Practice Preferences of Residency Graduates of the Medical University of South Carolina

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There is currently great concern within the medical profession regarding the perception that physicians are maldistributed both geographically and by specialty. Means are being sought to induce the training of fewer subspecialists and more physicians who would engage in primary care. However, more data and careful study are needed before consensus leads to major redirection in the graduate training of physicians.[1]

In 1975, a survey by Rosenberg of over 400 specialists revealed that three fifths of all those surveyed were doing some procedures outside the limits of their specialty.[2] Recently, more extensive data have shown that a large percentage of specialist physicians are indeed providing good general medical care to their patients. According to the report of a national survey of physicians by the University of Southern California, physicians in all specialties are the principal source of care to a substantial portion of their patients. Among 14 specialties for which data were analyzed, physicians who label themselves specialists indicated that from 20 to 72 percent of all patient encounters were in the principal care category, considered by the authors to imply continuity and comprehensiveness.[3]

Methods

The present study was constructed to help determine if physicians trained at the Medical University of South Carolina (MUSC) were likewise assuming health care responsibilities outside the realm of their particular area of expertise. Questionnaires were sent to 371 physicians who completed a basic residency program at the Medical University of South Carolina from 1973 through 1977. The following information was requested: the specialty in which residency was completed, whether practice was located in South Carolina or not, the percentage of time spent not practicing the specialty, and the reason for not practicing the specialty. Two hundred sixty-five questionnaires were returned; 255 (69 percent) were usable.

Results

Of the 255 physicians who returned the questionnaire, 123 (48 percent) practiced medicine in South Carolina (Table 1). Internal medicine, family practice, obstetrics-gynecology, and pediatrics were represented in addition to 21 other specialties and 10 medical subspecialties. Of the physicians surveyed, 76.5 percent reported that they did confine their medical practice to their specialty or subspecialty. Approximately 31 percent of the South Carolina respondents reported they did not confine their practice to their specialty or subspecialty as contrasted with approximately 17 percent of the out-of-state respondents. This disproportion was particularly apparent in the medical subspecialties. In South Carolina, 6 of 23 devoted all of their practice time to their subspecialty; nine of 16 out-of-state medical subspecialists were full-time in their subspecialty. Overall, the medical subspecialties had a greater percentage of physicians not confining themselves to their subspecialty (24 of 39) than the other specialties (34 of 180). The reasons given for not practicing a specialty or subspecialty were as follows: 32 due to a

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Table 1. Practice Preferences Among Specialists and Subspecialists

Respondents	Practicing Full-Time in Specialty/Subspecialty?								
	In South Carolina			Outside South Carolina			Combined		
	Yes	No	Total	Yes	No	Total	Yes	No	Total
Specialists	79 (79%)	21 (21%)	100	101 (87.1%)	15 (12.9%)	116	180 (83.3%)	36 (16.7%)	216
Medical Subspecialists	6 (26.1%)	17 (73.9%)	23	9 (56.3%)	7 (43.8%)	16	15 (38.5%)	24 (61.5%)	39
Total	85 (69.1%)	38 (30.9%)	123	110 (83.3%)	22 (16.7%)	132	195 (76.5%)	60 (23.5%)	255

variety of reasons, 7 due to a paucity of referrals, 7 due to too many specialists in the community, 13 due to inadequately established practices, and 8 others listed miscellaneous but specific reasons.

Discussion

The major finding emerging from the study is that a substantial majority (76.5 percent) of the physicians surveyed confined their medical practice to their specialty or subspecialty. On the other hand, 18.4 percent of the sample population whose practice was adequately established did not confine their medical practice to their specialty. The main cause for the dedication of practice time outside of a specialty could not be determined on the basis of the information gathered.

There is a striking difference between the propensity of the South Carolina physicians to devote practice time outside their specialty or subspecialty (30.9 percent) as contrasted with the physicians practicing out-of-state (16.7 percent). The likelihood that more MUSC-educated physicians practicing in South Carolina provide medical care outside their specialty or subspecialty than MUSC-educated out-of-state physicians is statistically significant at a .01 level of confidence. The reason for this interesting phenomenon is not apparent. Since the sample population was composed of both in-state and out-of-state physicians who were trained at the same institution, it may be assumed that this finding was not due to factors in the training of these physicians. Furthermore, there is no reason to attribute this discrepancy to simple physician preference. Other variables such as a demand for primary care, an excess of specialists, or other complex market influences must be at work.

The medical subspecialists are statistically far more likely (P=.001) to provide some type of care outside their subspecialty than the other specialists (excluding family practice and pediatrics, which are usually considered primary care). Perhaps this is because they have a background in a primary care-related discipline, as Rosenberg commented when she discovered the same trend in her national survey.[2] One or more factors in the health care delivery system in South Carolina are apparently influencing many subspecialists with previous training in basic internal medicine to provide some generalist-type care to their patients.

One must be cautious in assuming that the physicians (excluding family practice and pediatrics), who indicated that their medical practice is not confined to their specialty or subspecialty, are providing primary care to their patients. They are likely contributing to the medical care of the community in some general capacity, but not necessarily rendering principal care which, according to Aiken et al, connotes continuity and comprehensiveness.[3] A follow-up study would be interesting to document exactly what comprises the general medical care being delivered by these specialists and subspecialists and to learn what motivation lies behind this phenomenon.

References

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