How Many Family Physicians are Needed?

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It is becoming conventional wisdom today that the total number of physicians in the United States is rapidly approaching a surplus level, and that geographic and specialty maldistribution of physicians are the real problems related to physician supply. It is projected that the annual number of graduates of US medical and osteopathic schools will reach about 16,500 by 1980, over twice the 1966 level. In the last ten years the ratio of active physicians to population has increased about 20 percent and now totals 174:100,000, a ratio exceeded only by West Germany and Austria among Western developed countries.[1]

While there remains considerable debate as to the magnitude of shortage/surplus within individual specialties and specific approaches to the problems of physician supply, there is general consensus that the principal shortage involves primary care physicians. The Coordinating Council on Medical Education (CCME) in 1975 recommended an initial national target be established for at least 50 percent of graduating medical students to enter primary care training and practice.[2] Current federal health manpower policy has established requirements that the percentage of graduates entering primary care residencies must exceed 40 percent in 1979 and 50 percent in 1980 in order for medical schools to be eligible for capitation grants. The primary care disciplines are defined by the federal government as family medicine, general internal medicine, and general pediatrics.[3] Although the American Medical Association also views obstetrics-gynecology as a primary care specialty, the relative lack of comprehensiveness of services, combined with the predominantly surgical orientation of the discipline, greatly weaken this position. Recently, the Institute of Medicine has recommended that a substantial increase is needed in the proportion of residents in primary care specialties—at least 50 percent and perhaps as much as 60 or 70 percent.[4]

While recent recommendations for total numbers of primary care physicians have become quite specific, there has been less specificity with respect to the balance among the primary care disciplines themselves. In 1973, the American Academy of Family Physicians adopted a goal that sufficient family practice residency positions be developed to accommodate at least 25 percent of medical school graduates each year. At a recent reunion meeting of the Willard Committee, which in 1966 drafted the landmark Willard Report on Education for Family Practice,[5] the group recommended that a goal be established for 25 percent of

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American medical school graduates to enter residency training in family practice by 1985.[6]

No one primary care discipline can meet the large and diverse needs for primary care in the United States. Family practice has a particular contribution to make to primary care, however, because of its broad clinical orientation, focus on the family, comprehensiveness of services, flexibility, and demonstrated capability to address problems of geographic maldistribution of physicians. Internal medicine and pediatrics likewise have much to contribute to primary care, particularly if the trend toward subspecialization can be arrested. There is, however, disturbing evidence to the contrary. A recent study of over 600 physicians trained in primary care fields in Massachusetts between 1967 and 1972 showed only 28 percent of former residents in internal medicine and 56 percent of those in pediatrics devoting more than half their time to primary care in 1976. For these two groups, the fraction of full-time equivalent primary care physicians was only 0.27 and 0.42, respectively.[7]* Lee reported in 1976 that almost 40 percent of internists completing training since 1972 had been certified as subspecialists.[8]

Despite the remarkable growth of family practice residencies since 1969, no more than 15 percent of American medical school graduates can yet be accommodated by the available family practice residency programs. There are currently about 2,200 first-year positions in approved family practice residency programs in this country. This figure must be nearly doubled if the 25 percent goal for medical school graduates entering family practice is to be met. If continued and extensive subspecialization takes place in the other primary care specialties, the long-term requirements for family physicians may substantially exceed this goal, perhaps to as high as 35 to 40 percent of all physicians by the years 1990 or 2000. Careful monitoring of "primary care equivalents" will be required in order to determine the long-term need for family practice and the other primary care specialties.

Regardless of whether the national target for family physicians remains at the 25 percent level of all medical school graduates or if a higher goal is ultimately needed, the implications for training programs in family practice are clear. There must be continued expansion of these programs at both undergraduate and graduate levels, with a continued emphasis on quality control as represented by such efforts as the Residency Assistance Program.[9] Meeting this goal will require redoubled efforts within family practice, particularly with regard to faculty and program development, as well as the continued recognition by state and federal governments of the critical need to accord high priority to the support of these vitally needed programs.

*For each physician respondent, the total number of hours per week spent in providing primary care was divided by the mean number of hours in practice for each group. The ratio of full-time equivalents of primary care physicians to the total respondents for each group was then calculated.

References

1. Morrow JH, Edwards AB: US health manpower policy: Will the benefits justify the costs? J Med Educ 51:791, 1977

2. Coordinating Council on Medical Education: Physician Manpower and Distribution: The Primary Care Physician. Chicago, Coordinating Council on Medical Education, 1975, p 6

3. Whiteside DF: Training the nation's health manpower—The next 4 years. Public Health Rep 92:99, 1977

4. Scheffler RM, Weisfeld N, Hyg MS, et al: A manpower policy for health care. N Engl J Med 298:1058, 1978

5. Willard WR (chairman): Meeting the challenge of family practice. Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. Chicago, American Medical Association, 1966

6. Ruhe CHW: Looking ahead in medical education. AHME Journal 11(1):26, 1978

7. Wechsler H, Dorsey JL, Bovey JD: A followup study of residents in internal medicine, pediatrics and obstetrics-gynecology training programs in Massachusetts. N Engl J Med 298:15, 1978

8. Lee PR: Graduate medical education, 1976: Will internal medicine meet the challenge? Ann Intern Med 85:252, 1976

9. Stern TL, Chaisson GM: The residency assistance program in family practice. J Fam Pract 5:379, 1977