COMMENTARY

Diversifying the Federal Family Medicine Physician Workforce

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Federal family physicians include those employed by the Department of Defense's (DOD) Military Health System (MHS) and the Veterans Health Administration (VA). This network of family physicians includes active duty or reserve officers (US Army, Navy, Air Force, Coast Guard, and Public Health Service) and civilian physicians working as government employees. Family physicians have many reasons why they practice in the federal system, including service obligation, military family connection, and/or prior military service. Those serving on active duty may also be incentivized by education and housing socioeconomic programs, such as the GI Bill and VA Loan respectively. In addition, military resident physician salaries are 53% more than their civilian counterparts.[1] After residency graduation, military family physicians make between the median and 80th percentile for civilian salary, depending on their rank, when their basic allowance for housing, basic allowance for subsistence, board certification pay, and incentive pay is included.[2]

There are also unique benefits for civilian DOD and VA family physicians.[3] There is an established patient base to care for, and they do not need to build a patient panel.[3] Medical licensure in 1 state is valid in all 50 states within the MHS and VA.[3] Physicians are provided malpractice insurance that is covered under the Federal Tort Claims Act.[3] Through the Federal Employees Retirement System (FERS), a pension is offered to doctors in addition to a 401K, and those with prior military service can add those years to civilian service for retirement.[3,4] Another FERS DOD benefit is the Thrift Savings Plan account where the agency makes a bimonthly tax-deferred deposit equaling 1% of the basic pay earned per pay period.[4]

Regardless of the reason(s) for federal service, together these physicians have a shared mission to serve and care for a diverse patient population, including military service members and their families, retirees, and Veterans. In 2020, the DOD reported 16.1% of its approximately 2 million service members were Hispanic, and the racial composition of its non-Hispanic service members was 16.8% Black, 4.7% Asian, 2.5% multiracial, 1% Pacific Islander, and 1% American Indian or Alaskan Native.[5] In regards to educational achievement, 23.6% had a bachelor's or advanced degree.[5] Seventeen percent of service members were female, an increase from 15.5% in 2015.[5] Similarly, among the 9.1 million Veterans enrolled in the VA health care system in 2013, 23.5% were members of a racial and ethnic minority group.[6] Uniquely equipped to provide comprehensive care across the lifespan, including reproductive health and pediatrics, Federal family physicians lead in ensuring health equity.

According to the Association of American Medical Colleges (AAMC), 11% of US physicians are from minority groups representing 31% of the US population.[7,8] Black, Hispanic, Native Americans (American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans are groups identified as underrepresented in medicine (URM). While Jetty

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and colleagues found no difference in the overall racial composition of Federal family physicians compared with the overall sample, a pattern emerged when stratified by gender. There were more Black, Asian, and Native Hawaiian women in the federal group. While the exact reasons for this pattern are unclear, the intersections of race and gender are worth consideration. Systemic racism has disproportionately impacted some racial and ethnic groups. Jetty and colleagues also specifically highlight the economic burden of higher education as a factor in the lack of physician diversity, that is, accessibility to education and wealth gaps. Although current federal service does not always correlate to completion of military undergraduate and/or graduate medical education, military service provides a pathway to family medicine that can mitigate the economic burden.[9]

In 2021, the median 4-year cost of attendance for the class of 2022 was $263,488 and $357,868 for public and private institutions, respectively.[10] A recent exploratory survey of allopathic medical students responding to the Association of American Medical Colleges Matriculating Student Questionnaire (AAMC-MSQ) between 2017 and 2019 found an overrepresentation of the top quintiles of combined parental income across all racial and ethnic groups. Medical students from the bottom 3 quintiles were consistently underrepresented across all racial and ethnic groups.[11] Undergraduate Black (88%), Hispanic (82%), Pacific Islander (87%), and Native American (87%) students receive financial need-based Pell grants at a higher percentage than their white (74%) and Asian (66%) counterparts.[12] Furthermore, matriculating medical students from these underrepresented groups have more outstanding premedical debt.[7]

Options to finance medical education include self-financing, federal guarantee loans, Public Service Loan Forgiveness (PSLF), National Health Service Corps, Health Professional Scholarship Program (HPSP), and matriculation at the Uniformed Services University of the Health Sciences (USU).[13] Sixty-nine percent of the class of 2021 graduated with a median debt of $200,000, and educational debt seems to play a role in career choices.[9,10] Approximately 5% of matriculating students use federally funded national service scholarships.[13] Over a 30-year career, borrowers in primary care never catch up financially to those who self-finance or obtain federally funded national service scholarships.[13]

USU, "America's Medical School," is a tuition-free federal institution. While enrolled, students receive the full pay and benefits of a uniformed officer during their 4 years, approximately $70,000/annually.[14] Although there is an emphasis on military readiness and leadership, the medical school curriculum is similar to civilian academic health centers. Students complete their preclerkship education at USU's main campus located in Bethesda, MD, and then they participate in clinical experiences across national clinical campuses. The USU class of 2024 (n = 171) included 45% women, 33% from racial and ethnic minority groups (12% from URM groups), 18% first generation college students, and 61% have no prior military experience. Twenty-five percent of active-duty physicians are USU graduates. Most of the remaining active-duty physicians are HPSP recipients who attended an US accredited allopathic or osteopathic medical school. In addition to their scholarship covering full tuition for the school of their choice, HPSP students receive a stipend of approximately $28,000/annually.[14] Unfortunately, the HPSP demographics are not readily available. Both USU and HPSP students repay the nation for their education through service in the US Army, Navy, Air Force, or Public Health Service.[14]

In response to the need for a diverse military physician workforce, USU partnered with the US military services to create the first postbaccalaureate premedical program in the DOD—the Enlisted to Medical Degree Preparatory Program (EMDP2).[15] This enrichment program provides educational opportunities for enlisted service members, addresses upstream factors impacting physician workforce diversity and health equity, and serves as a pathway to medical school.[15] Since 2014, EMDP2 has matriculated 163 students who are more diverse than their USU classmates in terms of age, race, and parental socioeconomic status.[15] By fostering a more diverse USU student body, the EMDP2 creates an educational learning environment in which all students improve their cultural awareness and humility, increase their self-efficacy, and improve their educational outcomes.[15] USU graduates are thus able to provide culturally responsive health care and improve health outcomes for service members, beneficiaries, and retirees.[15]

A diverse family medicine physician workforce, reflective of the population they serve, is critical to the DOD and VA mission to provide comprehensive health care to military service members and their families, retirees, and Veterans. The VA projects the racial and ethnic composition of Veterans will change by 2045, where the proportion of non-Hispanic white

Veterans will decrease from 75% to 61%.[16] Veteran members of minority groups are projected to increase to 12–15% Black, 8–12% Hispanic, 2.1–3.9% multiple race, 0.7–1.6% Native American, and 0.3% Pacific Islander.[16] In addition, the percentage of women veterans is expected to nearly double by 2040, from 9% to approximately 17%.[17] Patient outcomes, communication, medication adherence, and patient satisfaction are improved when patients are cared for by racially concordant physicians.[18,19] Students from racial and ethnic minority groups may experience barriers to educational pathways to medicine, including the economic burden associated with higher education. Federal service including HPSP, matriculating at USU, or participating in the EMDP2 program should be considered by those seeking a career in family medicine. Furthermore, federal service may allow participation in the PSLF program.

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