

Personal Choice or Predestined?

The Road to Specialty Choice



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Purpose and Overview:

The purpose of this presentation is to comprehensively review the data available regarding influences on career choice of Internal Medicine and its subspecialties. From the analysis, three guiding principles for optimal recruitment of future physicians and physician leaders will be discussed.

Educational Objectives: At the conclusion of this presentation,

1. The learner will be able to recall historical trends in Internal Medicine (match rates, subspecialization, the advent of hospitalist medicine) and be able to discuss how these trends influenced the data published on career choice.
2. The learner will be able to describe how the interactions between all medical education learners impacts recruitment to Internal Medicine and its subspecialties.
3. The learner will be able to identify characteristics of individual learners that are associated with particular subspecialties of Internal Medicine.

The influences on specialty and subspecialty choice are universally relevant. This subject pertains to medical students, residents and faculty alike, whether one is choosing a career, or providing insight how to better recruit to a particular field. The data, primarily survey driven, reveals that overlapping factors of the applicant, her experiences and influences, and the current state of Internal Medicine and its subspecialties contribute to career choice. It is impossible to extricate these overlapping factors from each other. However, a better understanding of these factors, particularly in the context of generational changes and changes in medicine, provides a framework for how to recruit the next generation of physicians and physician leaders to Internal Medicine and its subspecialties. This Grand Rounds will review the various factors and influences observed and studied with regards to a career choice in Internal Medicine (IM) and its subspecialties.

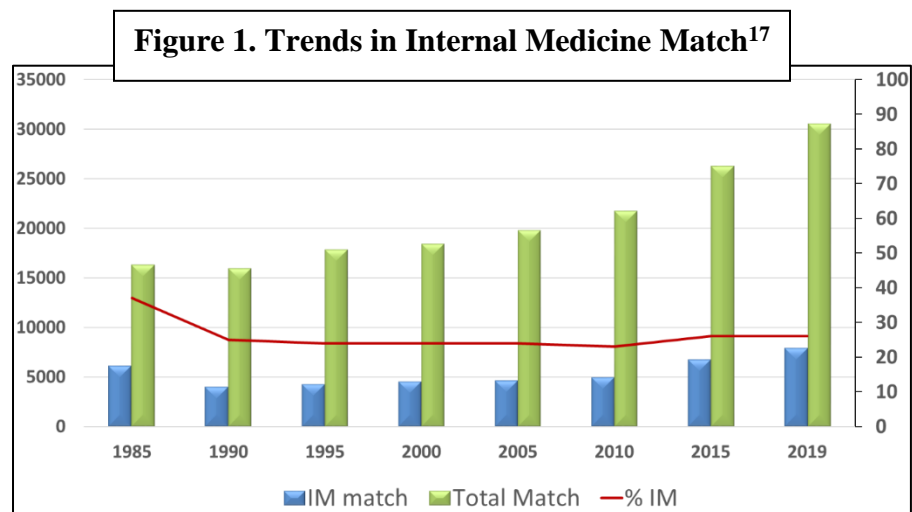
Medical Students

A summary of the data on the associations and influences on medical students' choice of IM can be categorized into factors associated with the applicant, with external influences and experiences, and with factors related to the discipline of IM itself.

The Applicant

To better understand the data, it is important to note that from the 1980s to the 1990s, IM suffered a drop in percentage of applicants, despite a rise in total applicants to residency (Figure 1). This was just before the dramatic rise in IM subspecialists, therefore the data reported in this time focused on characteristics of the students who gravitated towards IM and other primary care specialties versus surgery. Multiple reports found that students seeking IM were found to have a better tolerance for ambiguity than their surgical counterparts¹⁹⁻²². Individuals with a worse tolerance for ambiguity tended to be men*, white, and of younger age^{19,21}. Intolerance to ambiguity was also linked with self-reported reliance on higher technology and a negative orientation to patients with psychological problems²². Race of the applicant, as it pertains to specialty choice, was not, and as yet has not been adequately explored and needs further investigation.

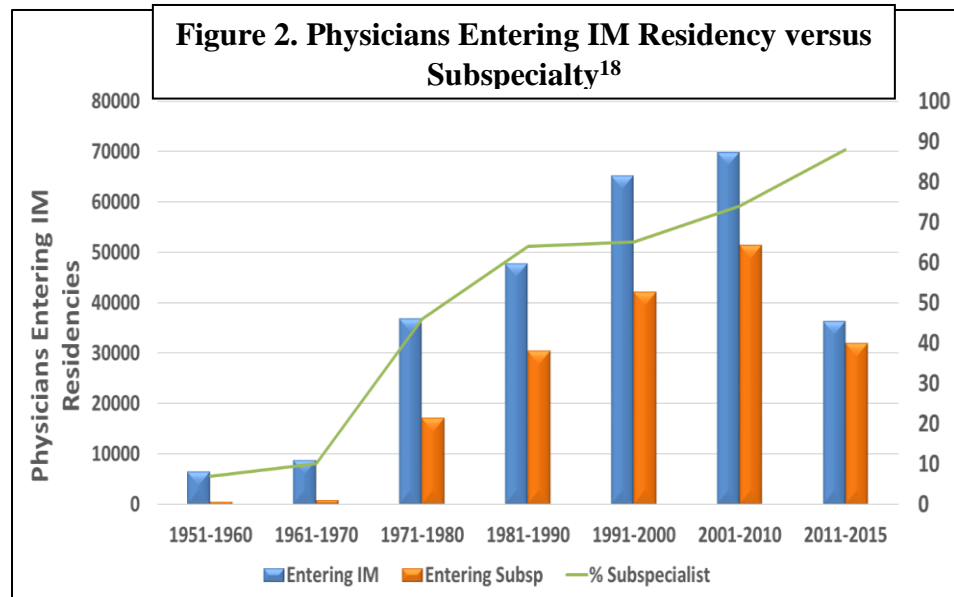
*The studies referenced in this discussion, with regards to gender, did not mention survey options other than male and female gender. Because of this, survey options such as Transgender Female or Male or other gender preferences were presumably unavailable.



External Influences and Experiences

Another contextual change to consider was the rapid rise of subspecialists over the decades (Figure 2). With the anticipation of an increased need for primary care physicians, several individuals turned their focus from personality traits and tolerance of ambiguity, to what

experiences and influential factors were associated with students who sought careers in Internal Medicine. Not surprisingly, medical students who scored honors on their IM clerkship, and those belonging to an IM interest group were associated with choice of IM on logistic regression analysis²³. With



regards to modifiable factors, medical students are more likely to choose IM when they have IM role models and mentors^{6,24}. This was irrespective of gender similarity or difference. Students also were more apt to pursue IM when they reported good IM educational experiences on their IM clerkships²³, and when they observed and interacted with residents and faculty positively^{23,25}. One study looked at open ended medical student essays responding to the query of how to make IM more attractive. The most repeated theme was to improve the IM faculty-medical student interactions²⁵. Similarly, students remarked observing IM residents with increased satisfaction and excellent competence, made the choice of IM more attractive²³. Not significantly influential was medical student IM sub-internship experience, though this is likely due to its timing in senior year, when students frequently have already determined their specialty choice²⁶.

Notably, there are important confounding factors that are not adequately addressed in these studies. It is difficult to separate the type of medical student who enjoys pathology of IM because of her/his own person, who may also report educational experiences in IM more enjoyable, versus whether the quality of the educational experience was a persuading factor to medical students.

Internal Medicine as a Destination

Medical students' perception of IM plays a large role in senior student specialty choice. Students find the positive attributes in medicine are the intellectual challenge, the ability to do meaningful work, IM's prestige/esteem as a specialty, and the ability to provide continuity of care^{23,27}. However, there are also factors that were described as detractors from pursuing a career in IM. One was the types of patients an internist cares for, specifically geriatric patients and those who are chronically ill^{23,27}. Other detractors are the workload, the need to bring work home, the

amount of paperwork, the lifestyle and lower income vs other specialties^{23,26,27}. Concurrent with this IM perception of high workload, students who scored high on the Maslach Burnout Inventory were less likely to choose a “less controllable lifestyle” specialty, to which IM was classified (others included family medicine, pediatrics, surgery, neurosurgery, OB/GYN, orthopedics, urology and vascular surgery)²⁸.

Finally, as the search to understand influences of career choice continued over the years, an opportunity to compare data from the 1980s to the 2000s arose by reviewing trends in the match and by comparing answers from the Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ) questionnaire between time points. What these studies found, was that perception of controllable lifestyle accounted for most of the variability in changing patterns in specialty choice. Specifically, students tended to be less interested in primary care specialties, while specialties such as emergency medicine and plastic surgery increased in popularity^{29,30}.

While medical students decide what specialty she/he wants to pursue, concurrently post graduate trainees are similarly deciding whether to practice General Internal Medicine or pursue a subspecialty.

Internal Medicine Residents

IM residents have three primary paths for career choice: to pursue primary care or General IM (GIM), to become a hospitalist, or to subspecialize. The following is a discussion of the factors and influences regarding these diverging paths. It should be noted, in the modern era, many IM residents practice hospital medicine for a limited period of time before pursuing a different path, such as a subspecialty. A discussion of these individuals and their motivations is beyond the scope of this discussion.

Primary Care (PC) versus Not Primary Care (NPC)

As mentioned previously, there has been a significant drop in the number and percentage of primary care physicians in the United States, which has been associated with increased rise of subspecialists (Figure 2). Garibaldi et al found that 54% of PGY2s declared an intent to go into GIM in 1998 versus 27% in 2003¹. The following observations regarding factors and characteristics of those more or less likely to pursue PC are made based on the literature and summarized in Table 1. A list of the primary literature on this topic is in Table 2, to demonstrate that the findings are largely survey driven, with respondents being largely IM residents and IM program directors (PDs).

The trainee characteristics associated with those more likely to pursue primary care are being a woman¹, a US medical graduate (USMG)¹⁻⁴, higher debt², and matriculating through an NRMP Primary Care Track Residency⁵. These individuals also tend to be less interested in income, enjoy caring for patients in an ambulatory setting, prefer a broad area of practice, and prefer long term relationships with their patients¹. They are also associated with having a primary care role model, a factor that appears to have higher impact on residents than on medical students⁶. Finally, peer and faculty encouragement to pursue primary care has been reported to influence this choice⁶.

Not surprisingly, many characteristics of those less likely to pursue primary care are the converse of the aforementioned qualities. These individuals are more likely to be men and international medical graduates (IMGs)¹, but also are noted to be younger, self-report a higher class rank², and have a higher American Board of Internal Medicine (ABIM) certifying examination score³. One study found IM program director letters ranking residents pursuing subspecialty to have higher medical knowledge, more humanism and higher level of competence³. The following associations have also been observed: those seeking subspecialty tended to be in a residency offering a preliminary track, be in a program associated with an increased number of fellowships⁷, and be in a residency with an X+Y scheduling model⁵. These associations likely reflect larger, academic programs, offering more opportunities to see subspecialties, leading to a higher likelihood of subspecialty choice.

There has been no observed association with the choice of primary care versus non-primary care in race, ethnicity, marital status, college major, hometown population size and whether the trainee attended public versus private medical school². In comparison, medical students who attended private medical school were associated with choice of IM, while type of medical school had no bearing on IM trainees' choice of PC versus NPC²³.

Table 1. Factors and Characteristics Associated with Primary Care¹⁻⁸

More Likely to Pursue		Less Likely to Pursue	
Person	Woman	Person	Man
	US medical		International medical graduate
	Higher debt NRMP Primary Care Track Residency Less interest in income Caring in ambulatory setting Prefers broad area of practice Prefers long term relationships w/ pts		Younger Higher self-reported class rank Higher ABIM certifying examination score IM PD letters- higher MK, humanism, competence
Experiences & Influence	Having a primary care role model (higher impact on residents>MS)	Experiences & Influence	Presence of Preliminary Track
			↑ # of fellowships available at hospital
	Peer/Faculty encouragement		X+Y scheduling model

Table 2. Summary of Primary Data Regarding Specialty Choice¹⁻¹⁶

Author	Year	Journal	Data Source	No participants
Andersen	1989	Ann Intern Med	National Study of IM Manpower (NaSIMM) data, PD surveys	423
Connelly	2003	J Gen Intern Med	AAMC files, medical students and residents	526 MS, 1139 residents
Grosso	2004	Teach Learn Med	ABIM, ACGME PD evaluations, R3s 1992-1998	44,988
Garibaldi	2005	Acad Med	ITE survey, PGY3s 1998-2003	25,700
Lorin	2005	Chest	Survey of 3 programs, IM residents	178
Diehl	2006	J Gen Intern Med	Survey of 2 programs, IM residents	265
McDonald	2008	Ann Intern Med	ITE survey, PGY3s 2003-2007	22,563
West	2009	J Gen Intern Med	ITE survey, PGY3s 2005-2007	17,044
Halvorson	2010	Am J of Med	ITE survey, PGY3s 2003-2006	17,015
Peccoralo	2012	J Gen Intern Med	Survey of 3 programs, IM residents,	225
West	2012	JAMA	ITE survey, PGY1 to PGY3s 2009-2011, demographics from NBME	57,087
Ratelle	2014	J Gen Intern Med	ITE survey PGY3s 2009-2011, demographics from NBME	57,087
Bonura	2016	Clin Infect Dis	Survey, national to IM residents	590
Miller	2017	J Gen Intern Med	Survey, Soc of Gen IM members	1011
Douglas	2018	JAMA Cardiol	Survey, national to 198 IM programs	1123
O'Rourke	2019	J Gen Intern Med	Survey of IM PC PDs (total 100)	70

Hospitalists

Hospitalists have had a dramatic impact on the field of Internal Medicine. Despite its recent inception in the mid-1990s, with the title of hospitalist being coined in 1996 by Drs. Robert Wachter and Dr. Lee Goldman³¹, it has grown dramatically in a short period of time. In 1998, hospitalist was not a career option on the In Training Exam (ITE) survey. Yet, by 2003, 7% of PGY3s planned to enter the field¹. In 2012 there were over 28,000 hospitalists in the United States, growing to almost 50,000 by 2017¹⁵.

Individuals going into hospital medicine are more likely to be men and train in a categorical, as opposed to a primary care track residency program¹³. Among those in a primary care track program, USMGs are statistically more likely to become a hospitalist as opposed to IMGs¹³. Those with increased debt choose hospital medicine, which tracks with the aforementioned observation of increased USMGs, since USMGs are well documented to have significantly more debt than IMGs^{10,11}. Factors that influence individuals to choose hospital medicine are the ability to have a broad area of practice, and a lifestyle with more time for family and non-work activities¹¹.

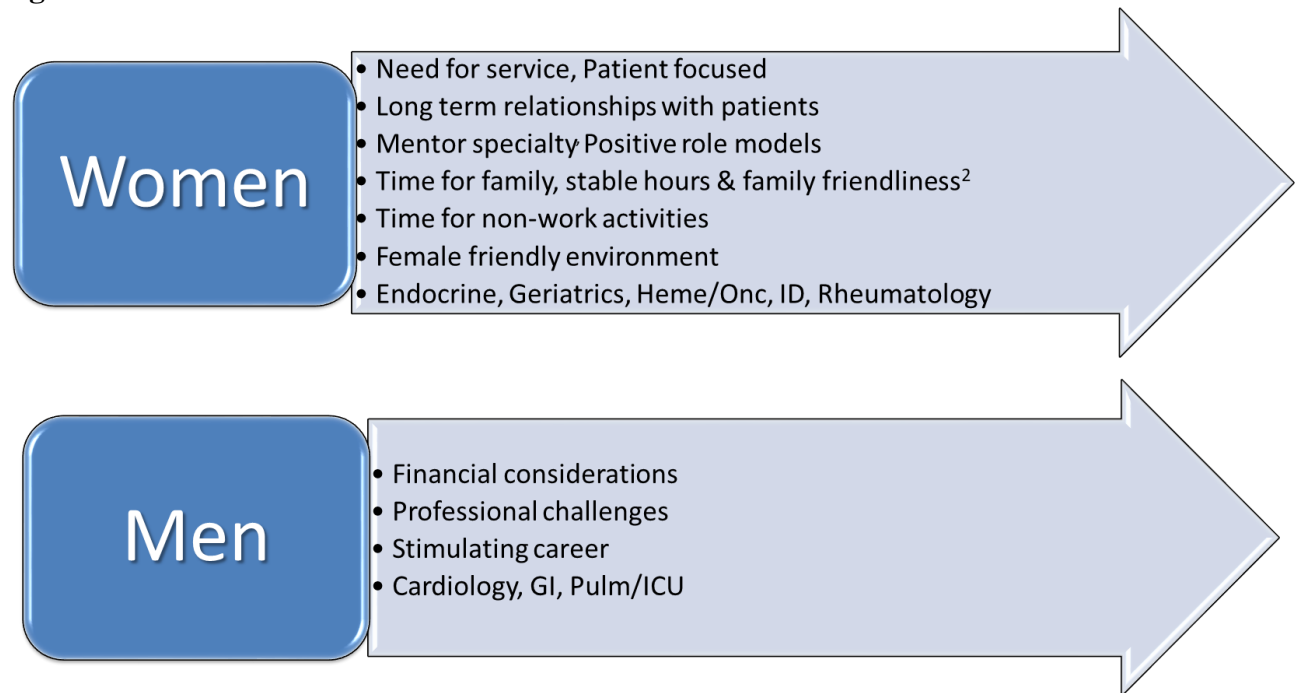
Since one of the larger data sets found that the most prevalent influential factor with respect to career choice was time for family¹¹, and this is viewed favorably in a hospitalist's career, the growth in hospitalists is not surprising.

Gender Differences in Priorities

A well-recognized trend in IM has been the increasing number of women, from 30% of residents in 1991 to 43.2% in 2016³². With this has been a concurrent increase of women in the various subspecialties. Most notably the highest rates of increase of women have been seen in

endocrinology, geriatrics and rheumatology. This is followed by less dramatic increases in gastroenterology (GI), hematology/oncology (H/O), infectious disease (ID) and rheumatology. The least amount of increase was seen in pulmonary/critical care (pulmonary/ICU), and the lowest in cardiology³². A compilation of data from four studies ranging from 2005 to 2018, help identify different influential factors between women and men^{1,11,12,16}(see Figure 3).

Figure 3. Gender Differences in Career Choice



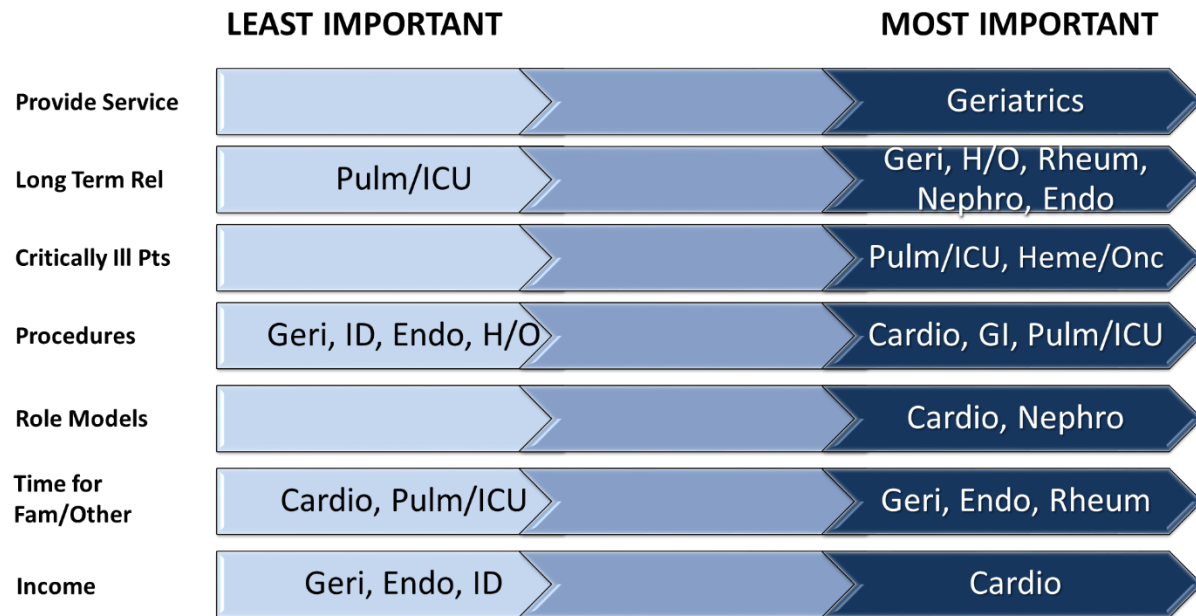
Women are more likely to rate the following as being very and most influential in their career decision making; a need for service, to be patient focused and have long term relationships with patients^{11,16}. Income is not a significant factor in women's career choice¹². External influences include the specialty of the mentor, having positive role models, regardless of gender, and being able to work in a female friendly and family friendly environment^{11,16}. Women also value having more time for family, stable hours and time for non-work activities^{11,16}. Time for non-work activities may not reflect "down time" or time for hobbies. Data has shown that women working in academic medical settings, compared to their male counterparts, are responsible for significantly more at home, whether it be child care or house work³³. Subsequently, there are more women in the subspecialties of endocrine, geriatrics, H/O, ID and rheumatology¹.

Men in IM residency have rated income and financial considerations as very and most influential in their career decision making^{1,12}. Other important factors include professional challenges and a stimulating career¹⁶. Thus, more men are associated with the subspecialties of Cardiology, GI and pulmonary/ICU¹.

Influential Factors and Subspecialties

The following figure is a compilation of influential factors for career choice, and how individuals going into the various subspecialties reported their importance, based on data from six studies, four of which report from the ITE survey data (See Figure 4).

Figure 4. Influential Factors and Subspecialties^{1,9,11,12,14,16}



Those going into geriatrics rated providing a service as most important, in comparison with the other subspecialties. Residents who valued having long term relationships with patients tracked to careers in endocrinology, geriatrics, hematology/oncology, nephrology and rheumatology, while those choosing pulmonary/ICU as their career rated this as least important. Not surprisingly, pulmonary/ICU and hematology/oncology careers were associated with the importance of caring for critically ill patients, and the subspecialties that perform the most procedures attracted the residents who rated opportunity to perform procedures highest importance, as compared to those going into endocrinology, geriatrics, hematology/oncology and ID. Role models play a more significant role for those interested in cardiology and nephrology, and income is of higher importance to those also seeking cardiology careers. As reflective of the data above with regards to gender, importance of time for family and non-work activities is associated with endocrinology, geriatrics and rheumatology, with the converse being cardiology and pulmonary/ICU^{1,9,11,12,14}.

Data Specific to Specialties

There is a small volume of data specific to the specialties that reflect national trends in match rates (Table 3). In Cardiology, there has been a recent surge in publications examining why the percentage of women pursuing the specialty has not risen substantially, in comparison to the other specialties, and in the setting of an increasing female resident population^{16,32,34-39}. Findings suggest that cardiology is perceived by residents as having adverse work conditions, interfering with family life and overall lacking in diversity. While women in cardiology report a high

satisfaction in their careers, they also report higher levels of discrimination than their male counterparts, are more likely to be single and are less likely to have children³⁸. In gastroenterology, one survey explores experiences of discrimination and harassment in female versus male trainees, while also finding women to be trained less than their male counterparts in advanced endoscopic training. It is unknown if the latter findings are secondary to decreased interest or opportunity⁴⁰. Endocrinology lacks data specific to its specialty in general, while resident surveys before and after a hematology/oncology rotation shows a decrease in interest in the specialty after the experience. This decreased interest was particularly noted in men with lower resilience, and in individuals with overall lower empathy scores⁴¹. Those investigating influences for pursuing infectious disease found that medical school experiences in ID have a positive impact¹⁴. Nephrology's dip in match rates has prompted exploration, with posited reasons for this being related to reimbursement, lifestyle and overall satisfaction in practicing nephrologists. Similar to ID, early exposure in medical school, as well as early research experience and mentorship affect recruitment positively⁴². A survey of Hospice and Palliative medicine fellows reported more exposure to the field in residency than in medical school, and 95% of them received negative comments about their choice⁴³. Pulmonary/ICU fellows tend to come from programs with larger ICUs and programs where residents run codes^{9,44}, and rheumatology has enjoyed a resurgence in desirability, which happens to also track with an increased income⁴⁵. Geriatrics, while its own subspecialty, in many studies was categorized as a PC specialty, and therefore has similar data to PC as discussed above.

Table 3. Data Specific to the Subspecialties^{9,14,16,38,40-48}

Specialty	Noteworthy	Author
Cardio	↓ women possibly due to poor work conditions/lifestyle, ↑ discrimination, interferes w/ family life & not diverse	Douglas, Lewis
Endocrinology	Absence of data	
Gastroenterology	Negs: ↓ jobs (esp in academics), not intellectually challenging, too procedure oriented, ↑ discrimination for women in interviews & training, ↓ advanced endoscopic training for women	Benya, Arlow
Hematology/Oncology	↓ interest post rotation, a/w ↓ empathy overall & ↓ resilience for men	McFarland
Infectious Disease	↓ IMG visa attainment, ↓ jobs, ↑ hospitalists Med student experience- 65% of residents decided before residency	Chandrasekar, Bonura
Nephrology	Negs: Poor lifestyle, poor income, ↓ satisfaction of nephrologists Interested: + exposure in med school, early research experience, mentorship	Adams
Palliative Care	Desire to alleviate suffering, improve end of life care & communication Most had no experience in MS, most had experience in residency 95% received neg comments on career choice	LeGrand
Pulmonary/ICU (PICU)	IM prgrms w/ ↑ interest: larger ICUs, residents as code leaders, more ICU mos, more role models & ↑ satisfaction of PICU fac	Minter, Lorin
Rheumatology	# of applicants from 2014-2017 ↑ by 44% (230 to 332) while mean post fellowship salary rose. Pros: Desired intellectual interest, controllable lifestyle, external constraints, practice content	Tran, Rahbar

Lifestyle

As previously discussed, surveys of medical students' views of IM reveal that they consider it to be a demanding field with an uncontrollable lifestyle, requiring more paperwork than other specialties, and a greater need to bring work home^{23,26,27}. This would lead one to believe that

those choosing IM as their specialty, would rank lifestyle as a less important factor, having already filtered out those avoiding workload distress. Yet the data from the resident literature shows that lifestyle is the number one most important factor in decisions regarding the next step in their career¹¹. In general, lifestyle has become a much more important factor in career choice over the years^{11,29,49}. There are several possible reasons for this.

Generational changes

One reason for the rise in influence for more family time and non-work activities on career choice may be the changing priorities of different generations. Baby Boomers, born between 1946 and 1964, are ambitious, goal-oriented, do not require constant feedback, and are known to be the “workaholics”. Now in their 50-70s, they hold positions of power and authority. Contrast this with Generation X, born between 1965 and 1980, who like to work independently, have minimal supervision and are motivated by flexible schedules. They are credited for introducing work-life balance. Millennials (Generation Y), born after 1980, are similar to Gen X’ers in their desire for flexible schedules, but also are collaborative, like immediate feedback, and do not mind changing jobs^{16,50}. Millennials are the largest age group in the country, and the fastest growing segment of today’s workforce. Along with the Gen X’ers, their desire for better balance and flexibility has undoubtedly affected the current medical workforce, and will continue to do so.

Increase in dual physician couples

According to an AMA Insurance Agency survey of nearly 5000 doctors, about forty percent of physicians are likely to marry another physician or health professional⁵¹. Consistent with this report, after its inception in 1984, the couples match has shown a relatively steady increase in participants, with a success rate in 2019 of 95%. Dual physician and dual income households have different priorities, particularly with regards to income and time for family and non-work activities when considering career choice, as opposed to single physician households, leading to a change in factors and influences in career choice.

Changing priorities

Some may argue that the focus on lifestyle might be from the rising number of women in IM over the years, most recently reported as near 45%³² in 2016. As previously seen in the data, women report higher influences of flexibility and time for family^{11,16}. However, this was disproved by thirteen years of data from over 180,000 aspiring physicians, showing that women were more likely to choose an uncontrollable lifestyle compared to men⁴⁹. Instead, we should consider that the natural evolution of priorities throughout training may be the greater factor. Medical students, frequently younger, less likely to be married, and less likely to have children, often have different goals and priorities as compared to residents who are at a different stage of their life. Later in life, priorities change to include consideration of a partner, her/his career, children and aging parents. This is true for women and men alike.

Current Work

We currently have a manuscript under review that investigates whether self-reported confidence in IM residents correlates with subspecialty choice. Prior data has shown that men have higher

self-reported confidence in procedural performance, as compared to their female counterparts⁵²⁻⁵⁴. Surveying our own UTSW IM residents as well as IM residents from Northwestern, our combined data reflected the same. However, we also found male residents' higher self-reported confidence in procedures was associated with a higher likelihood of pursuing a procedural based subspecialty, while female residents showed no association between level of self-reported confidence and career choice. Rather, women with higher confidence tracked both with choice of GIM and with procedural specialties. Our data also reflected other observations mentioned previously; we found a higher prevalence of women seeking GIM as a career, as compared with men, and men rating income as a higher level of influence as compared to women.

Table 4. Self-reported Confidence in Men and Women by Skill and Career Choice

	Communication Skills	P-value	Clinical Skills	P-value	Procedural Skills	P-value
GIM						
Men, N=21	6.35 (1.18)	0.19	5.65 (1.60)	0.02	4.90 (2.20)	0.17
Women, N=33	6.83 (1.36)		6.64 (1.51)		5.70 (2.00)	
Non-procedural Subspecialty						
		0.10		0.08		0.006
Men, N=56	6.91 (1.35)		6.61 (1.73)		6.11 (2.09)	
Women, N=59	6.49 (1.35)		6.07 (1.54)		5.02 (2.04)	
Procedural Subspecialty						
		0.13		0.11		0.03
Male, N=68	7.07 (1.14)		6.90 (1.38)		6.64 (1.62)	
Women, N=54	6.75 (1.08)		6.49 (1.47)		5.92 (1.96)	

Figure 5. Confidence and Choice of Career

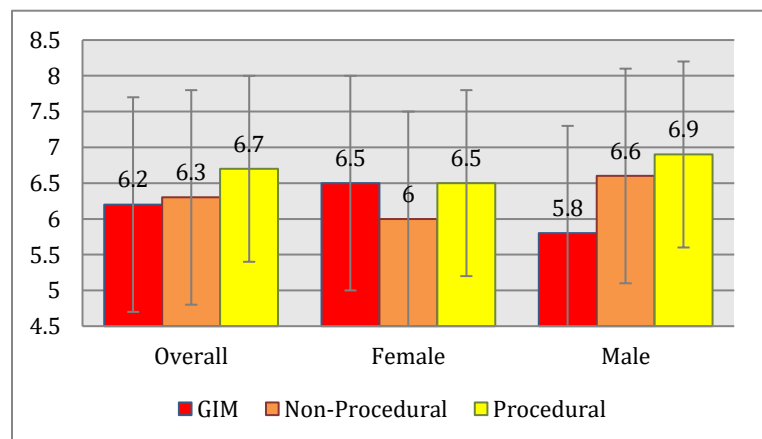


Table 5. Differences between men and women in factors influencing career choice

	Overall (n=291)	Men (n=145)	Women (n=146)	p-value
Preference for setting of practice (inpatient vs. outpatient)	3.84 (0.82)	3.77 (0.81)	3.91 (0.82)	0.15
Desire to develop long-term patient relationships	3.74 (1.03)	3.66 (1.06)	3.82 (0.99)	0.18
Desire for more time for family	3.62 (1.00)	3.56 (0.96)	3.68 (1.05)	0.28
Desire to work with high acuity patients	3.46 (1.04)	3.51 (1.04)	3.40 (1.04)	0.39
Current or past mentorship	3.42 (1.15)	3.45 (1.23)	3.39 (1.06)	0.69
Desire for more time for non-work activities	3.41 (1.04)	3.38 (1.00)	3.45 (1.07)	0.60
Earning potential	3.09 (0.98)	3.22 (0.97)	2.96 (0.97)	0.03
Desire to perform procedures	3.01 (1.26)	3.17 (1.30)	2.86 (1.20)	0.04
Significant other or family influence	2.77 (1.26)	2.71 (1.24)	2.83 (1.28)	0.43
Administrative responsibilities	2.41 (0.96)	2.36 (0.98)	2.47 (0.93)	0.35
Personal debt	2.26 (1.16)	2.19 (1.16)	2.32 (1.17)	0.34

Personal Choice or Predestined?

Is specialty choice and ultimate career choice personal choice or predestined? It is both. The person, her/his influences and experiences, and the destination are inextricably linked. The person affects her/his experiences and vice versa, and the appeal or dislike of a destination is related to the person's priorities. As well, an institution with a strong IM clerkship experience affects both the person and the appeal of IM as a specialty. Even more complicating, is that all three are continually in flux. Regardless of what percentage career choice is personal or predestined, this comprehensive review of the data reveals the necessary approach to attract and recruit the best aspiring physicians into IM and its subspecialties;

1. The Unique Individual- whether a student or a resident, the choice of what path to take is contingent on who the person is, what experiences she/he has had or will have, and her/his value system. I would argue that effective coaching and mentoring requires time and effort to understand the individual's construct and value system, so that guidance not only reflects the mentor's wisdom and experience, but also recognizes the needs/desires of the individual.
2. The Influence- The structure of medicine fractures our medical education system into silos of undergraduate medical education, graduate medical education and continuing medical education. These well-defined stages of learning are both necessary and a deterrent to collaboration. It disregards that we are all learners on a continuum. Evidence of widening chasms and its consequences can already be seen in the following challenges in education: 1) the controversy over reporting of the United States Licensing examinations (2) the duality of summative letters (Deans letters, Program Directors letters), being both letters of recommendation as well as a

handoff of competence for further training and (3) the ever present conflict of faculty medical educators' role as teacher and evaluator and how learners' perception of educators affect faculty educator reputation and promotion.

In truth, there is ample opportunity to collaborate amongst levels of learners, yet little to no incentive to do so. However, the data clearly shows role modeling, mentorship, faculty-student interactions, the satisfaction and competence of our residents and the perceived workload and lifestyle of practicing physicians help shape what our medical learners choose for their future. A commitment to collaboration, role modeling, mentoring and coaching, to both our residents and students could have a significant impact on our ability to recruit the best to Internal Medicine and its subspecialties.

3. Change and Diversity- Lines are dividing groups in medicine in a multitude of ways. There are lines between generations, between genders, between generalists, hospitalists and specialists, and between academicians and private practitioners. Rather than lamenting generational differences, it would be prudent to capitalize on the strengths of each generation and learn from one another. Younger generations can enhance collaboration, innovation and technology, while more mature generations can model and teach commitment, dedication, perseverance and loyalty. Also, attracting a diverse group of applicants to any field, increases the pool of skills, ideas and perspectives. Given the changing landscape of priorities, with an emphasis on lifestyle, those who work towards flexible schedules and optimization of time will be the ones who recruit the best and most diverse individuals to their field.

Conclusions

There are many factors that influence career choice, with a growing body of literature exploring what these factors are and how they vary over time. As generations, culture and medicine continue to change, this ubiquitous subject will need additional data to help guide recruitment of IM physicians and physician leaders. Based on current knowledge, the following is key: 1) it is important to understand the individual and her/his value system, 2) it is critical to recognize the influence of all learner levels on each other, and to take advantage of opportunities to coach, mentor and role model, and

3) we must recognize change and value diversity to effectively recruit in the current era. Heeding these three guiding principles in recruitment will allow us to attract the best aspiring Internal Medicine physicians and leaders to our institution.

■ With Deepest Appreciation to...

Coaches, Mentors, Sponsors	Colleagues	Future of Medicine	Family
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