Factors Associated With Medical Students’ Career Choices Regarding Internal Medicine

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Context  Shortfalls in the US physician workforce are anticipated as the population ages and medical students’ interest in careers in internal medicine (IM) has declined (particularly general IM, the primary specialty serving older adults). The factors influencing current students’ career choices regarding IM are unclear.

Objectives  To describe medical students’ career decision making regarding IM and to identify modifiable factors related to this decision making.


Main Outcome Measures  Demographics, debt, educational experiences, and number who chose or considered IM careers were measured. Factor analysis was performed to assess influences on career chosen. Logistic regression analysis was conducted to assess independent association of variables with IM career choice.

Results  Of 1177 respondents, 274 (23.2%) planned careers in IM, including 24 (2.0%) in general IM. Only 228 (19.4%) responded that their core IM clerkship made a career in general IM seem more attractive, whereas 574 (48.8%) responded that it made a career in subspecialty IM more attractive. Three factors influenced career choice regarding IM: educational experiences in IM, the nature of patient care in IM, and lifestyle. Students were more likely to pursue careers in IM if they were male (odds ratio [OR] 1.75; 95% confidence interval [CI], 1.20-2.56), were attending a private school (OR, 1.88; 95% CI, 1.26-2.63), were favorably impressed with their educational experience in IM (OR, 4.57; 95% CI, 3.01-6.93), reported favorable feelings about caring for IM patients (OR, 8.72; 95% CI, 6.03-12.62), or reported a favorable impression of internists’ lifestyle (OR, 2.00; 95% CI, 1.39-2.87).

Conclusions  Medical students valued the teaching during IM clerkships but expressed serious reservations about IM as a career. Students who reported more favorable impressions of the patients cared for by internists, the IM practice environment, and internists’ lifestyle were more likely to pursue a career in IM.
Many of the factors that may affect students’ perceptions of IM and influence their decisions have changed in complex ways since the earlier studies. We designed this study to inform educators, practitioners, and those with a policy interest in the physician workforce. We sought to understand current students’ impressions and concerns about careers in IM and to identify potentially modifiable factors in their decision making in a national sample.

METHODS
The Clerkship Directors in Internal Medicine (CDIM) Task Force on Enhancing Student Interest in IM Careers conducted a cross-sectional study of fourth-year medical students in spring 2007 at 11 US medical schools (George Washington University, Washington, DC; New York University, New York; Uniformed Services University of the Health Sciences, Bethesda, Maryland; University of California, San Francisco; University of Chicago, Chicago, Illinois; University of Florida, Gainesville; University of Pittsburgh, Pittsburgh, Pennsylvania; University of Utah, Salt Lake City; Warren Alpert Medical School of Brown University, Providence, Rhode Island; Washington University in St Louis, St Louis, Missouri; and Yale University, New Haven, Connecticut). Five of 11 schools were selected because task force members from those schools agreed to participate in the survey; the other 6 schools were invited to achieve a range of regions, public/private status, research funding, and percentage of students matching in IM. No invited schools declined to participate, although 1 task force member withdrew before survey development was completed. At each participating school, the site investigator participated in the study as a coauthor. The survey was distributed after students submitted their residency match lists but before match day to confirm that students had finalized a specialty choice and minimize bias based on students’ satisfaction with their match results.

Through a series of conference calls and in-person meetings, 7 members of the CDIM Task Force representing 7 different institutions developed and revised the survey items. Items on perceptions of IM and factors influencing career choice were identified from a comprehensive literature review and a 1990 survey of medical students. Researchers conducted 7 focus groups at 7 participating schools with 43 students to elicit current issues influencing their career choices. The CDIM Task Force revised the survey items after reviewing transcripts from student focus groups. Prior to distribution, the final survey was pilot-tested for clarity and completeness by CDIM Task Force members.

The survey (eAppendix, available at http://www.jama.com) included 24 questions about demographics, debt, experiences on the core IM clerkship and subinternship (type of hospital, presence of inpatient/outpatient experience, grades), IM interest group participation, and specialties chosen or considered. Demographic questions included race and ethnicity because studies have suggested an association between these characteristics and career decision making. Students self-reported this information using options defined by the investigators on the survey. Twenty-four questions addressed students’ perceptions of IM compared with other specialties they had chosen or considered (1=very much pushed me away from IM, 2=somewhat less in IM, 3=same, 4=somewhat more in IM, 5=very much more in IM, 6=don’t know/no opinion). Thirty-two questions asked students to rate items that influenced their career decisions regarding IM (1=very much pushed me away from IM, 2=somewhat pushed me away, 3=no influence, 4=somewhat attracted me toward, 5=very much attracted me toward IM). The primary outcome was student career choice, selected from a list of 46 specialties as defined by the NRMP.

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The survey was distributed through an online survey software system. Each site investigator obtained students’ email addresses from the school’s Office of Curricular/Student Affairs. Students were invited to participate via email. Nonresponders were sent up to 5 follow-up emails. Participants received a $15 online gift certificate as an incentive. Because of Department of Defense policy, Uniformed Services University did not offer incentives. A cover information sheet served as waiver of institutional review board approval of the study. Each participating school’s institutional review board approved the study.

Data Analysis
Descriptive statistics were calculated for all participants; continuously scaled variables were normally distributed. Internal medicine career choice was defined as IM, general IM, or any combination of IM and another specialty recognized as IM by the American Board of Internal Medicine (IM with dermatology, emergency medicine, family medicine, medical genetics, neurology, pediatrics, or psychiatry). Results were similar when we excluded the 27 students who had reported combined IM specialties, and we thus report analyses with the broader definition. Students choosing other specialties were grouped into 4 specialty groups: family medicine, pediatrics, surgical (general surgery, neurosurgery, obstetrics/gynecology, ophthalmology, orthopedics, otolaryngology, plastic surgery, urology), and other. χ² Analyses were used to compare the specialties across demographic characteristics.

Factor Analysis
We conducted principal components analysis with varimax rotation to determine the underlying latent clusters within the 24 items about perceptions of IM and within the 32 items about influences on career choice. Factors were retained based on Eigenvalues greater than 1. Items were assigned to factors based on their largest loading; simple structure was obtained using factor loadings greater than 0.35 for this assignment. Four of us (K.E.H., S.J.D., P.S.O., M.D.S.) reviewed the factors derived for interpretability and labeled the underlying constructs. We calculated the Cronbach α coefficient for each factor to determine its scale reliability and determined a mean score for each factor. To aid interpretation, perceptions and influences factor scores were dichotomized at the midpoint on a 5-point scale (below 3.0 vs 3.0 or greater) and reported as proportions as well as means.

We calculated the effect sizes for perceptions and influences factors to show the practical significance of the magnitude of differences in means between students choosing IM and those not choosing IM. Unlike statistical significance, which is influenced by our large sample size, effect size is independent of the sample size. We used the Cohen d statistic, which is the ratio of the difference between the 2 means to the pooled standard deviation. An effect size at or exceeding 0.8 is considered a large effect, suggesting practical importance. Among the students not choosing IM, we compared those reporting they had seriously considered IM (general IM, subspecialty IM, hospitalist medicine) with those who had not, using t tests for the perceptions and influences factors.

A 1-way analysis of variance was done to compare the 5 specialty groups for each of the 5 perceptions and 3 influences factors. Significant omnibus F tests were followed by Scheffé post hoc tests with the significance set at .05. The Scheffé tests were chosen to address the uneven number of respondents in each group. Additionally, the analysis calculated a partial ω², which is an effect-size estimate for analysis of variance and approximates the percentage of variance in the dependent variable accounted for by the differences in responses according to specialty groups.

Logistic Regression
We conducted a logistic regression analysis to determine the association of demographic items and the influences variables derived from the factor analysis on IM career choice. The perceptions factors were not included in the logistic regression because these factor constructs overlapped significantly with the influences factors and because students reported their perceptions relative to other specialties they had individually considered, not relative to an absolute standard. Demographic predictors were screened first for model selection by comparing students who chose IM vs those who did not, using χ² tests for categorical predictors and t tests for continuously scaled variables. To adjust for the nested structure of the data, 2 exploratory data analyses were conducted: the generalized estimating equation technique and the logistic regression model with the site variable included. There were no systematic differences across the 11 schools. Given the lack of variability across sites and the limitations of the small cluster size, a public/private school variable was chosen as the optimal model to control for potential school-level variability.

A first logistic regression model included the dependent variable of IM career choice and the independent demographic variables that in the literature have been associated with career choice: school type (public/private), age, sex, ethnicity (underrepresented minority or not), marital status, children, having had an ambulatory IM clinical experience, satisfaction with the core IM clerkship, attendance at an IM interest group event, additional degrees on medical school graduation, debt (dichotomized at greater than $120,000 based on average total educational debt reported on the 2007 Association of American Medical Colleges [AAMC] Graduation Questionnaire), and receiving honors or an A grade in the core IM clerkship. In a second logistic regression model, the 3 influences factors were added to expand the ability to explain career choices. We examined the interaction effect of key variables on the dependent variable (IM career choice). Only 1 interaction term was
marginaly significant, and we decided not to include it in the second model given the disproportionate distribution of the independent variable. We considered the logistic odds ratios significant at \( P < .01 \) to reduce the likelihood of type 1 error resulting from the numerous predictor variables considered in the logistic regression. We used SPSS statistical software version 16 (SPSS Inc, Chicago, Illinois) for all data analyses.

**RESULTS**

The survey response rate was 1177 of 1439 (82%) and ranged from 67% (113/169) to 91% (83/91) at each school. Characteristics of participants are shown in Table 1. Participants had a mean (SD) age of 27.7 (3.2) years, with 79.0% aged 24 to 29 years, and 48.4% were male. These results are comparable with all US medical students completing the AAMC Graduation Questionnaire in 2007, among whom 82.9% were aged 24 to 29 years and 49.6% were male.28

Overall, 274 students (23.2%) reported they were most likely to enter careers in IM, including 24 (2.0% of the total sample) in general IM and 27 (2.3% of the total sample) in IM combined programs, most commonly medicine-pediatrics. The next most commonly selected specialties were surgical subspecialties (orthopedics, otolaryngology, ophthalmology, pathology, neurology, radiation oncology, radiology/diagnostic, and internship only (transitional, preliminary medicine, preliminary surgery)).

### Table 1. Characteristics of 1177 Fourth-Year Medical Students at 11 Medical Schools by Intended Specialty

<table>
<thead>
<tr>
<th>IM (n = 274)</th>
<th>Family Medicine (n = 58)</th>
<th>Pediatrics (n = 138)</th>
<th>Surgical Fields (n = 294)</th>
<th>Other Specialties (n = 413)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD), y</td>
<td>27.9 (3.6)</td>
<td>28.9 (3.8)</td>
<td>27.3 (2.4)</td>
<td>27.4 (2.7)</td>
<td>27.5 (3.3)</td>
</tr>
<tr>
<td>Male</td>
<td>135 (49)</td>
<td>19 (33)</td>
<td>34 (25)</td>
<td>164 (56)</td>
<td>218 (53)</td>
</tr>
<tr>
<td>Underrepresented minority</td>
<td>24 (9)</td>
<td>10 (18)</td>
<td>14 (11)</td>
<td>38 (14)</td>
<td>44 (11)</td>
</tr>
<tr>
<td>Married</td>
<td>96 (35)</td>
<td>30 (52)</td>
<td>53 (39)</td>
<td>91 (33)</td>
<td>139 (34)</td>
</tr>
<tr>
<td>MD degree is only graduate degree on graduation</td>
<td>217 (79)</td>
<td>44 (76)</td>
<td>110 (80)</td>
<td>237 (81)</td>
<td>347 (84)</td>
</tr>
<tr>
<td>No children</td>
<td>246 (90)</td>
<td>123 (89)</td>
<td>45 (78)</td>
<td>258 (88)</td>
<td>356 (86)</td>
</tr>
</tbody>
</table>

**Student Characteristics**

| Private school | 169 (62) | 18 (31) | 80 (58) | 165 (56) | 204 (49) | <.001 |
|Received honors, A grade, or equivalent highest grade in IM clerkship | 150 (55) | 15 (26) | 51 (37) | 147 (50) | 174 (42) | <.001 |

**School Characteristics and Experiences**

| Ambulatory IM part of the core IM clerkship | 175 (68) | 35 (70) | 87 (66) | 173 (63) | 266 (68) | .62 |
| Had an outpatient IM clinical clerkship or preceptorship | 257 (94) | 50 (86) | 131 (95) | 276 (94) | 393 (95) | .11 |
| Satisfied with core IM clerkship | 237 (86) | 47 (81) | 108 (78) | 225 (77) | 305 (74) | .003 |
| Attendance at 1 or more IM interest group events | 125 (46) | 15 (26) | 40 (29) | 72 (25) | 118 (29) | <.001 |

| Medical school experience provided me with enough insight into what an internist does to make an informed decision | 209 (76) | 40 (69) | 110 (80) | 231 (79) | 330 (80) | .46 |
|Debt more than $120,000 | 111 (41) | 25 (43) | 64 (46) | 125 (43) | 196 (47) | .42 |

| Timing of career choice | Prior to core clerkship year | 33 (12) | 34 (25) | 11 (19) | 65 (20) | 65 (17) | <.001 |
|During core clerkship year | 129 (47) | 70 (51) | 21 (36) | 170 (53) | 167 (44) |
|After core clerkship year | 112 (41) | 34 (25) | 26 (45) | 84 (26) | 150 (30) |

*Abbreviation: IM, internal medicine.
*Included categorical or general IM or IM combined with dermatology, emergency medicine, family medicine, medical genetics, neurology, pediatrics, or psychiatry.
*Included general surgery, neurosurgery, obstetrics/gynecology, ophthalmology, orthopedics, otolaryngology, plastic surgery, and urology.
*Included anesthesiology, dermatology, emergency medicine, neurology, pathology, preventive medicine, physical medicine and rehabilitation, psychiatry/neurology, radiation oncology, radiology/diagnostic, and internship only (transitional, preliminary medicine, preliminary surgery).
*Represents statistical significance based on \( \chi^2 \) test for proportional distribution.
*Self-identified as African American or Native American race or Hispanic/Latino ethnicity.
tic surgery, urology (13.8%), pediatrics (11.7%), emergency medicine (7.0%), anesthesiology (6.4%), general surgery (4.9%), family medicine (4.9%), and obstetrics/gynecology (4.2%). These percentages are similar to NRMP match data for US students in 2007, which show 22.3% in IM or IM combined fields; 6.6% in surgical subspecialties, excluding ophthalmology, which has a separate match; 12.5% in pediatrics; 7.2% in emergency medicine; 5.8% in general surgery; 7.7% in family medicine; and 5.9% in obstetrics/gynecology. Median debt category was $100,001 to $110,000 (interquartile range from $100,001-$200,000 category to $160,001-$170,000).

The majority of respondents (78.3%) agreed or strongly agreed with the statement “I was satisfied with my core IM clerkship.” Only 228 of all respondents (19.4%) felt that their core IM clerkship...

Table 2. Factor Analysis of Perceptions of Internal Medicine Careers Compared With Other Specialties Chosen or Considered Among Fourth-Year Medical Students

<table>
<thead>
<tr>
<th>Factor and Corresponding Survey Items (Cronbach α Coefficient)</th>
<th>Students Choosing IM</th>
<th>Family Medicine</th>
<th>Pediatrics</th>
<th>Surgical Fields</th>
<th>Other Specialties</th>
<th>Effect Size</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual challenge (.63)</td>
<td>No. 266</td>
<td>50</td>
<td>131</td>
<td>261</td>
<td>376</td>
<td>818</td>
<td></td>
</tr>
<tr>
<td>Mean 4.19&lt;sup&gt;d&lt;/sup&gt;</td>
<td>3.28</td>
<td>3.34</td>
<td>3.48</td>
<td>3.36</td>
<td>0.27</td>
<td>.399</td>
<td>1.19</td>
</tr>
<tr>
<td>95% CI 4.12-4.26</td>
<td>3.14-3.42</td>
<td>3.25-3.42</td>
<td>3.41-3.55</td>
<td>3.30-3.43</td>
<td>.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Commitment to patient care (.61)</td>
<td>No. 258</td>
<td>52</td>
<td>123</td>
<td>245</td>
<td>353</td>
<td>773</td>
<td></td>
</tr>
<tr>
<td>Mean 3.67&lt;sup&gt;d&lt;/sup&gt;</td>
<td>3.00&lt;sup&gt;g&lt;/sup&gt;</td>
<td>2.88&lt;sup&gt;f&lt;/sup&gt;</td>
<td>3.18&lt;sup&gt;h&lt;/sup&gt;</td>
<td>3.31&lt;sup&gt;h&lt;/sup&gt;</td>
<td>0.18</td>
<td>.318</td>
<td>0.80</td>
</tr>
<tr>
<td>95% CI 3.61-3.72</td>
<td>3.13-3.13</td>
<td>2.82-2.95</td>
<td>3.12-3.24</td>
<td>3.24-3.38</td>
<td>.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Prestige of IM (.62)</td>
<td>No. 228</td>
<td>46</td>
<td>113</td>
<td>218</td>
<td>332</td>
<td>709</td>
<td></td>
</tr>
<tr>
<td>Mean 3.04</td>
<td>2.92</td>
<td>2.93</td>
<td>2.96</td>
<td>3.04</td>
<td>0.02</td>
<td>.004</td>
<td>0.14</td>
</tr>
<tr>
<td>95% CI 3.00-3.09</td>
<td>2.84-3.00</td>
<td>2.88-2.98</td>
<td>2.91-3.02</td>
<td>3.00-3.09</td>
<td>.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Role models (.72)</td>
<td>No. 247</td>
<td>49</td>
<td>127</td>
<td>256</td>
<td>362</td>
<td>794</td>
<td></td>
</tr>
<tr>
<td>Mean 3.46&lt;sup&gt;d&lt;/sup&gt;</td>
<td>2.58&lt;sup&gt;h&lt;/sup&gt;</td>
<td>2.54&lt;sup&gt;h&lt;/sup&gt;</td>
<td>2.80&lt;sup&gt;i&lt;/sup&gt;</td>
<td>2.63&lt;sup&gt;k&lt;/sup&gt;</td>
<td>0.23</td>
<td>.267</td>
<td>1.10</td>
</tr>
<tr>
<td>95% CI 3.37-3.54</td>
<td>2.39-2.76</td>
<td>2.44-2.65</td>
<td>2.72-2.87</td>
<td>2.57-2.69</td>
<td>.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Personal/professional satisfaction (.89)</td>
<td>No. 222</td>
<td>48</td>
<td>113</td>
<td>240</td>
<td>322</td>
<td>723</td>
<td></td>
</tr>
<tr>
<td>Mean 2.79&lt;sup&gt;n&lt;/sup&gt;</td>
<td>2.73&lt;sup&gt;h&lt;/sup&gt;</td>
<td>2.63&lt;sup&gt;k&lt;/sup&gt;</td>
<td>2.49&lt;sup&gt;n&lt;/sup&gt;</td>
<td>2.62&lt;sup&gt;k&lt;/sup&gt;</td>
<td>0.10</td>
<td>.259</td>
<td>0.61</td>
</tr>
<tr>
<td>95% CI 2.75-2.82</td>
<td>2.66-2.79</td>
<td>2.59-2.68</td>
<td>2.45-2.53</td>
<td>2.58-2.66</td>
<td>.001</td>
<td>.001</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; IM, internal medicine.

*Scale for responses: 1 = this issue is much less in IM than other specialties, 2 = somewhat less in IM, 3 = the same in IM, 4 = somewhat more in IM, and 5 = much more in IM.

Excludes students selecting 6 = don’t know/no opinion for each item.

<sup>a</sup>Includes intellectual challenge in IM, breadth of knowledge needed by an internist, and opportunities to do research in IM.

<sup>b</sup>Differed significantly from the 4 other specialty groups based on post hoc Scheffe tests.

<sup>c</sup>Includes interns’ ability to have meaningful relationships with patients, interns’ ability to spend enough time with his/her patients, time an internist spends thinking about patients outside of work, and opportunities to feel competent in what I do in IM.

<sup>d</sup>Differed significantly from the IM, surgical fields, and other specialty groups based on post hoc Scheffe tests.

<sup>e</sup>Differed significantly from the IM, family medicine, and pediatrics specialty groups based on post hoc Scheffe tests.

<sup>f</sup>Includes income potential in IM, paperwork in IM, prestige of IM at my medical school, ease of getting into an IM residency, and time an internist spends on reimbursement and insurance issues. (The item income potential in IM and prestige of IM at my medical school were reverse scored.)

<sup>g</sup>Includes enthusiasm internists have shown for mentoring medical students, the effort IM residents and attending invested in recruiting me to IM, level of satisfaction among IM residents, and satisfaction among practicing internists/attendings.

<sup>h</sup>Differed significantly from the IM and surgical fields specialty groups based on post hoc Scheffe tests.

<sup>i</sup>Differed significantly from the IM, family medicine, and pediatrics specialty groups based on post hoc Scheffe tests.

<sup>j</sup>Includes income potential in IM, paperwork in IM, prestige of IM at my medical school, ease of getting into an IM residency, and time an internist spends on reimbursement and insurance issues.

<sup>k</sup>Differed significantly from the IM, surgical fields, and other specialty groups based on post hoc Scheffe tests.

<sup>l</sup>Differed significantly from the IM and surgical fields specialty groups based on post hoc Scheffe tests.

<sup>m</sup>Includes income potential in IM, paperwork in IM, prestige of IM at my medical school, ease of getting into an IM residency, and time an internist spends on reimbursement and insurance issues.

<sup>n</sup>Differed significantly from the IM, family medicine, and pediatrics specialty groups based on post hoc Scheffe tests.

<sup>o</sup>Includes income potential in IM, paperwork in IM, prestige of IM at my medical school, ease of getting into an IM residency, and time an internist spends on reimbursement and insurance issues.

<sup>p</sup>Includes income potential in IM, paperwork in IM, prestige of IM at my medical school, ease of getting into an IM residency, and time an internist spends on reimbursement and insurance issues.

<sup>q</sup>Differed significantly from the IM, surgical fields, and other specialty groups based on post hoc Scheffe tests.

<sup>r</sup>Differed significantly from the IM, family medicine, and pediatrics specialty groups based on post hoc Scheffe tests.

<sup>s</sup>Differed significantly from the IM, surgical fields, and other specialty groups based on post hoc Scheffe tests.
ship made a career in general IM seem more attractive, whereas 574 (48.8%) felt it made a career in subspecialty IM more attractive. Of those who had had an outpatient IM clerkship or preceptorship, 365 (33.0%) felt it made a career in outpatient general IM seem less attractive, but a similar proportion (346, 32.1%) felt it made such a career seem more attractive. Most students (1020, 78.2%) agreed or strongly agreed that their medical school experience provided them enough insight into what an internist does to make an informed decision about IM as a career.

Comparisons across the 5 specialty groups revealed that students choosing family medicine were slightly older and more likely to be married, and family medicine and pediatrics had a higher proportion of women (Table 1). Students choosing IM were more likely to be attending a private school, report receiving an honors grade in their IM clerkship, report high satisfaction with the IM clerkship, and have attended at least 1 IM interest group event.

Perceptions of IM Training and Careers

Compared with other specialties, they had chosen or considered, students perceived IM as requiring more paperwork (800, 68.0% of respondents), requiring a greater breadth of knowledge (731, 62.1%), and having a lower income potential (760, 64.6%). Many also perceived that the IM residency selection process was less competitive (680, 57.8%) and that IM residents were less satisfied (602, 51.1%) than residents in other specialties.

Career Choice Influences

The items most frequently cited as somewhat or very much pushing students away from IM careers were paperwork and charting in IM (748, 63.6%), attractiveness of other (non-IM) specialties (575, 48.8%), types of patients an internist sees (534, 45.4%), and the need to bring work home as an internist (497, 42.2%), and the appeal of being a primary care physician (486, 41.3%). The item on debt, “the loans I have to repay,” pushed 26.1% of students (307) away from the field.

The perception factor scores were somewhat or very much pushing students away from IM careers were the intellectual challenge of IM (770, 65.4% of all respondents), teaching on the IM rotation (748, 63.6%), the continuity of care in IM (703, 59.7%), the competence of IM residents (670, 56.9%), and the responsibility for patient care during the core IM clerkship and subinternship (660, 56.1%). Conversely, the items most frequently cited as somewhat or very much pushing students away from other fields reported similar perceptions of the prestige of IM compared with other fields they had considered. However, even students choosing IM felt that personal/professional satisfaction was greater in other fields they had considered, as reflected by the mean score of less than 3.0 (Table 2). The large effect sizes for perceptions of intellectual challenge, commitment to patient care, and role models for those choosing IM suggest the practical importance of these factors.

Factor Analysis

Perceptions. Principal components analysis of the perceptions items yielded 5 underlying factors that explained 58.4% of the variance in responses (Table 2). Cronbach α for the scales ranged from .61 to .89. As shown by mean scores and effect sizes in Table 2 and in dichotomized factor scores (percentage above 3.0) in Figure 1, students choosing IM were more likely to report that intellectual challenge, commitment to patient care, role models, and personal/professional satisfaction were more favorable in IM than all students choosing other specialties. Students choosing IM and those choosing other fields reported similar perceptions of the prestige of IM compared with other fields they had considered. However, even students choosing IM felt that personal/professional satisfaction was greater in other fields they had considered, as reflected by the mean score of less than 3.0 (Table 2). The large effect sizes for perceptions of intellectual challenge, commitment to patient care, and role models for those choosing IM suggest the practical importance of these factors.

The perception factor scores were also compared across all 5 specialty groups. Students choosing IM were significantly more likely than the other 4 specialty groups to report that intellectual challenge, commitment to patient care, and role models were more favorable in IM than other specialties considered. Prestige of IM was not significantly different across the 5 groups. Students choosing IM and family medicine felt more favor-
ably about personal/professional satisfaction in IM than students choosing surgery, but even the students choosing IM and family medicine felt that personal/professional satisfaction was greater in other fields they had considered than in IM.

**Influences.** Principal components analysis of the influences items yielded 5 underlying factors; 2 were dropped due to low reliability. The remaining 3 factors (Table 3) accounted for 46.1% of the variance in responses. Cronbach α for the scales ranged from .79 to .80. As shown by mean scores and effect sizes in Table 3 and in dichotomized factor scores (percentage above 3.0) in Figure 2, students choosing IM were more likely to be attracted to IM by the educational experience, nature of patient care, and lifestyle factors than students choosing other specialties. The large effect sizes for educational experiences and nature of patient care suggest the practical importance of these factors.

The influence factor scores were also compared across all 5 specialty groups. Students choosing IM were significantly more likely than the other 4 specialty groups to report that their educational experiences attracted them toward IM. The nature of patient care was a stronger influence attracting students toward IM among those choosing IM compared with the other 4 specialty groups. Those choosing IM and surgical fields were significantly more likely to report that the lifestyle in IM attracted them toward the field than students entering the other specialties. Students choosing family medicine and pediatrics scored the lifestyle in IM as more favorable than students choosing the remaining specialties grouped as “other.”

Among students not choosing IM, 399 (44.2%) had seriously considered it and 504 (55.8%) had not. Comparing students who had considered IM vs those who had not, those who had considered IM perceived that personal/professional satisfaction (mean score, 2.62 vs 2.56; 95% confidence interval [CI] for difference in means, 0.01-0.11; effect size, 0.19) and role models (2.73 vs 2.61; 95% CI, 0.04-0.21; effect size, 0.10) were not as unfavorable in IM than other fields they had chosen or considered. However, the effect sizes were small, and both groups felt that these factors were more favorable in other fields, reflected by the mean factor scores of less than 3.0. When asked about influences on their career choice, those who had considered IM were more likely to report that their educational experiences (3.50 vs 3.21; 95% CI for difference in means, 0.22-0.36; effect size, 0.54) and nature of patient care (2.84 vs 2.66; 95% CI, 0.10-0.25; effect size, 0.32) in IM had attracted them toward the field. Educational experiences attracted both groups toward IM, reflected by the mean score greater than 3.0, and the nature of patient care pushed both groups away from the field. The effect size was mod-

### Table 3. Factor Analysis of Influences on Fourth-Year Medical Students’ Career Choice Regarding Internal Medicine

<table>
<thead>
<tr>
<th>Factor and Corresponding Survey Items</th>
<th>Students Choosing IM (n = 274)</th>
<th>Family Medicine (n = 58)</th>
<th>Pediatrics (n = 138)</th>
<th>Surgical Fields (n = 293)</th>
<th>Other Specialties (n = 413)</th>
<th>Effect Size</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational experiences (.80)b</td>
<td>3.94±4.00</td>
<td>3.29±3.54</td>
<td>3.22±3.41</td>
<td>3.23±3.36</td>
<td>3.31±4.11</td>
<td>0.19</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>3.88±3.64</td>
<td>3.09±3.39</td>
<td>2.57±2.72</td>
<td>2.56±2.69</td>
<td>2.73±2.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nature of patient care (.79)f</td>
<td>3.57±1.64</td>
<td>2.65±1.64</td>
<td>2.62±1.64</td>
<td>2.78±1.64</td>
<td>0.31</td>
<td>&lt;.001</td>
<td>1.24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.70±2.78</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle (.80)c</td>
<td>3.14±1.64</td>
<td>2.86±1.64</td>
<td>2.96±1.64</td>
<td>3.16±1.64</td>
<td>2.60±1.64</td>
<td>0.21</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.82±2.86</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; IM, internal medicine.

bScale for responses: 1 = very much pushed me away from IM, 2 = somewhat pushed me away, 3 = no influence, 4 = somewhat attracted me toward, and 5 = very much attracted me toward IM.

cOne person did not answer this part of the questionnaire.

P Value calculated from a t test comparing the means of the 2 groups, students choosing IM vs students not choosing IM.

Includes teaching on the IM rotation, competence of the IM residents I worked with, responsibility for patient care I had in my IM core clerkship and subinternship, status of IM at my medical school, efforts internists made to recruit me to IM, intellectual challenge of IM, and opportunities to feel competent in what I do as an internist.

Differed significantly from the 4 other specialty groups based on post hoc Scheffé tests.

Includes my feelings about taking care of chronically ill patients; my feelings about treating terminally ill, dying patients; my feelings about taking care of elderly patients; types of patients an internist sees; my feelings about treating alcoholic and drug-abusing patients; appeal of being a primary care physician; and continuity of care in IM.

Differed significantly from the IM, pediatrics, surgical fields, and other specialty groups based on post hoc Scheffé tests.

Differed significantly from the IM and family medicine specialty groups based on post hoc Scheffé tests.

Includes time and workload demands of an IM career, time away from work I would have as an internist, time and workload demands of IM residency, how internists role model a satisfying family life, and length of IM residency and fellowship.

Differed significantly from the family medicine, pediatrics, and other specialty groups based on post hoc Scheffé tests.

Differed significantly from the IM, surgical fields, and other specialty groups based on post hoc Scheffé tests.
erate for educational experiences and small for the nature of patient care.

**Logistic Regression**

Results of logistic regression analyses are shown in Table 4. Significant predictors were reported in the final model with a P value < .01. In the model with only demographic variables, private school (odds ratio [OR], 1.72; 95% CI, 1.25-2.36), satisfaction with IM clerkship (OR, 2.06; 95% CI, 1.36-3.11), and attendance in IM interest group events (OR, 2.49; 95% CI, 1.84-3.35) were all significantly associated with IM career choice. In the model with influences factors, male sex (OR, 1.75; 95% CI, 1.20-2.56), private school (OR, 1.88; 95% CI, 1.26-2.83), and all 3 influences factors (favorable impressions of their educational experiences in IM [OR, 4.57; 95% CI, 3.01-6.93], favorable feelings about caring for IM patients [OR, 8.72; 95% CI, 6.03-12.62], favorable impressions of internists' lifestyle [OR, 2.00; 95% CI, 1.39-2.87]) were significantly associated with IM career choice. These findings indicate that, for example, a 1-unit shift higher on the Likert scale on the nature of patient care factor (showing that students indicated more favorable feelings about caring for IM patients) is associated with 9-fold greater odds of being attracted toward an IM career.

**COMMENT**

The United States is confronting a potential crisis in health care for older adults, with projected increases in the aging population and declines in IM specialty choice, the primary specialty treating complex elderly patients. Recognizing that studies addressing specialties that treat older adults have broad implications for US health care, we surveyed graduating students and found that they were satisfied with their IM educational experiences but reported serious reservations about the quality of life and rewards of IM compared with other specialties. Unfortunately, students were discouraged by the challenges of caring for the types of patients in IM.

Students were dissuaded from IM by their experiences with elderly and chronically ill patients. Other studies have shown that students' attitudes about caring for elderly and chronically ill patients decline during training.5,29 The high OR we found for the nature of patient care in IM suggests that educational efforts to enhance students' experiences with such patients could motivate more career interest in IM. However, paradoxically, almost two-thirds of our participants identified continuity of care as an attractive feature of IM, suggesting that they desire meaningful patient relationships but not the burden of responsibility for IM patients in the current practice environment.30 Simply providing more exposure to IM patients may worsen attitudes, and consensus is lacking about optimal curricular methods of teaching chronic illness care.31 Curricula and faculty development are needed that empower students to coordinate the complex care of patients with multiple chronic diseases. Such educational innovations might counteract the decline in students' attitudes toward these challenging patients.

Male students were more likely to pursue IM, but other student characteristics were not associated with choosing IM. Others have found that being female, being married, and having children were associated with choosing IM.14,18,32 In our study, the positive relationship between male sex and IM career choice was revealed after controlling for differences in the attraction to the nature of patient care in choosing IM, and earlier studies may not have adequately considered mediating variables. The most salient demographic factor for our participants may be their generation. Current students comprise the Generation X and Millennium groups, and characteristics attributed to these groups have included less emphasis on devotion to work and more on personal satisfaction and fulfillment outside of work.33 Few students planned careers in general IM and the influence of an ambulatory IM experience during medical school was mixed. In contrast, earlier studies supported an ambulatory general IM experience as a powerful curricular mechanism to attract students to the field.34 More recently, frustrations in the practice environment have led general internists to bemoan the field, and in some cases, to leave it.35 For residents, exposure to hectic primary...
Table 4. Predictors of Choosing Internal Medicine as a Career Among 1177 Fourth-Year Medical Students Based on Demographics and Influence Factors

<table>
<thead>
<tr>
<th>Variable*</th>
<th>Model With Demographic Variables Only</th>
<th>Model With Demographic Variables and Influence Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (CI)</td>
<td>P Value</td>
</tr>
<tr>
<td>Private school</td>
<td>1.72 (1.25-2.36)</td>
<td>.001</td>
</tr>
<tr>
<td>Underrepresented minority</td>
<td>0.72 (0.44-1.17)</td>
<td>.18</td>
</tr>
<tr>
<td>Married</td>
<td>1.13 (0.81-1.58)</td>
<td>.47</td>
</tr>
<tr>
<td>No children</td>
<td>1.71 (0.98-3.00)</td>
<td>.06</td>
</tr>
<tr>
<td>Received honors or A grade in core IM clerkship</td>
<td>0.77 (0.57-1.04)</td>
<td>.09</td>
</tr>
<tr>
<td>Satisfied with core IM clerkship</td>
<td>2.06 (1.36-3.11)</td>
<td>.001</td>
</tr>
<tr>
<td>Attendance at 1 or more IM interest group events</td>
<td>2.49 (1.84-3.35)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>MD degree only graduate degree on graduation</td>
<td>0.97 (0.66-1.42)</td>
<td>.87</td>
</tr>
<tr>
<td>Debt more than $120 000</td>
<td>0.88 (0.65-1.17)</td>
<td>.37</td>
</tr>
<tr>
<td>Male</td>
<td>1.00 (0.75-1.34)</td>
<td>.99</td>
</tr>
<tr>
<td>Had outpatient IM clerkship/preceptorship during medical school</td>
<td>1.53 (0.82-2.85)</td>
<td>.18</td>
</tr>
<tr>
<td>Age</td>
<td>1.06 (1.00-1.11)</td>
<td>.04</td>
</tr>
<tr>
<td>Influence</td>
<td>4.57 (3.01-6.93)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Educational experiences</td>
<td>2.00 (1.39-2.87)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; IM, internal medicine; OR, odds ratio.

*All variables were dichotomized except for age and 3 influence factor variables.

*Self-identified as African American or Native American race or Hispanic/Latino ethnicity.

*Odds ratio for age corresponds to change in 1 y.

*Odds ratios for 3 influence factors correspond to change in 1 unit on a 5-point Likert scale.

Lifestyle was predictive of IM career choice in our study, but with a smaller effect size than the nature of patient care or educational experiences factors. Our measures suggest that students believe that internists and IM residents face expectations to work intensively. Duty hours restrictions for residents have compressed residents' workload into fewer hours, requiring them to work at a hectic pace.45 In a recent study, IM clerkship directors asked to identify the factors influencing their students' career choices regarding IM identified the practice environment as the most important disincentive to choosing IM.46 Similarly, in our study, students perceived paperwork and charting as well as reimbursement and insurance requirements as greater in IM than other fields. Lifestyle is a prominent driver of career choice,22 and the fact that more than 40% of our participants selected specialties with controllable lifestyles suggests that lifestyle may be a stronger factor in attracting students toward other fields than away from IM.

Other findings from this study also suggest that students may be more turned on by other specialties than turned off by IM, somewhat in contrast to prior literature.18 Our participants’ attitudes toward the intellectual tradition of IM and continuity with patients were positive. To rebuild and sustain the US generalist physician workforce, improving students’ experience of IM in medical school may no longer be sufficient. Although the IM clerkship is consistently rated highly by graduating medical students nationally,28 our participants reported that role modeling by internists, as manifested by encouraging students to choose the field and job satisfaction, was less favorable than role modeling in other specialties they considered, as shown in Table 2. Current students recognize the increasing demands on internists, particularly primary care physicians, to accomplish large numbers of preventive and therapeutic interventions during short visits with chronically ill patients while also managing increasing...
administrative expectations. Internal medicine, along with family medicine and surgery, was identified as a specialty students were most likely not to choose based on “bad-mouthing” of the discipline by physicians and other students. This study has limitations. We did not survey all US medical students, although we had a large sample size and high response rate from a diverse sample of medical schools with similar demographics and a similar proportion of specialty choices compared with all US medical students. Because we did not study students longitudinally, recall bias may have influenced responses regarding specialties previously considered but not chosen, and we cannot determine whether students will change their specialties later or sub specialize within IM. Data were based on self-report, and we did not correlate students’ stated specialty preferences with match results. Although students reported feeling adequately informed about IM careers, we cannot determine the accuracy of their knowledge of the field. Our findings represent associations with selection of IM as a career choice and may not be causal.

Our large sample of US medical students expressed reservations about careers in IM because of patient complexity, the practice environment, and the lifestyle compared with other specialties. Students’ career choices regarding IM result from the interplay of lifestyle, personal and professional satisfaction, and the challenges of caring for the chronically ill in a health care system that still focuses on acute care. Given the aging population with increasing needs for internists’ care, research is needed to learn more about these attitudes and strategies to improve the attractiveness of generalist IM practice. Career interest in general IM is particularly low, reflecting the challenges in the primary care practice environment. A national effort to address the factors affecting students’ career choice regarding IM is needed and should include interventions to modify the nature of work and lifestyle in the field.

Author Contributions: Dr Hauer had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Hauer, Durning, Kernan, Fagan, Mintz, Schwartz.

Acquisition of data: Hauer, Durning, Kernan, Fagan, Mintz, Battistone, DeFer, Einicki, Harrell, Reddy, Schwartz.


Drafting of the manuscript: Hauer.

Critical revision of the manuscript for important intellectual content: Hauer, Durning, Kernan, Fagan, Mintz, O’Sullivan, Battistone, DeFer, Harrell, Boscadin, Schwartz.

Statistical analysis: Hauer, Durning, O’Sullivan, Boscadin, Schwartz.

Obtained funding: Hauer, Einicki.

Administrative, technical, or material support: Hauer, Kernan, Fagan, Mintz, Battistone, DeFer, Harrell, Reddy, Schwartz.

Study supervision: Hauer, Durning, Schwartz.

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Additional Information: The eAppendix is available at http://www.jama.com.

Additional Contributions: Charles McCulloch, PhD, University of California, San Francisco (UCSF), assisted with data analysis. The staff of the Clerkship Directors in Internal Medicine and Kathleen Kerr, BA, UCSF, helped with data collection and management, and Salina Ng, BA, UCSF, helped with data organization. Dr McCulloch received a consulting fee. None of the other individuals received any compensation for their contributions.

REFERENCES


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I never taught language for the purpose of teaching it; but invariably used language as a medium for the communication of thought; thus learning of language was coincident with the acquisition of knowledge.

—Anne Sullivan (1866-1936)