The number of US medical students entering family medicine continues to decline. Despite the increased presence of family physicians on medical school faculty and increased exposure to family medicine during training, students still cite lack of respect and excessive knowledge base to master as reasons for not choosing our specialty. Specific changes must be made to family medicine residency training to make it more attractive to students and more compatible with the realities of practice today. These changes include eliminating maternity care as a requirement, lengthening training to 4 years, and reducing the number of residency slots available. These changes will ensure that graduating family physicians will be better prepared for practice, better qualified to obtain privileges in the hospital and clinic, and more respected by their colleagues and the public.

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The Future of Family Medicine Project offers a broad and comprehensive assessment of how the specialty must respond to the changing face of clinical practice. The report focuses heavily on how clinical practice should change to improve the quality of care delivered by practicing family physicians. Many of the recommendations, such as electronic medical records and improved access to care, are already occurring, being driven by market forces and the medical profession as a whole. Unfortunately, the report offers few specific recommendations for changes at the level of undergraduate and graduate medical education. Given that the numbers of US medical students choosing family medicine continues to decline, the future of family medicine may rely more on how the specialty responds to declining student interest in the specialty. The Arizona Study clearly identified what we have always known: that family medicine still suffers from a lack of respect among the profession as a whole and that students are concerned with mastering what they see as an unreasonably large body of knowledge. To respond to these concerns, I propose three specific changes to family medicine graduate education.

1. We must eliminate pregnancy care as a required component of training.

In the last 20 years, the percentage of family physicians delivering babies has hovered at around 30%. Labor and delivery skills must be recognized for what they are: clinical skills that motivated family physicians can master and practice competently but that are not part of the core “basket of clinical services” that most family physicians offer and should be trained in. Pregnancy care training should be offered as an elective track for those residents interested in it or as a required part of individual programs that identify it as part of their core mission. Eliminating “obstetrics” maternity care as a requirement will strengthen training for those residents choosing it and will better support their future practice and privileging in several ways.

First, delivery room experiences will be concentrated on those residents who will use those skills in the future. Many programs currently struggle to achieve the 40–50 deliveries per resident expected by the Residency Review Committee (RRC). While some programs may drop obstetrics rotations altogether, many programs with limited available labor and delivery experiences will be able to offer more robust training to a select group of interested residents. At the same time, residents not interested in performing deliveries will have additional elective time for development of skills they will use.

Second, stronger resident clinical experience for those who desire to perform deliveries will bolster privileging and credentialing for family physicians, as well as improve respect among our obstetric colleagues. Privileging for proce-
dures is becoming more dependent on volume of experience in training. An elective obstetrics track would allow the RRC to raise the bar for interested residents by setting an unquestionable standard for family medicine training in management of labor and delivery.

Third, offering obstetrics electives, rather than required rotations, will improve relations between family medicine residencies and obstetric departments. Every program director knows how one unmotivated resident on an obstetric rotation can poison the attitudes of obstetricians, nurses, and obstetrics residents. Family medicine residents rotating through obstetrics services who are fewer in number but more motivated will build better relationships and engender greater respect within those departments.

Finally, eliminating the delivery requirement will help attract high-quality students interested in primary care. How many bright students avoid family medicine because they don’t see the logic of a required block of training in delivery skills they will never use or of which they are simply afraid? Conversely, students interested in performing deliveries will see better opportunities for adequate training and may be more comfortable choosing family medicine.

2. **We should extend training to 4 years.**

We must acknowledge that the body of knowledge required to be competent in primary care is rapidly expanding. In addition to mastery of this content, residents must continue to obtain the volume of inpatient clinical experience and procedures necessary to qualify for privileges under increasingly stringent requirements from hospitals, insurers, and employers.

A 4-year curriculum would improve the image of family medicine as the premier specialty for primary care. As a specialty, we have led the way in terms of curricular content requirements and board recertification; we should acknowledge that family medicine is a demanding specialty that requires a broad range of knowledge and experience. Extending training would clearly bolster respect among students, colleagues, and the public and would also bolster credentialing processes for family physicians.

Four years would allow adequate development of advanced skills. Residents wishing to perform endoscopy, stress testing, advanced obstetrics, or other elective procedural skills would have additional available elective time to achieve their goals.

Four years would be more attractive to better students. Do we really want students choosing our specialty because it’s the quickest pathway to practice? Or, do we want students choosing it because they will receive the training necessary to be competent in primary care and the opportunity to develop procedural skills without sacrificing the full scope of primary care?

Four years would also better support family medicine’s academic mission. Residents would have greater opportunities for research time, dedicated research electives, and greater exposure to a continuous patient population for clinical research purposes.

Finally, a 4-year requirement would allow us to most painlessly effect one other vital change in family medicine residency training—a reduction in the number of residency positions offered.

3. **We must significantly reduce the number of residency positions available.**

This year (2004), only 1,198 US seniors competed for 2,884 slots offered in the Match, while 1,058 were filled by international medical graduates (IMGs).\(^4\) By July 2004, most of the remaining slots will have been filled with IMGs who did not match. This means that over half of all new family medicine residents are IMGs. At no time in our history has the gap between positions offered and positions filled with US graduates been so great.

While there are certainly many excellent foreign-trained physicians who should be able to obtain residency training in the United States, there can be no doubt that maintaining more than twice the number of positions compared to the number of US graduates entering the specialty will eventually lower the quality of our residency graduates. This will certainly be the death of the specialty, and allowing this situation to continue is simply irresponsible.

Given that this problem has been evolving over the last 5 years, it is obvious that there is little collective will to address the issue voluntarily. Expanding training to 4 years, and capping the number of total residents per program, would be the most painless way to reduce PGY-1 slots by about 25%. This would still provide an excess of positions for US graduates, allowing them significant freedom of choice, and would still provide many positions for qualified international graduates. Programs would maintain their Medicare reimbursement status and, with the same total number of residents, should be able to maintain a similar level of clinical productivity.

**Conclusions**

In summary, I believe we should feel a greater sense of urgency over the declining numbers of students entering the specialty and actively address the attitudes causing that decline. Despite having family medicine departments and required family medicine rotations on virtually every medical school campus, we still suffer from a lack of respect and understanding among other physicians, students, and the public. As credentialing processes become more stringent in inpatient and outpatient settings, we face in-
creasing biases, hospitals setting procedure volumes we cannot meet, and even insurance companies refusing to reimburse us for certain diagnoses. Strengthening our training and focusing it more appropriately on our core basket of services may be the best steps we can take to ensure the future success of our specialty.

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