

Virtual Mentor

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Balancing Prestige with Personal Satisfaction and Social Need in Specialty Choice

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“Basically, no matter what they wrote on their med school applications, people really want to make money.”

“Really? I don’t hear *my* friends talking about money.”

“OK, maybe money isn’t the top priority for everyone, but all of us want other people to be impressed that we’re doctors.”

It was 1977, early in my medical school years. A cynical senior student—my older sister—was responding to my confusion about why several of the top students in her class had chosen specialties like radiology that allowed plenty of access to gizmos but minimal patient contact.

The number of medical students who pursue primary care has long been a concern [1], but the prestigious fields when I was a medical student in the ’70s were internal medicine, general surgery, and orthopedics. Although orthopedics residency programs continue to be highly selective, internal medicine now ranks near the bottom in North America. The next most selective specialties are now all high-tech: otolaryngology, radiation oncology, dermatology, and diagnostic radiology [2]. Paradoxically, these specialties, which allow for undeniably easier lifestyles than internal medicine, family medicine, pediatrics, ob/gyn or general surgery, also pay more than the fields with challenging night call—a combination that can’t help but nudge students’ career choices away from the most needed fields. This current trend in the U.S. is not inevitable or universal: internal medicine and general surgery are still the most selective residency programs in contemporary Australia [3].

During our specialty explorations 35 years ago, students already expected to do residencies rather than go into “general practice.” Family medicine was a new, rapidly growing specialty. Then, as now, populations lacking adequate primary care were abundant. More physicians were needed in both rural and urban communities in every state, while affluent suburban areas were oversupplied with physicians. Then, as now, those whose lives were disorganized by mental illness, poverty, or substance abuse needed ER visits for primary care (as well as for trauma and mental health care). But despite the challenges of hands-on caring, we felt there was prestige in being medical students, period.

After my sister's internship, the Public Health Service sent her to a remote South Dakota town with fewer than 1,000 residents, which was culturally challenging at the time. No one but the lone physician assistant had any education beyond high school. With no Internet, the intellectual stimulation came from the Sunday *New York Times*, delivered by mail approximately a week late. No medical information was available, either, outside the textbooks she had taken with her.

Since my sister's isolated work in the late '70s, the information age has enhanced patient safety and professional satisfaction for physicians in rural practice. Medical information, formal consultations, radiology readings, and informal professional conversation are all easily available online. But the popularity of rural practice has not bounced back, nor has the percentage of medical students pursuing primary care. Students entering medical school with an interest in primary care often change their minds after encountering the myriad specialties and subspecialties with all their bells and whistles, and even schools designed specifically to produce primary care physicians have struggled to fulfill this mission [4].

Why are students in North America abandoning this initial interest? Not only is care of the underserved undeniably challenging—explaining medical conditions and forming therapeutic alliances requires time and deliberate practice even in affluent suburbs where patients are more often culturally similar to medical practitioners—but medical students, like most Americans, tend to be enamored of gadgetry. In medicine, this tendency to believe in the therapeutic power of any new technology over primary care practitioners' expertise has been provocatively dubbed “gizmo idolatry” in *JAMA* [5]. Even outside of medicine, the work of professionals whose “tech” relies on face-to-face communication with others—teachers and religious leaders, for example—is less well rewarded than the high-tech work of professionals like engineers. The intrinsic rewards for the former are great, but salary and prestige do not follow. Within medicine, a pediatrician, family practitioner, or psychiatrist rarely earns as much as a gastroenterologist busy with endoscopies; salary and prestige follow high-tech more than high-touch specialties. Prestige associated with technology is not guaranteed to be permanent, though; even “rocket scientists” note recent decline in their societal status [6]. Recognition of contemporary medicine's “gizmo idolatry” is a first step toward rebalancing prestige in the direction of the primary care physician's true value to society.

For the individual physician, nothing beats the intrinsic rewards of working closely with real patients. I've counseled students who had been advised by their parents not to follow them into high-tech, low-touch fields because they felt like burnt-out, selfish technicians by the end of their first decade in practice. I wouldn't want to be someone who does anything over and over and never learns patients' stories—whether the repetitive practice is endoscopy, cataract removal, or prescribing acne medication. It is easy to be seduced by the admiration of peers at matching into a selective specialty, but maturity and self-respect allow one to see the benefits of serving human need.

A general surgeon myself, I have been embarrassed by colleagues whose enthusiasm for their cool tools or drive to be recognized for developing new procedures seemed to exceed their concern for their patients. But I am more appreciative of technology-enchanted subspecialists now than I was 35 years ago. When I was a student, cholecystectomy meant NG tubes, more than a week of hospital stay, and an incision 8-10 inches long across the upper abdomen. We always placed a messy Penrose drain through an inch-long stab incision, bigger than any of the port sites for current laparoscopic cholecystectomies. Naturally, after that major procedure patients needed months to fully recover. Thanks to other surgeons' drive to play, excel, or innovate, removal of the gallbladder became an outpatient procedure. Similarly, the most common major operation during my med student years was "exploratory laparotomy," always painful and frequently complicated by infections, incisional hernias, and bowel obstructions. Major surgery for diagnosis is now completely obsolete, though, thanks to the people (like my sister's classmates whose interest in radiology baffled me) who developed the ultrasounds, CT scanners, MRIs, and other devices.

That said, while the needs of society are important, medical students are also people with legitimate needs and interests. Resentful, unhappy primary care providers probably do less good for their patients (or friends and family) than happy high-tech radiation oncologists or robotic surgical innovators. The AAMC is probably right to not prescribe fixed percentage targets for each specialty.

So what should a current medical student do? Get to know your own values and priorities. Go into as many different clinical settings as you can with an open mind. We don't always know what kind of medical practice will make us happy, but clerkship experiences can help overcome our preconceptions. Acknowledge the needs of others and geographical, societal, and family obligations. And remember that you are not necessarily locked into a particular place, specialty, or type of practice. Many clinicians change locations or specialties. Others pursue private practice the majority of their time, but make altruism a priority by regularly staffing local free clinics or intermittently working in other underserved areas, whether in this country or elsewhere in the world.

When all is said and done, all medical specialties have enormous prestige in the eyes of nonphysicians, and the vast majority of physicians in the United States earn plenty of money. There is definitely no one "right answer" for your specialty choice—most of us could be happy in a wide variety of specialties.

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Further Reading

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