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Saving Primary Care

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It is time to face the facts: Primary care in the United States is on death row. Although generalist, family, and general internal medicine physicians represent the largest numbers of physicians and provide the majority of medical care, entry into these specialties has decreased. Since 1998, the number of graduating physicians entering family medicine has decreased by 12%. Although the number of graduates entering internal medicine and pediatrics has remained stable, the number of graduates choosing to pursue study of an internal medicine subspecialty has increased by 21%, and the number of graduates pursuing a pediatric subspecialty has increased by 62%.[1] Moreover, substantial numbers of graduating general internists are taking jobs as hospitalists; ~83% of hospitalists are internists.[2] The toll of these trends on primary care has been dramatic. Among third-year internal medicine residents in 2003, only 27% planned to practice general internal medicine, one half the rate of 1998 graduates.[3] Add to this trend the current and near future attrition from primary care—when the first time-limited diplomates in internal medicine were required to recertify, 21% of general internists reported that they were no longer working in internal medicine.[4] Furthermore, 35% of physicians are aged more 55 years and will be retiring within the next couple of decades.[5]

THE EXODUS FROM PRIMARY CARE

The 2 most commonly cited explanations for the exodus from primary care are money and lifestyle. Socioeconomic trends in medicine and lifestyle choices among graduating physicians have changed. Within internal medicine, tremendous disparities in income across subspecialties have emerged. On average, a gastroenterologist earns more than twice as much as a general internist.[6] With median indebtedness on graduation from medical school ranging from $115,000 (public institution) to $150,000 (private institution),[7] the prospect of earning a median annual income of $158,000 as a general internist is not appealing to new physicians. Not surprisingly, higher debt is associated with selecting careers other than primary care.[8] In large part, the income discrepancies between primary care physicians and subspecialists are the result of procedures, which are highly valued by all payment systems. For example, Medicare pays a subspecialist 5 to 40 times more to perform a procedure than it pays a primary care physician to discuss whether the procedure is consistent with the patient's goals. Moreover, most payment systems do not recognize the value of avoiding more expensive care. The telephone call or e-mail that prevents an office visit is uncompensated. The primary care geriatrician who makes several calls to family members and subspecialists to formulate a plan and then places daily follow-up calls to monitor and adjust treatment, all in an effort to keep a patient out of the hospital, receives none of the thousands of dollars of savings that accrue to Medicare as a result of the avoided hospitalization. Most physician payment systems encourage more, not efficient or better, care.

The second commonly recognized reason for the decline of primary care physicians is lifestyle. A recent study identified "controllable" lifestyle as the most important reason for specialty choice among graduating physicians.[9] In the office, primary care physicians feel pressured and unable to spend enough time with their patients. In fact, physicians rate having more time to spend with patients as being the most effec-

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tive strategy to improve quality of care.[10] Yet more than one half of the same physicians believe that improving quality would mean less income.[10] Primary care also requires substantial work that occurs outside the context of face-to-face encounters and beyond the traditional boundaries of the scheduled office visit or usual work hours. Telephone calls, family meetings, and e-mail correspondence are necessary components of primary care that add to the unpredictability of the workday. Beyond these direct patient care responsibilities, an additional burden of administrative paperwork is required to help patients negotiate the fragmented health care system and to sometimes meet social needs (eg, moving to an assisted-living facility).

At the end of the day, many primary care physicians feel they are leaving tasks unfinished. They are worn out and frustrated and feel guilty for not meeting their responsibilities to their patients or their families. Thus, failure to attract large numbers of graduating physicians to primary care should hardly come as a shock. It is somewhat surprising that anyone enters the primary care field.

So what is to be done? One solution would be to abandon the primary care physician model altogether in favor of midlevel providers coupled with subspecialists. This approach is widely used in subspecialty and surgical practices in which physician assistants and nurse practitioners complete the work that is closest to primary care. Another alternative to primary care physicians is walk-in clinics staffed by nurse practitioners, which are appearing in retail locations. Yet, these solutions do not provide the comprehensive, longitudinal relationships that characterize the primary care model. Moreover, evidence suggests that the public desires primary care physicians.[11] Primary care physicians can provide high-quality and more efficient care than subspecialists.[12,13]

SAVING PRIMARY CARE

The alternative approach to abandoning primary care would be to save it. The simple solution to saving primary care would be to pay primary care physicians more. Although payment reform is essential, it alone is insufficient to salvage primary care. A more comprehensive approach to saving primary care is needed to make the practice more desirable. An empiric, although not evaluated, model would posit that physician satisfaction (and specialty desirability) depends on professional factors, personal factors, and the interaction between these 2 factors. Professional factors include:

- Intellectual stimulation ("Is my work interesting and challenging"), meaning ("Am I contributing to the greater good of individuals and society?");
- Resources and support ("Do I like my work environment?" "Do I have the support I need to do my work?");
- Independence ("Do I have decision-making ability to benefit my patients?");
- Respect ("Do my patients and peers hold me in high regard?");
- Collegiality ("Do I feel like I am part of a community of professionals with similar goals and needs?");
- Potential for professional growth ("Can I advance in the coming years?");
- Lifestyle ("Are my work and work hours circumscribed and predictable?"); and
- Compensation ("Can I support myself and my family?").

Personal factors include: family, community responsibilities, geographic location, and personal interests and growth. Finally, each physician must establish her or his own balance between personal and professional priorities. When these priorities are in conflict, discontent follows.

Fortunately, all of these professional factors are mutable, and improvement is possible. This article recommends 7 steps that the profession, health care systems, academic medicine, governmental agencies, and insurers (including the Centers for Medicare and Medicaid Services) could take to revive primary care.

Discarding the Artisan Model

First, medicine as a profession must discard the artisan model of primary care. Although each patient is an individual with unique needs, the notion of a single physician who alone knows every intricacy of a patient and serves as the sole contact is unrealistic. Such a model may work for concierge medicine in which practice sizes are far smaller than in traditional settings, but it is untenable for most primary care physicians. Physicians have been their own enemies in expecting primary care physicians to function in antiquated roles. Once they relinquish their impressions of what a primary care physician is supposed to do, primary care medicine can begin to redefine the job description to make it more appealing.

Promoting a New Vision

Second, primary care medicine must actively promote a new and positive vision of primary care physicians as specialists. In 1776, Adam Smith described the value of specialization, which has endured as a major principle of economics: "Each individual becomes more expert in his own particular branch, more work is done upon the whole, and the quantity of science is considerably increased by it."[14] The primary care physician is a specialist in the comprehensive care of the patient. In the 21st century, primary care is an integral part of an organized health care system and team of providers. Indeed, medicine must embrace and promulgate the notion of the primary care physician as quarterback rather than decathlete. As team leader for a patient, the

primary care physician is responsible for getting the job done but does not perform every function personally. Rather, this model capitalizes on the primary care physician's unique knowledge and skills, which are complemented by the skills of other team members. Professional organizations, such as the American College of Physicians and the American Academy of Family Physicians, need to actively market this new image of the primary care physician to the general public.

Changing Medical Groups

Third, medical groups need to fundamentally change the work of primary care physicians by applying systems approaches. These approaches, which increase quality while improving service, include better information systems (eg, electronic health records) to support decision making and documentation, integration of quality improvement into patient care processes, and delegation of patient care tasks (eg, data collection, urgent care of minor illnesses, comanagement of chronic conditions, and health education) to lower-level providers whenever possible. In other words, primary care physicians need to make it as easy as possible to do the right thing to improve their patients' health.[15] Only then can primary care physicians fully realize the attractions that brought most of them to medicine—accurate diagnosing and implementing successful therapy, shared decision making with patients, and comforting those who cannot be cured. By eliminating the drudgery of practice, primary care physicians will have time to rediscover the pleasure of talking to patients and, most important, being their advocates. This advocacy may range from appealing to an insurer to obtain coverage for a desired treatment to protecting patients from tests and procedures they do not want. Physicians have a unique opportunity to be more than dispensers of medical care; they can become part of their patients' lives as trusted friends. Sometimes, delivering bad news or discussing hospice care can be among the most meaningful aspects of a primary care physician's responsibilities.

Training Programs

Fourth, training programs must expose students and residents to desirable primary care practices. These practices must use systematic approaches and efficient health care delivery models. After all, this time is the best opportunity for physicians-in-training to test drive the careers they will soon select. Dysfunctional practice settings send strong messages. Residents who must make countless phone calls to schedule patient appointments and tests may quickly decide that primary care is not the life for them. Curiously, the infrastructure provided at many academic general internal medicine clinics is far less than at subspecialty clinics in the same institutions. In clinical teaching settings, physicians-in-training must have role models who practice primary care medicine for a living, enjoy it, and are committed to the discipline.

Improving Professional Lifestyles

Fifth, medical groups need to improve the professional lifestyles of primary care physicians. If primary care is to recruit physicians, it also must recognize that these physicians are mothers, fathers, spouses, partners, daughters, and sons. They are community leaders, artists, and little league coaches. More than ever, physicians want to have lives outside of their careers. Failure to accommodate the desired lifestyles of the next generation of physicians will drive them to enter specialties, such as dermatology or radiology, that offer predictable work hours, less call, and more flexibility. To be competitive, primary care must similarly respect the personal and professional life choices of today's graduating physicians. Physician groups need to explore creative solutions, such as shared practices in which patients relate to more than 1 primary care physician. Such job sharing and redesign is being used successfully among business executives.[16,17]

Financial Incentives

Sixth, state and local governments should recognize that the lack of primary care physicians is an impending crisis for health care. Accordingly, loan repayment programs and other incentives to enter primary care should be initiated.

Finally, payers need to better compensate primary care physicians. The current reimbursement systems are heavily weighted toward the skills and training required to perform procedures rather than cognitive effort. With few exceptions (eg, large group and staff model managed care systems), payers have been blind to the value that primary care providers bring to quality of care. Payment systems fail to appropriately acknowledge the evaluation, reasoning, management, coordination, communication, and advocacy roles of primary care physicians that are the core of health care in the United States. These elements of care must be compensated to reflect their value.

Given the current economic climate, it is unrealistic to expect substantial new money from commercial insurers or the Center for Medicare and Medicaid Services to support higher salaries for primary care physicians unless there are savings elsewhere. Rather, funding would need to come from redistribution of payments to physicians or for other services. Such zero-sum game approaches to increase compensation of primary care physicians will be hard-fought battles, pitting physician specialty against physician specialty or physicians against other components of the health care system. Nevertheless, such approaches should be considered.

Other tweaks, such as pay for performance, have been proposed as vehicles to increase primary care physician income. Early evaluation of the UK experience with pay for performance suggests that physician income increases substantially and quality of care improves.[18] However, the UK experience was accompanied by the infusion of additional money into the health care system, which is unlikely in the current US economic environment. Moreover, the early evaluation of the US experience is less convincing that either quality will be improved substantially[19] or that physicians will receive higher remuneration.[20] Even in the best case scenario, it is still uncertain that payment linked to quality would be sufficient enough to make it worthwhile to enter primary care. A more fundamental overhaul of the payment system is needed. Unless a graduating physician can expect to earn enough to repay a student loan, purchase a house, and begin a family within a decade of completing training, the discipline cannot hope to recruit physicians.

In the absence of any momentum for payment reform, some primary care physicians have already pursued methods to increase income by converting to concierge practices or opting out of insurance plans (including Medicare), insisting that patients pay full charges and making them collect whatever portion they can from their insurers. Similarly, some physicians have begun charging for telephone calls and meetings. Although these efforts may benefit individual physicians, they apply only to the segment of the patient population who can afford to use their services. Other primary care physicians have captured revenue streams, such as performing pulmonary function tests, cardiodiagnostic tests, or minor biopsies, that are traditionally the purview of subspecialists. However, this approach does not solve the fundamental problem of paying for the needed services that primary care provides. A more comprehensive strategy of payment reform is needed.

Implementing these 7 steps is a tall order that will require the efforts of diverse groups, including professional societies, medical groups, health care organizations, academicians, governmental agencies, and payers. Nevertheless, successful implementation would improve the attractiveness of primary care as a career and preserve the elements that both patients and physicians desire. Persisting with models that fit 20th century medicine are, in the words of F. Scott Fitzgerald, "boats against the current, borne back ceaselessly into the past."[21] It is time to either revitalize primary care in the United States or give up on it. Sadly, inaction is tantamount to the latter.

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