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BECOMING A PHYSICIAN

Primary Care — The Best Job in Medicine?

Beverly Woo, M.D.

I first met Mr. B. during my internship, when he was a 29-year-old musician who had been admitted to the hospital with atypical pneumonia. After he was discharged, he kept his follow-up appointment with me, and I became his primary care physician. During the next 10 years, he succeeded in stopping smoking, and his major concern was his lack of steady employment. Just before turning 40, Mr. B. developed idiopathic thrombocytopenic purpura (ITP). His thrombocytopenia responded to corticosteroids, but it recurred when the dose was tapered. Between the medication and the uncertainty, he became depressed.

During the next 10 years, Mr. B. divorced and remarried, and he found a terrific job. He then developed hypertension and painful attacks of gout. Management of these two new conditions along with his ITP required constant juggling of his medications. In 2004, Mr. B. came to see me because of right-lower-quadrant abdominal pain. A screening colonoscopy in 2003 had shown only an adenoma, but now another colonoscopy revealed adenocarcinoma of the cecum. I referred him to an excellent surgeon and then an oncologist and helped him make important clinical and life decisions until his death last year from bowel obstruction at the age of 60.

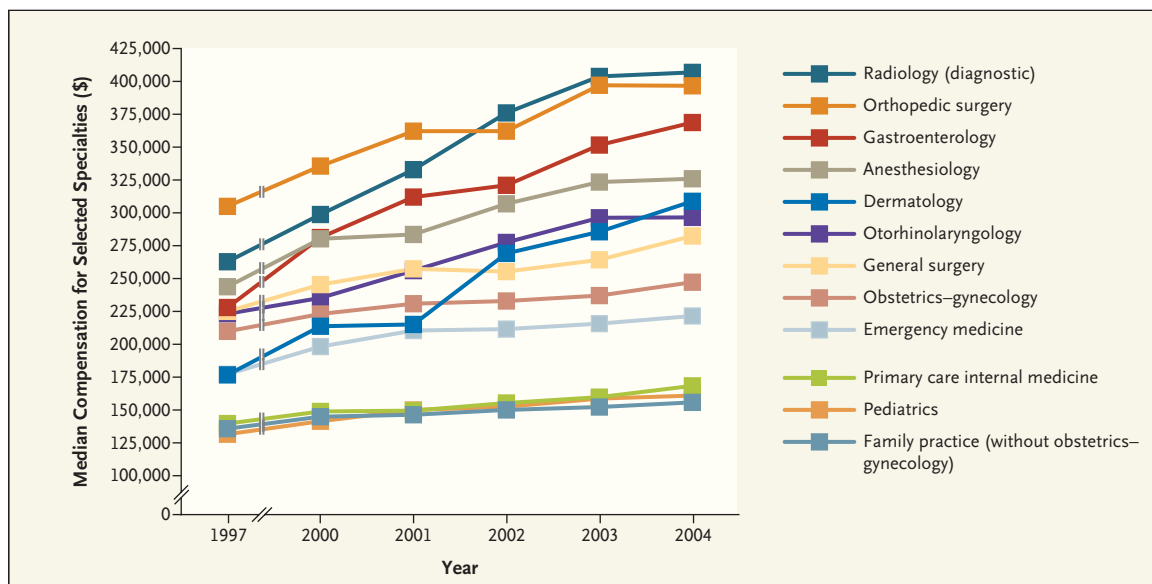
After he died, I reflected on my 30-year relationship with Mr. B. I recalled that he had often called or sent me notes with updates and questions. In his medical record, I found a note he had sent after seeing the hematologist for his ITP in 1983: "Great phone call from Dr. G. He said bone marrow perfect. Body is making antibody against platelets. . . . Steroids fixed blood count. . . . See Bev, she will take care of you!" It meant a great deal when Mr. B. told me, at several points in our relationship, how grateful he was that I was caring for him and how important it was to have a doctor he could trust. It was a privilege to be Mr. B.'s physician, and it is a great source of satisfaction that I was able, with my colleagues, to help him, whether his needs were big or small.

The opportunity to develop long-term relationships with patients like Mr. B. is only one of many rewarding aspects of being a primary care physician. It is endlessly fascinating to me, for instance, that patients' symptoms can be manifestations of so many different disorders. In my practice, an older woman with forgetfulness turned out to have central nervous system Lyme disease, and a younger woman with a subtle change in her speech had amyotrophic lateral sclerosis. Another patient's fatigue was caused

by Addison's disease — but it could have been a symptom of heart failure, cancer, depression, or even transient ennui. Recently, a woman who came seeking advice about a diet because she could no longer button her blue jeans turned out to have ascites and ovarian cancer.

As a primary care physician, I see firsthand how social factors affect patients who have chronic diseases. Mr. S. had a relapse of alcoholism after separating from his wife, Ms. R.'s glycosylated hemoglobin level skyrocketed when her daughter became ill, and Ms. H. had an exacerbation of her colitis when she lost both her job and her housing. Because primary care doctors are often the only physicians whom a patient visits, we must identify problems that are frequently difficult to talk about, such as alcohol and drug use, domestic violence, and risky sexual practices. And there is the need to care for an increasing number of patients with multiple complex medical conditions in this era of shortened hospital stays. Clearly, practicing primary care medicine is much more challenging than "just learning how to use Dyazide" — the scoffing description that the director of a residency program offered a colleague of mine when he said he wanted to go into the field.

So I should have had plenty of



Median Compensation for Selected Medical Specialties.

Data are from the Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005.

ammunition ready when a third-year medical student made an urgent appointment with me to talk about her future. “I just came here so that one person would tell me that I wasn’t crazy to go into internal medicine,” she said. She had come to medical school because she wanted to take care of patients, she said, but she was discouraged by negative remarks about primary care medicine made by faculty members and fellow students. Then she asked me whether I liked being a primary care doctor.

I hesitated before I answered — after all, I thought, it was true that morale had declined among primary care practitioners during the past few years. I told her, honestly, what I considered to be the problems as well as the rewards of this career path, and said I thought that primary care was a really good job. Later, I wished that I had told her what I really think: that taking care of patients as their primary care doctor is the best job in medicine.

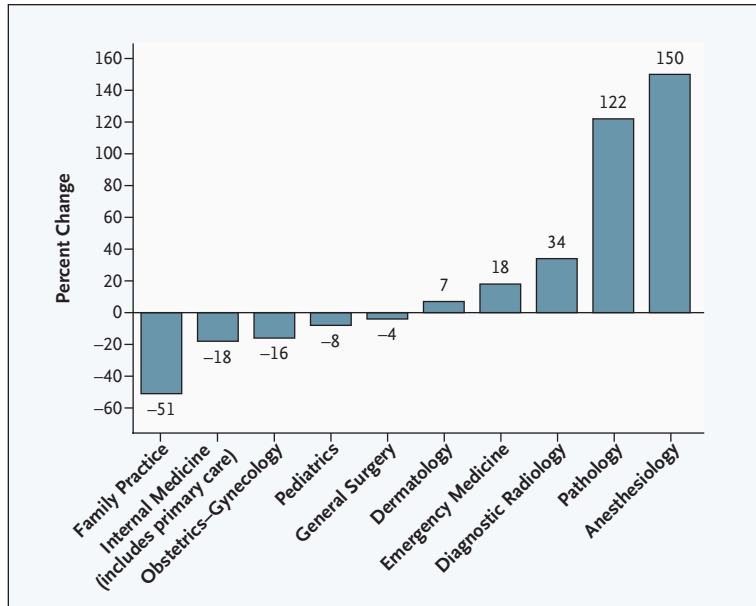
When I was a third-year med-

ical student in the 1970s, like her I was attracted to primary care medicine and was discouraged by my mentors. My career choice was aided, in part, by a prevailing sense that primary care medicine would be part of a larger social and political movement toward more equitable health care. Also, the timing was right: I was able to enter one of the recently established residency programs in primary care internal medicine, which were funded by the federal government and private foundations that believed the country needed more primary care physicians. Primary care practice has been a challenging and deeply satisfying career for me. So I couldn’t help feeling disappointed when I learned that this student chose another specialty. I’m sure she would have been a wonderful primary care doctor.

It is disturbing to me that changes in our health care system have made primary care medicine less satisfying for practitioners and less attractive to students and residents. Primary care physicians are

under pressure to see patients at a faster pace than ever before, even as their responsibilities increase. Add to these difficulties the increasing administrative burdens and the fact that the remuneration for primary care specialties is at the bottom of the pay scale for physicians (see line graph), and it is no wonder that primary care medicine is in crisis.

Students and residents see that primary care physicians are dissatisfied and have little optimism that this part of our dysfunctional health care system will be fixed anytime soon. They are voting with their feet, choosing more lucrative specialties that have more “controllable” responsibilities.^{1,2} The proportion of U.S. medical school graduates entering the three primary care specialties (internal medicine, family medicine, and pediatrics) dropped from 50 percent in 1998 to 38 percent in 2006 — that is, a loss from primary care of more than 1500 students this year, as compared with 1998 (see bar graph).³ Moreover, the percentage of third-year



Percent Change between 1998 and 2006 in the Percentage of U.S. Medical School Graduates Filling Residency Positions in Various Specialties.

Data are from the National Resident Matching Program.

residents in internal medicine planning to become general internists who are not hospitalists decreased dramatically during this period, from 54 percent in 1998 to 27 percent in 2003, a year in which only 19 percent of first-year internal medicine residents were planning on such a career.²

Some have said that this decline reflects a lack of commitment among the current generation of trainees. I disagree. Medical students and residents are no less idealistic or dedicated today than they have been in the

past. But the decrease in job satisfaction, the increase in educational debt (which now routinely exceeds \$100,000), and the growing disparity in salary relative to other specialties could together create a strong sense that becoming a primary care physician may be a fool's errand. If the current problems of primary care practice are not addressed, the number of students and residents entering the field will undoubtedly continue to decline.

With all the changes in our health care system, one thing remains constant: the needs of pa-

tients. Patients want a continuing relationship with a doctor whom they trust, and they increasingly need that doctor to act as an advocate to help them get the best care within a fragmented health care system.⁴ A strong primary care infrastructure is associated with better health outcomes, lower costs, and a more equitable health care system, since primary care is key to providing services to vulnerable populations.⁵ There is an urgent need to reverse current trends. Although the line of students signing up for a career in primary care medicine is getting shorter, the line of patients in need of primary care doctors is getting longer every day.

An interview with Dr. Woo can be heard at www.nejm.org.

Dr. Woo is a primary care physician at Brigham and Women's Hospital and an associate professor of medicine at Harvard Medical School — both in Boston.

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FOCUS ON RESEARCH

Marburg Hemorrhagic Fever — The Forgotten Cousin Strikes

Heinz Feldmann, M.D.

Related article, p. 909

More than 30 years after the discovery of Marburg virus as the causative agent of an outbreak of severe viral hemorrhagic fever in Germany and the former

Yugoslavia in 1967, the long-forgotten pathogen has struck twice in the recent past, leaving no doubt about its survival in nature or its pathogenic potential. The

first strike came in 1998 (and lasted until 2000), when Marburg virus hit a gold-mining community in the northeastern region of the Democratic Republic of the Congo,