I have changed my specialty three times. When I finished my residency and joined a six-physician group with “consultants” in its name, I was an internist and my daily practice took me to two offices and multiple hospitals, where I not only took care of my own patients but also consulted on orthopedic, gynecological and family medicine cases, handling renal failure, ventilator management and even myocardial infarctions. Medical subspecialists existed at the time, but there were few of them even in my urban/suburban practice setting. When people asked me what kind of doctor I was, I usually said “general internist” and defined myself in terms of what I didn’t do: “I don’t take care of kids, I don’t do surgery, and I don’t deliver babies.”

Gradually, internal medicine residencies began cranking out subspecialists—pulmonologists who managed ventilators; nephrologists who did fluid, electrolytes and renal failure; and cardiologists who had started using catheters to treat those MIs I had been seeing. The name of our group, Consultants Internal Medicine (CIM), quickly became an anachronism. I continued to see patients both in the hospital and the office, but I saw only my own patients. When people asked me what kind of doctor I was, I said “primary care internist,” adopting the term, “primary care,” that had by then gained currency with the medical profession and by the general public.

Most recently, after CIM closed and I moved to a clinic in a large health care system, I stopped seeing my patients in the hospital and now restrict my activities to office practice. I still identify myself as a primary care internist, but my duties have further narrowed since my early days.

Primary care itself has had as many identities as I have since I began practicing in 1977, even though the idea is as old as the Rockwell painting of the family doctor. Indeed, the general practitioner and his heir, the family physician, have for years epitomized the initial concept of primary care, taking care of patients and their families cradle to grave. But it soon became apparent that if primary care meant taking care of the everyday medical needs of patients, then internists, gynecologists and pediatricians also fit the title. Recent shortages of primary care doctors have encouraged the integration of nurse practitioners, physician assistants and even EMTs into primary care. In some settings, it is teams of providers who do the job of Rockwell’s doctor.

The shortages are the product of technological allure and economic forces. Subspecialists have all the gadgets, and using those gadgets pays better than listening to patients. For medical school graduates facing $200,000 in educational debt, the choice of specialty sometimes boils down to simple financial arithmetic.

So what will lure future medical students into the ranks of primary care? Perhaps the advent of the team approach to medical care delivery will appeal to them. Perhaps the ability to deliver comprehensive care to a community will draw some. Perhaps the bonuses offered by large health care systems will tempt others. But the main draw now and always—the thing that keeps me at it and what is reiterated again and again in our article about why physicians choose primary care is relationships with patients. As one respondent said, “It’s all about the patients.” MM

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