Trained to Avoid Primary Care

The message came unexpectedly. On a Tuesday night, while my wife and daughter were asleep in the next room, I ran hurriedly through the day's e-mails to make sure I hadn't missed something important. Despite duty-hours restrictions and elective rotations as a second-year resident, I still rarely went to bed with my family. Message 38 for the day:

> Dear Dr. Dowdy,
>
> I am a social worker writing to you regarding a patient we shared. His name was Daniel Kovacs. Mr. Kovacs died yesterday. The Public Administrator's office is making final arrangements for Mr. Kovacs because he was indigent, had no durable power of attorney, and no next of kin listed. Because you were his primary care provider, I am wondering if you have any information about any relatives or friends who may want to give him a dignified burial. I would like to contact them before letting the county bury the body in an unmarked grave.

I sent off a quick reply—"He had no next of kin . . . I hope his final days were peaceful."—and moved on to the next message. Mr. Kovacs was a 69-year-old man with metastatic bladder cancer. He hadn't been to my office in almost a year. My thoughts turned to the paperwork the county would request the next day. The entirety of my primary care training to date had consisted of about 50 afternoon clinic sessions, but I also had 12 months of inpatient care under my belt. I hadn't seen a case of elbow pain or active menopause yet, but if there was a skill I had acquired by now, it was filling out a death certificate.

While reading message 39, I suddenly felt tears in my eyes; tears not for my patient, but for myself. I had chosen a career in medicine to dedicate myself to healing the lives of others, and before my training was even complete, I was treating the end of a life as nothing more than e-mail 38, on another Tuesday night.

I spent the next 15 minutes holding a mental memorial for Mr. Kovacs. He had two loves in life: his girlfriend and his chessboard. In both aspects, his life was one of tragedy. He had emigrated from Hungary in 1960 and lost his wife to illness soon afterward. He then fell in love again, gave up his job as a painter to be with his new girlfriend, and was lost when she left him. He never found work or love again. Problem number one on his agenda for our first meeting: "I wish I could see my girlfriend one more time." He had been a Hungarian junior chessmaster in the 1950s and had continued to play competitively for years after coming to the United States. By the time we met, he spent his time playing street chess with other members of the San Francisco homeless community.

Mr. Kovacs had metastatic bladder cancer and a 6.5-cm aortic aneurysm. He consistently declined treatment for either.

"I could never have surgery or chemotherapy, Doc. No one would look after me while I recovered."

Various attending physicians responded to his stoicism with a mix of indignation and resignation, but because I had a different supervisor for each visit, no one ever saw him more than once. I ultimately decided that I could not fix Mr. Kovacs' physical ailments. Instead, we tackled problems higher on his agenda than on mine. I stopped pressing for aggressive treatment. He started talking about his goals in life and how to achieve them. I requested that he return to see me in 3 months; however, my hospital schedule had been mapped out for only 2 months. Consequently, Mr. Kovacs was told that an appointment card would be mailed to him. Being homeless, he had no address. I tried to call, but his telephone number was disconnected. My next contact with him would be e-mail 38.

I had begun residency in internal medicine convinced that I would pursue subspecialty fellowship. It was more about prestige than the money. I had made countless calls to consultants for advice, and I wanted to be on the other end of that line. I liked the idea of primary care in theory, but it wasn't sexy enough, to put it bluntly. The most intelligent, captivating, and exuberant physicians I knew were all subspecialists. It never crossed my mind that the closest thing I had to a primary care mentor during internship was my clinic preceptor, a chief resident whom I saw once on a good week and was now an infectious diseases fellow.

Despite the lack of mentorship, Mr. Kovacs and other clinic patients have convinced me to pursue a career in primary care. Mr. Kovacs showed me that I could not think about his bladder or aorta without also considering his girlfriend and his chessboard. He always greeted me with a smile, even while declining every medical intervention I offered. I learned that I needed to deal with a patient's social and psychological complexity to feel fulfilled. Sadly, because I lacked that primary care mentor, it was Mr. Kovacs, and not a physician, who taught me that I was a primary care physician at heart.

When I finish residency, I will be one of less than 20% of my residency program colleagues pursuing a career in primary care. After nearly 3 years in residency and having spent about 10% of my clinical time learning primary care, this does not come as a surprise. The problem isn't just the amount of time spent in primary care; it's how that time is spent. My typical clinic session starts at 12:30 p.m. I simultaneously eat lunch, listen with one ear to a preclinic teaching conference, rummage through the previous week's laboratory test results, and wonder how to manage the toughest inpatient cases from the morning. I am then re-

leased to see clinic patients in rapid-fire fashion for 4 hours: find the chart, greet, interview, examine, plan, discuss with attending physician, discuss with patient, write note, repeat. Before going home, I often return to the inpatient wards to see the patients whose conditions I have been puzzling out. I do not return to clinic for another week.

In this whirlwind of medical delivery, the negative effect of nonclinical tasks on resident morale cannot be overstated. It's not just lack of mentors or haphazard schedules. Every day I come to clinic, I am reminded firsthand of the nonclinical burdens faced by every primary care provider in the country. I fill out refill authorizations, disability requests, nonformulary medications, and employment clearances. I look up patient addresses, ICD-9 codes, immunization records, and laboratory test results. I wait on hold to talk to pharmacies, insurance companies, medical equipment providers, and case managers. I cannot perform these tasks at home or during my commute because of privacy restrictions. I am acutely aware that every form and telephone call takes minutes of "daddy time" away from my 6-year-old daughter. I have seen her less during my residency than at any other time in her life.

By contrast, my subspecialty experiences during residency have been focused and continuous. I spend entire months on consult services and in specialty clinics living, thinking, and breathing cardiology or infectious diseases and interacting with mentors on a daily basis. I come out of those months excited about what I've learned. Because continuity clinics lack the capacity to train residents 5 days a week, I can't have a similarly intensive primary care experience until I finish residency. And even though I know subspecialists work at least as many hours as primary care physicians, my latest night home every week during subspecialty elective months is still the night of my continuity clinic.

None of this excuses me for feeling annoyance instead of grief when I heard of Mr. Kovacs' death. However, it's still hard to escape one thought. Maybe residents are being trained not to enjoy primary care.

In the end, I remain committed to primary care, but I continue to have occasional moments of doubt. I still wonder if I'd be a better father and husband if I didn't have to stay late to call insurance companies and pharmacies. I still ask myself whether I will be able to practice with a passion that will inspire future trainees to follow the same path. For now, these concerns are outweighed by the sense of purpose I experience in partnering with such patients as Mr. Kovacs. But I do wonder if I'm learning in a system designed to persuade me otherwise, a system that still fails to value primary care.

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