FROM THE EDITORS' DESK

Making the Case for General Internal Medicine

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My mother's general internist (I'll call him Dr. M) cares for her complex medical problems with impressive technical and interpersonal skill. She is 89; he is in his early 70s. I often wonder, when Dr. M retires, will anyone be there to take his place? Approximately 25 % of U.S. residency training slots are in internal medicine (IM), but at least 60 % of IM graduates pursue subspecialty fellowships; among the remainder, half or more are taking hospitalist positions. That leaves less than 5 % of US medical school graduates in pursuit of careers like Dr. M's. In California, where my mother lives, 47 species of plants and animals are listed as endangered. They should add the office-based general internist to the list.

The decline of the office-based general internist couldn't come at a worse time. The number of Americans over age 65 is expected to double by 2030, reaching nearly 20 % of the population. The elderly take more medicines, make more visits, and require a more complex mix of skills than their younger counterparts. And, like Dr. M, the physician workforce itself is aging; more than 250,000 physicians are over age 55. Community health workers, nurse practitioners, health coaches, "primary care technicians," and others practicing "at the top of their licenses" can help care for the swelling population of older Americans. But patients like my mom still need a doctor.

This issue of *JGIM* features a Special Symposium on Geriatrics. This collection includes papers on clinical care, research and policy. The article by Chang et al.¹ is particularly enlightening with respect to the emerging workforce crisis. Geriatricians are among the most professionally satisfied of all physicians, yet their numbers are small and insufficient to serve the growing number of elderly. Chang et al. urge collaboration between internal medicine and geriatrics as the surest way to ensure high quality care for the generation of retiring Baby Boomers.

Other articles in this issue underscore why sons and daughters across the country should worry about the endangered office-based internist. In an analysis of data

from the National Ambulatory Medical Care Survey, Edwards et al.² report that the percentage of primary care provided by specialists is declining over time. Generalists are filling the gap, but will this last? Spatz et al. show that lack of a usual source of care is associated with increased mortality after myocardial infarction.³ Finally, the article by Ahmedani et al.⁴ underscores the role of primary care physicians in delivery of mental health services, specifically preventing death by suicide. The authors found that 83 % of patients dying by suicide received health care in the prior year, but only 24 % received a mental health diagnosis. An accompanying editorial by Duberstein and Jerant⁵ makes the case for "optimistic humanism": attending to clinical judgment and patients' desires, while avoiding the extremes of "biomedical exuberance" and therapeutic nihilism.

Office-based general internal medicine faces many challenges, but its survival is crucial to meet the health care needs of our aging population. Meeting these challenges will require creative energy and adaptability, empirical evidence and political will. In this and future issues, *JGIM* aims to stimulate dialogue, highlight innovative solutions, and inspire students and trainees to pursue careers like Dr. M's.

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