

COMMENTARY

The Growth of Family Medicine Resident Debt

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The history of people and their relationships with debt is an interesting one. Although some embrace debt as necessary or even opportunistic, for many, debt represents stigma—a scarlet letter and constant reminder of something that is owed or has been left incomplete. For many, debt is something that should carry shame. I grew up harboring ideas of good debt and bad debt. My education, the one that my parents instilled in me was essential but that they could not quite pay for, was good debt. Educational debt was not something to be ashamed of, rather, it was a marker of my future earning potential. Of course, I understood that this too would have to be paid back, but educational debt was respectable, at least. After 4 years of undergraduate training and (almost) 3 years of medical school, I watched as colleagues were driven to choose their specialty based on any number of factors. Lifestyle and indebtedness were high on the list, as were availability of mentorship and prestige. As I decided on family medicine, I knew that I was making a decision that would significantly lessen my earning potential, and admittedly this made my decision more complicated. By then I was sufficiently disabused of the notion that my

debt was good or bad, but I still had a lot of it. Ultimately, I found myself making a decision that had less to do with respectability or debt, and more to do with choosing a career and a specialty that had my respect.

Family physicians play quarterback to the US health care system. We provide full-spectrum care, often to the most vulnerable patients.^{1–3} In the context of a national pandemic, we have served as a principal part of a public health delivery enterprise. There are not enough of us,^{4,5} we are underpaid,^{6,7} and suffer from burnout,^{8,9} but every day we find creative solutions to complex problems. Despite this service, Phillips et al describe a disturbing trend that can only lead to fewer of us being committed to this work. The debt of family medicine residents is rising rapidly, and perhaps more appalling, increases among those with remarkably high debt have almost doubled.¹⁰ As an osteopathic family physician who graduated with a debt load that surpassed the median, I am unsurprised. Most of my co-residents had similar debt loads and felt that the debt incurred while pursuing a family medicine career could be most effectively tackled by pursuing careers outside of academic medicine or public service. Out of nine residents, I was the only one to enter academic medicine; consistent with current trends demonstrating that family medicine residents with high levels of indebtedness are less likely to choose jobs in federally qualified health centers, a Veterans Affairs facility, or academia.¹¹

These shifts, a decrease in physicians pursuing both academic family medicine and service careers, have significant implications for an already struggling workforce. Despite the desperately needed growth in primary care physicians, the share of the physician workforce dedicated to primary care from 2005 to 2015 decreased from 44% to 37%.¹² Current projections show a deficit of 21,000 to 55,000 primary care physicians by 2032.⁴ While several national family medicine organizations have

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set a goal of graduating 25% of US medical students by 2030,⁵ fewer physicians pursuing academic careers means less mentorship for medical students; a key driver in determining specialty choice. An existing salary gap between physicians in academia and nonacademic family physicians exacerbates these challenges.^{13,14} Why should graduating students invest in a specialty that quite literally hinders their ability to invest in themselves?

While some workforce dynamics have shifted, many have worsened or remained unchanged. Physicians from backgrounds underrepresented in medicine (URiM) are more likely to practice primary care and serve the most vulnerable communities,¹⁵ but these physicians make up less than 13% of all active physicians despite comprising over 30% of the US population.^{15,16} Moreover, URiM physicians represent less than 10% of full-time academic faculty¹⁶ and are more likely to have significant educational debt,^{17,18} further complicating efforts to recruit and retain diverse students and representing an additional barrier to expanding diversity within primary care and addressing health disparities. Those who do enter academia are often disproportionately tasked with the work of achieving diversity efforts and taxed via isolation, lack of mentorship, and fewer opportunities for promotion.^{19,20} Ultimately, asking physicians from marginalized communities to continue to make choices that represent a disinvestment in their future career earnings is not a question of altruism, but rather an example of a lack of commitment to equity.

Family medicine gained my respect as a specialty with the strongest commitment to social justice. The health care of the nation has depended on this commitment, requiring family physicians to fund, through skyrocketing levels of personal debt, the delivery of quality health care to the most vulnerable populations. But as family physicians, we make these personal investments because we are committed. If primary care, and the physicians who provide this care, are truly valued resources, teaching hospitals, health care administrators, payers, and policymakers must prioritize similar investments. An equitable distribution of health care is one that prioritizes the health of everyone and distributes resources to those who need them, including primary care physicians. A commitment to social justice and equity should not be mutually exclusive from achieving adequate compensation free from disproportionately onerous liability. A commitment

to equity should not subsidize the cost of providing the nation's health care with the debt of those we have already taxed.

To see this article online, please go to: <http://jabfm.org/content/34/3/665.full>.

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