A Primary Role for Primary Care

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In a recent Wall Street Journal Report, Drs. Atul Grover and Elliott Fisher went head to head on the issue of creating new residency slots to increase the supply of physicians. Grover, the chief public policy officer for the Association of American Medical Colleges, argues that patient demographics and the failure of recent innovations in health care delivery to reduce demands on physician time mandates that the pipeline for new physicians be expanded. Fisher, director of the Dartmouth Institute for Health Policy, argues that by working "smarter," eliminating unnecessary care and better organizing care we can do just fine with our current supply. Let me explain, from the perspective of a primary care physician, why Grover is more or less correct and Fisher is off target.

The Dartmouth Institute and the work of Fisher and Drs. John Wennberg, H. Gilbert Welch and others have helped to shed light on inefficiencies in our system of delivering care. There can be no doubt that too many tests are ordered, too many drugs prescribed and too many procedures done that not only lack justification, but might be harmful to the patient. The health care "system" abounds with perverse incentives that reward doctors for doing more stuff and listening less. Because direct-to-consumer advertising of the ever-growing array of expensive new medications assures us of blessed freedom from depression, dyspepsia, dyspnea and dysfunction of the erectile type, patients have high expectations that every malady or potential malady needs a workup and a pill.

I believe that a well-trained primary-care work force is central to top-quality and cost-effective care, a belief that has been substantiated by many studies and is recognized by nearly every stakeholder in the U.S. health care economy. It is the family doctor, the trusted friend and adviser to the patient throughout his life, who is best equipped to engage in the shared decision making that Dartmouth Institute views as key to effective health care. While Fisher's notion that members of a "health care team" can handle many patient complaints without the input of a physician, my experience as a family doctor for 30 years has shown me that those visits for minor illness quite often evolve into highly informative and invaluable interactions with patients. On the books, a visit may be listed as "sore throat," but a primary care physician who has sufficient time with a patient can use it for a thorough discussion of risk factors, stressors and family dynamics. The new metrics-oriented world too often discounts such interactions and relationships. To paraphrase Einstein, "All that counts cannot be counted, and all that can be counted may not count." Fisher's vision of a brave new world in health care delivery would subject many patients to deficient and impersonal care, while demoralizing the ranks of the remaining docs, who will be largely relegated to electronic paper pushing.

We clearly need to develop additional training slots, particularly in true primary care, to meet the needs of our growing population and the expansion of health care coverage. To the credit of the system, more women than ever are entering the physician work force, and they should be able to take the time off to raise their families in the manner they see fit. For better or worse, fewer physicians of this generation work the 24/7 schedules of their predecessors. At my hospital, we now have 25 "hospitalists" who have taken over the work of primary-care physicians for inpatient medicine. These are internists and family physicians who would otherwise be available to provide outpatient primary care.

And "working smarter," the overused mantra of health care policy experts, will not close the gap between supply and demand in primary care. According to a study published in the November/December 2012 Annals of Family Medicine, 52,000 additional primary care physicians will

be needed by 2025 — 33,000 for population growth, 10,000 for the aging population and 8,000 for the additional number of insured patients. The common sense approach is to train more primary-care physicians in advance of the demographic tsunami, as opposed to playing catch-up with physician supply. I believe that every U.S. citizen should have not only comprehensive, affordable coverage, but also access to a personal family physician.

Dartmouth's Geisel School of Medicine has joined many other prestigious medical schools in perpetuating the so-called "Dean's Lie" regarding its output of primary-care physicians. It was reported that 44 of the 103 graduates in the Dartmouth Class of 2013 selected primary-care specialties. Reality check: Only five went into family medicine, with the remainder selecting "primary care" specialties that have little to do with primary care. It is estimated that 85 percent of students going into internal medicine will subspecialize (cardiology, gastroenterology, rheumatology, etc.) while 65 percent of students selecting pediatrics will do the same. It's not that we don't need well-trained specialists; it's just that we need a higher proportion of medical school graduates to choose genuine primary care. Just as we need to fix our insurance system and reimbursement for primary care — Fisher and the Dartmouth Institute are strangely silent about how the $300 billion to $400 billion that is siphoned off to support multiple profit-oriented insurance companies affects the delivery and cost of health care — we also need to change the way we educate medical students to make primary care more attractive.

Health care reform and health care policy have taken on unimaginable and truly incomprehensible levels of complexity. Too often lost is the simple need to resurrect a more personal approach toward doctoring. If we do so, while embracing technology that supplements but does not supplant patient care, achieving real reform will not be so complicated.

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