

Endangered species

Let us discuss family physicians and general internists, the two hundred thousand doctors who provide most primary care in the United States. Let us face the reality that until a solution is found that improves their lifestyles, self-esteem, and reimbursement . . . the already dysfunctional health care system in this country may become even worse. The facts are these:

- Between 1997 and 2005 the number of U.S. medical school graduates entering family practice residencies dropped by fifty percent.

- Only twenty percent (down from more than fifty percent in 1998) of third-year internal medicine residents will go into general internal medicine; of the remainder almost sixty percent will become subspecialists and fifteen percent will be hospitalists.

- The ratio of people to geriatricians in the United States is about one hundred thousand to one.

Do these numbers reflect a callous loss of empathy among new physicians, a marked decrease in their desire to care for chronic disease and all aspects of a patient's care? I doubt it. But it does appear that students' idealism and commitment to serve the suffering are being diluted and are diffusing away when the reality sinks in that the mean annual compensation for specialists ranges from 70 to 350 percent more than that for primary care physicians. Added fuel to choosing career decisions in the specialties is the accumulated educational debt of new MDs, one that often exceeds \$100,000.

Does having all these specialists guarantee that we have longer, healthier lives? Not really. Residents in the United States (per capita expenditure of about \$6000) are less healthy than their peers in England (\$2164 per capita expenditure for medical care), and these differences exist at all points on the socioeconomic distribution. Dartmouth Medical School investigators have compelling evidence that patients in high-spending regions in the United States (longer hospital stays, longer ICU stays, and more physician visits) have slightly shorter life expectancies and less satisfaction with their care than those in areas with lower spending. Health care costs in the USA are still rising at twice the rate of inflation. Workers continue to give their pay raises to the health system.

These problems—diminishing interest among medical students in primary care, a less healthy populace, and excessive costs—are related both in cause and in potential cures. A common cause, identified by the Stanford Universal Health Care Group and by the Commonwealth Fund, is the failure, over the past fifty years, to recognize and adapt to the emergence of chronic disease as the dominant health problem confronting our health care system. What we need now is a practice of medicine that would improve both patient care and physician satisfaction. Ingredients of such a plan might include:

- Providing continuity of care by a team that includes allied health professionals and is led by a primary care physician
- Making the patients central members of the health care

team by respecting their needs, uncertainties, and goals, and providing them with education while expecting their studied involvement in decision making

- Giving an ample amount of preventive medicine tailored for each person

- Establishing the primary care physician and her team as those who will develop evidence-based advice for patients about medications, specialty referral, and the cost-benefit of procedures

- Ensuring ready access to care with swift replies to telephone calls and electronic mail, same-day appointments, access to community-based resources, and availability to one-on-one sessions with the doctor.

But how could these teams operating in this paradigm be reimbursed? Certainly not by current formulae. Why not try a system used by many other professions: Payment by the hour?

Each member of the primary care team could be paid a rate per hour based on their level of training. "Administrative time," including telephone calls, e-mail, reading journals or internet material relevant to specific patients, coordinating referrals, and completing insurance forms would be reimbursed at an hourly rate less than that paid for face-to-face patient/doctor interaction. This reimbursed time to reflect, to read, to talk with consultants and patients would increase quality of care, increase job satisfaction, decrease errors, and diminish numbers of malpractice suits.

How can our society pay for giving primary care physicians reimbursement sufficient to draw our students back into this field and provide patients with the type of care (not the amount of care) that they deserve? That is not to be solved in this column, but if it is agreed not to let primary care and the chronic disease care model die away, solutions might include a small tax on the profits of the peripheral health economy—the device manufacturers, insurance companies, and pharmaceutical companies. For that matter, for-profit as well as not-for-profit hospitals that have excessive revenue over expenses could contribute to the pool as well. If there is true will and determination among our elected officials, while saving primary care policies (such as a well-designed single payer system) also could be set in place to provide coverage to those forty-seven million Americans without health insurance.

These will strike many as radical ideas, but such may be necessary to give the primary care base of our superb subspecialty care superstructure a continued life.

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Editor