Myths and Facts: Specialty Choice

**MYTH:** Federal legislation designating graduate medical education (GME) funding for specific specialties is the best way to address concerns about a shortage of primary care physicians.

**FACT:** Mandating specialty composition would hamper efforts to respond to local communities’ varying and emerging physician workforce needs.

While every indication is that the physician shortage will remain evenly split between primary care and subspecialties, local shortages may vary and significant changes may occur over time. Using frequently updated federal and local data, medical schools and teaching hospitals are able to adjust to the dynamic nature of a community’s health care workforce needs. Prescribing a static specialty composition or targeting increases to a singular discipline in legislation would stymie efforts to adapt to varying and evolving workforce needs. Additionally, the Medicare Payment Advisory Commission (MedPAC) has recommended using other mechanisms to address the supply and distribution of physicians, including clinical reimbursement, the National Health Service Corps (NHSC), and Title VII health professions education programs.

**MYTH:** The medical profession discourages medical students from pursuing careers in primary care.

**FACT:** Specialty choice is a very personal and complex decision that medical students make before they graduate from medical school.

Recent studies show that medical school-level factors account for only 8 percent of the variation in a student’s likelihood to choose a primary care specialty.¹ In fact, medical schools spend considerable time advising students on the specialty that aligns most closely with their interests, talents, and overall life goals, and in several cases schools have implemented programs to encourage careers in primary care.²

Clerkships during third and fourth years of medical school contribute greatly to medical students’ career choices, and in one study the most influential factors in their decisions are the type of patients they will see, the intellectual challenges of the field, and the work-life balance it affords.³ Another study found that “controllable lifestyle” increasingly is becoming a top factor influencing specialty choice after controlling for income, work hours, and duration of residency years.⁴

Thoughtful workforce analyses and proposals must recognize that family demands, the careers of spouses, and other personal lifestyle choices that have little relationship to educational programs themselves are major factors determining where and in which specialty a physician will practice. Policies cannot gauge the “success” of a medical school or a residency program on the basis of outcomes that are largely the result of the personal choices of the physicians themselves.

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² The Duke University School of Medicine officially launched the Primary Care Leadership Track in 2011 after a two-year pilot phase. The program combines community service, experience, and requires a year of community-engaged research, with a goal of preparing physicians to work with and learn from communities to improve care delivery and produce better outcomes.


MYTH: Residency training only occurs in inpatient teaching hospitals.

FACT: More than nine out of 10 (93 percent) residency programs train their residents in a non-hospital setting.

According to a survey conducted by the Accreditation Council for Graduate Medical Education (ACGME), non-hospital settings are a significant portion of a medical resident's training, regardless of what specialty they choose. For the 2012–2013 academic year, 92.8 percent of residents and 83.2 percent of subspecialty residents completed a portion of their training in ambulatory or non-hospital settings. These non-hospital settings include community health centers, private physicians’ offices, Veterans Affairs (VA) ambulatory services, ambulatory surgery centers, and hospital-based continuity clinics.⁵

MYTH: Medical school debt is the top factor influencing the career choices of medical students.

FACT: There is little to no evidence linking student debt and physician specialty choice.

While debt may factor into career choices, annual surveys of graduating medical students show the two most influential factors are a student's personal interests/skills and the content of a specialty.⁶ Work-life balance issues and role models also are at the top of the list. Student debt has ranked consistently near the bottom of factors influencing specialty choice.

A January 2013 study in Academic Medicine found that “physicians in all specialties can repay the current level of education debt without incurring more debt” and concluded that “a primary care career remains financially viable for medical school graduates with median levels of education debt.”⁷ The article illustrates the capacity of physicians to repay their education debt and shows that even “at the most extreme borrowing levels … options exist to mitigate the economic impact of education debt repayment … [including] an extended repayment term or federal loan forgiveness/repayment program, such as Income Based Repayment (IBR), Public Service Loan Forgiveness (PSLF), and National Health Service Corps (NHSC).”⁷

For more information, visit www.aamc.org.

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⁵ Accreditation Council for Graduate Medical Education Graduate Medical Education Data Resource Book 2012–2013.
⁶ Association of American Medical Colleges Medical School Graduation Questionnaire: 2013 All Schools Summary Report.