A PIECE OF MY MIND

Primarily Care

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Recently, I ended a 40-year career in the practice of primary care medicine. I did not stop because I was burned out or unable to continue. I stopped because I had too much respect for the profession. Primary care practice, done well, requires a high degree of mental agility. I wanted to stop before I became the medical equivalent of a former all-star baseball player and started batting .200 in the quality of my medical care.

I began my medical training around the same time as the establishment of the first primary care training programs. I was the first full-time primary care physician hired at my hospital. From my perspective primary care medicine always seemed under duress in one way or another.

Residents told me that medical school faculty discouraged students from choosing a primary care career. There was the idea that no one would want to go into primary care because of the lure of technological medicine. This point of view forgot to consider the enormous rewards of long-term relationships with patients, which is what initially drew me to primary care.

At my hospital, for reasons that are unclear to me, it was often the surgeons who had the most antipathy toward the primary care physicians. This ended when they got to know us and realized that we were as talented as everyone else, and that we also controlled to whom the specialty referrals were directed.

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The next threat to primary care was the rise of health maintenance organizations (HMOs). Early on, it was feared that HMOs would undermine the patient-physician relationship because of the divided loyalties of the physician between the payer and the patient. At least in my geographic area, the demands of a savvy patient population and the power of the tertiary teaching hospitals overcame the HMOs' ability to restrict care. As someone who came of age in the rebellious late 1960s, I was not someone who was tempted to abridge my view of a patient's needs.

Next came the HIV epidemic, which threatened to overwhelm hospitals and primary care offices with desperately ill patients. I remember patients coming into the hospital with their first symptom and ending up dead in a matter of days. Amazingly, medicine developed treatments that transformed the affliction into a chronic disease that was best treated in multidisciplinary clinics.

Being near the bottom of the pay scale was another deterrent to students going into primary care. The need to pay off educational debt was and is certainly a big factor in career choice. It is not mentally harder just mentally different to be a medical subspecialist than it is to be a primary care physician. A primary care physician has to continually keep track of a large panel of patients; absorb mountains of data from consultants and laboratory and imaging reports; and see patients quickly, while attending to the proliferating tasks of the primary care visit and maintaining energy and openness to recognize the subtle clues of less-than-simple diagnoses. All of this has to be done while attending to the emotional needs of the patient. It is not easier than doing a colonoscopy. Although I believe that subspecialists deserve a financial premium for the extra years of their training, the remuneration of primary care physicians should otherwise be commensurate.

The current threat to primary care physicians' happiness seems to be the electronic health record (EHR).[1] Although change can be challenging, I, frankly, have never understood the extent of physician aversion to this form of record keeping. I believe it made my life far more efficient. In the pre-EHR days in my clinic, the paper charts were frequently misfiled or signed out elsewhere when I needed them. I still have, as a reminder from those days, a now-obsolete loose-leaf binder that held a lab flow sheet on each of the patients I saw. When a lab result returned on a patient, I manually entered it into the flow sheet because I could never be sure that the patient, the chart, and the lab result would all be in the same place at the time that I needed them. With the EHR, I can have the chart available for a phone call without leaving my desk, and I can write letters for patients and do medical encounter charting with just a few keystrokes to bring up stock phrases.

I agree that the EHR does get in the way of communicating during the medical encounter. My rule is if the patient is telling me about objective data like past medical history, I can look at the computer. If the patient is speaking about the reason for the visit or anything with emotional content I look at the patient.

I had the good fortune to stay in one practice at a small urban teaching hospital for my entire career. I had a patient who was in her 30s when I met her and in her 70s when we said goodbye. Working at a municipal hospital was challenging because it was always financially unstable, and the administration regularly tried to lower my salary and that of others. What kept me there was the hospital's mission to meet the needs of the community. As I considered a postresidency

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career, I fantasized about working at a municipal hospital taking care of economically disadvantaged patients. At my hospital, I had the added benefit of working with an ethnically diverse population. One day in my clinic I saw 9 patients, none of whom spoke English as a first language and none of whom spoke the same language as any other patient. I often felt as if I were traveling the world without having to leave my examination room.

Practicing medicine did get harder over the years. It was not because medicine became more complicated, though I am glad that I no longer have to try to understand the immune system. It became harder because of the proliferating tasks of the medical encounter. Keeping track of the ever-increasing number of health maintenance requirements like immunizations and breast, prostate, and colon cancer screening sometimes made it hard to remember to find out why the patient came to the office in the first place.

There are 3 things that I am most proud of in my career. They are not the articles I have written on the patient-physician relationship, though I am proud of those.[2-4] It is also not the unusual diagnoses I have made, though there is a certain thrill in recognizing something obscure. I am most proud of 3 things that patients or their family members said to or about me.

The first was by a patient who said that unlike other physicians he saw, I never made him feel like I was rushing to catch a train.

The second was relayed to me by a colleague who shared a mutual patient. The patient told my colleague that when we were together, I made the patient feel like the patient was the only other person in the world.

The third was from the son of an older immigrant patient who told me that he was proud to bring his father to see me because, unlike many physicians in his home country, I treated his father with respect.

As I was saying goodbye to my patients over my final 6 months in the office, I became aware of some things that I did not think about in the daily thrum of practice. The first was how deeply grateful the patients were for what I had done for them and for our connection. More men than women cried during the last visit, perhaps a testimony to a general lack of supportive relationships for men. The other was a realization of just how many of my patients had unsolvable problems. Whether for biological, social, or psychological reasons, they just never got better. I had to admit to myself a guilty sense of relief that I would no longer have to bear the weight of these problems. On occasion, I felt the need to apologize for not being able to do more for them. Most said it did not matter because they were grateful that I was there to listen to them and support them. This is the value and reward of primary care.

Conflict of Interest Disclosures: None reported.

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