continuing initiatives of family medicine organizations that promote and support career choice, such as the Society of Teachers of Family Medicine's preceptor initiative and the numerous activities of the American Academy of Family Physicians (AAFP)—online resources, the FUTURE conference, and a recently launched "Be Their First" initiative.[21] Some, particularly AAFP, are investing energy and resources directly and in collaboration[22,23] to advance the posture of the discipline and payment reform, a change thought to be inextricably linked to primary care's ability to flourish.

The last unified family medicine-wide effort, the 25 × 2030 collaborative, apparently has died on the vine, leaving uncertainty regarding strategy and no interconnected initiative across and explicitly representing all of "the family" let alone the other primary care disciplines. The limited success up to now begs the question: Can we afford to just wait and expect better results if we only do more of the same?

Authors of the AAFP 2024 Match report,[12] lamenting the sluggish pace of change in the primary care physician workforce, seem to believe otherwise. They call for "disruptive change" to reform both the nation's medical education system and bring about the payment structure that supports

primary care to flourish. I agree. And although I do not claim to know how to do so, I believe that the best chance for a transformative shift will come from a coordinated, deliberate, and united alliance within all the primary care disciplines, and led by family medicine. Primary care is, after all, what we do. So, what's next, family medicine?

*FOOTNOTE

The 2025 Match and publication of the analysis by the AAFP occurred while this article was in press. The results of the 2025 Match continue to raise concerns. Despite growth to 817 categorical family medicine residencies offering 5,357 positions, the family medicine 2025 Match represents only 13.4% of all positions offered in all specialties, a drop of 0.2% since 2024, and 11.2% of all US students and graduates who matched in 2025, a decline by 1.6% over 2024. The AAFP continues its call to action including a "level of disruptive change" to the medical education system.[24]

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