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In January 2006, the American College of Physicians published a report containing this dire warning: “Primary care, the backbone of the nation’s health care system, is at grave risk of collapse.” Demand is growing, according to the report, but medical students, worried about intense practice pressures on generalists and lagging compensation, are increasingly opting for other specialties. Moreover, fewer college graduates are choosing to study medicine. In this issue of *Proto*, we explore the implications of a doctor shortage for our aging population.

Although the dearth of physicians touches many specialties, its impact on primary care may be most worrisome. Part of the trouble is that primary care’s image—of kindly doctors giving shots, treating sore throats and preaching prevention—doesn’t reflect reality. The best internists, pediatricians and family physicians are master diagnosticians who analyze subtle clues to devise treatment plans. Many coordinate an intricate web of care for older patients plagued with growing lists of problems.

Yet such rewards do not appear to inspire today’s medical students. Many seek the excitement (and higher salaries) of cutting-edge disciplines. Others opt for specialties that also leave time for a life outside medicine. In 1998 more than 50% of third-year internal medicine residents chose careers in general internal medicine. In 2003 that figure had plummeted to 27%.

A future in which a shrinking cadre of primary care physicians must look after a ballooning population of older patients will have profound consequences. It will become more difficult for patients to find a generalist, and those who do have one will experience longer waits for appointments and rushed office visits. Finally, such a shortage will hurt quality of care and boost costs as rudderless patients see the wrong specialists or suffer the effects of ill-advised drug interactions.

Fixing this broken system will require many changes. Some palliative measures—better use of information technology to ease administrative burdens and a team approach that hands off some care to nonphysician clinicians—could help. But we also need a reimbursement system that puts greater value on what primary care physicians do. That won’t happen quickly or without debate. Yet against this background of shifting demographics, finding a solution can’t wait much longer.

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