COMMENTARY

The Differing Career Choice Paths of MD and DO Family Medicine Residents: A Call to Action

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Amid an alarming shortage of primary care physicians,[1] our discipline benefits from continued re-examination of the experiences of new graduates. Barr and colleagues from the American Board of Family Medicine have analyzed a national sample of first-year Family Medicine residents. They found that more of these residents selected Family Medicine during their Family Medicine clerkship than at any other time. Graduates of osteopathic schools were more likely to select Family Medicine earlier in their medical education process – before medical school, during their preclinical education, or during the clerkship. In contrast, graduates of MD-granting schools were more likely to choose Family Medicine after clerkships were completed or during the interview and match process. A relatively small proportion of both groups chose Family Medicine after the main residency match (9% of DO residents and 8% of MD residents).[2]

As Family Medicine educators, our role in shaping the future workforce is threefold:

1. To select medical school candidates who share the values of the discipline
2. To create educational experiences that encourage students to choose Family Medicine
3. To teach students and residents so they will become excellent Family Physicians

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None of these goals supplants the others. All are essential. The work of Barr and colleagues reminds us of our key role in creating these educational experiences and draws attention to the Family Medicine clerkship, as a core experience. For a large minority of medical students, the clerkship is the "moment" when they make a career decision. It is safe to assume that for those who had a strong interest in Family Medicine before the clerkship, that core curricular experience solidified and affirmed their choice.

This is not the first study to clearly demonstrate the importance of the clerkship. Many studies have demonstrated that a clerkship in primary care is associated with primary care specialty choice, and that relationship may be stronger for Family Medicine clerkships and Family Medicine career choice.[3] The uniqueness of the Barr study is their large, national sample; the assessment of first-year residents, who have made a career choice recently; and the opportunity to compare those who attended osteopathic and allopathic institutions. The results invite us to consider policy implications in a new way.

Family Medicine clerkships became widespread in the 1990s, when Family Medicine educators worked for their wide adoption. Unfortunately, research focused on clerkships has decreased since that time.[3] It is easy to overlook this fundamental innovation. For example, every year, every medical student at Michigan State University's (MSU) College of Human Medicine spends 6 weeks working with a community physician, experiencing the heart of Family Medicine in sites that span the entire state of Michigan. A similar experience happens for students in the MSU College of Osteopathic

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Medicine and for students in each of the 5 other medical schools in the state, an extraordinary cumulative educational experience that relies on the family physicians of Michigan. These physicians are almost all hardworking, busy professionals who donate their time to benefit our learners and their future patients.[4] This same experience is replicated at medical schools across the country and around the world.

When clerkship experiences are done well, students come to know the practice style of their teaching physicians intimately; they also glimpse the experiences of their patients. They see the magic of the patient-physician relationship – and that witnessing work cannot be matched by any lecture or discussion.[5] Medicine, at its heart, is still built on one-on-one, apprenticeship-style teaching. These tiny, golden moments have the power to change students' career paths.

The authors call for us to make this core educational experience core for every student – for MD-granting medical schools to make Family Medicine clerkship an educational requirement, as it is for DO-granting schools. We wholeheartedly support this call for action. The authors point out that "requiring a clerkship is not enough" – a clerkship should be a quality educational experience, which means it must be well-resourced. But a required Family Medicine clerkship will be held to high standards of excellence from the Liaison Committee on Medical Education (LCME), which has a strong reputation for rigor in all areas of the curriculum. Setting the standard is the first step.

Although the LCME mandates that students have required clinical experiences in a range of care contexts, there is no specific requirement for a clerkship in Family Medicine.[6] It is not well known how many MD-granting schools currently have Family Medicine clerkships, rather than primary care clerkships, because national survey instruments do not distinguish between the two. Research supports the value of Family Medicine specifically, and indicates that more prolonged clerkship experiences more strongly influence student choice.[3]

In contrast, the Commission on Osteopathic College Accreditation (COCA) requires a Family Medicine clerkship.[7] This requirement likely reflects broader institutional support for Family Medicine at osteopathic schools, and a broader cultural orientation toward primary care practice. It would be easy to attribute the higher Family Medicine match rates of osteopathic institutions to selection of students who have an interest in Family Medicine at the time of admission, or at the very least, an interest in whole-person care. In contrast, MD-granting schools attract more applicants with an interest in nonprimary care careers.[8]

Barr's findings suggest that this difference in students at the time of admission is a part of the reason for the relative success of osteopathic schools: more DO residents selected Family Medicine before medical school than MD residents. But the data suggest there may be more happening throughout the curricular trajectory.[2] It is possible that more MD students select Family Medicine at the end of their education because they have a pivotal late experience, but students may also conclude that they are less competitive for other specialties. In contrast, osteopathic students seem to experience an educational environment that orients toward Family Medicine more strongly, all along the way.

In addition to the COCA-required Family Medicine clerkship, COCA requires the presence of some primary care leadership, and includes a focused definition of primary care:

> *A COM may organize its medical faculty under an organizational structure of its own design, but the leadership of the COM's clinical education must include one or more actively licensed osteopathic physicians who are AOA or ABMS board certified in a primary care discipline (family medicine, internal medicine, or pediatrics) with proven experience in teaching and academic leadership in a medical education setting.*[7]

Although the leadership and faculty composition of MD-granting and osteopathic schools have not been compared in several decades, historic data suggest that osteopathic schools offer more primary care physician faculty, immerse students in more primary care educational experiences, and are more likely to encourage primary care careers.[8] Many studies have demonstrated that strong institutional support for primary care is associated with the proportion of graduates who practice primary care.[9]

Medical schools should aim to meet the physician workforce needs of the population. Our country is in a true primary care crisis. Recent estimates suggest that half of Americans live in a primary care Health Professional Shortage Area.[10] Modeling from researchers at Harvard University indicates that adding more primary care physicians to the shortage area counties would measurably increase life expectancy in those

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counties, even after controlling for other factors.[11] At a time when the value of higher education is being questioned, we must be evidence-based and responsive. A change in LCME requirements would not, by itself, fix the nation's primary care shortage – but it would be a step in the right direction. In addition, based on Barr's findings, we call all US medical schools—both MD- and DO-granting—to create an environment supportive of primary care training and to support adequately resourced Family Medicine clerkships to help increase the US primary care workforce.

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