The Future of Primary Care

Philip Shaver, MD

The American College of Physicians recently voiced concern about a shortage of physicians, particularly general internists who are the traditional primary care physician for most Americans. In 2007, a survey of students graduating from medical schools in the United States found that only five percent planned to enter general internal medicine. To discuss the importance of primary care and its future, Eisenhower convened a group of primary care physicians. Participants included Mehrdad “Mike” Abbasi, MD, Internal Medicine; James Gaede, MD, Family Medicine, and Robert Waterbor, MD, Internal Medicine. The session was moderated by Eisenhower Cardiologist Philip Shaver, MD.

Dr. Shaver: I want to start by defining what we mean by primary care: internal medicine, family practice, pediatrics are generally considered primary care practices. Dr. Waterbor, why did you go into internal medicine?

Dr. Waterbor: I graduated from medical school in 1970, and I went into internal medicine because I believe a good internist is equipped to be a good detective.We see whatever comes through the door, and it can be anything from a surgical problem to an obscure medical diagnosis, and part of our job is to be able to recognize when something serious may be going on.

But,many things have changed. There has been an explosion of medical information, which makes it impossible for a general internist to have a reasonable understanding of the whole field of medicine. General internists now are playing more of the role of triage agents and primary care screeners.

Dr. Shaver: Internists used to be the “doctor’s doctors.” They were often the smartest people in the class, and there was great respect for them. Today, the United States primary care system is struggling. Increasing demands and expectations, coupled with diminishing economic margins, have created a challenging work environment.

Dr. Waterbor: Besides liking the detective aspect of the field, I do like the long-term commitment to patients that goes along with it.Getting to know patients is not only gratifying in its own right, but really enables me to assess their health a lot more easily. I no longer do many of the procedures I used to do, because specialists now do those things.When I first came to Palm Springs in 1975, there was no oncologist, no nephrologist here. There was only one neurologist. So, the variety of procedures is no longer there.

Dr. Shaver: There is also an economic penalty for being a primary care physician versus a specialist. But, you are saying there is an emotional reward that comes from getting to know patients and being with them when they’re sickest. Dr. Gaede, why did you go into Family Medicine?

Dr. Gaede: I was in South Dakota working with a small town general practitioner during one of my medical school rotations, and on the first day, we did a bowel resection for a colon cancer, took out a gallbladder, and delivered two babies. That was just the morning…. This experience (and the remainder of my time spent with this physician) was an intense and wonderful experience and was one of many significant influences to become a Family Physician.

Dr. Shaver: Would you make the same choice again?

Dr. Gaede: Absolutely. Being a board certified Family Physician has allowed me to have a broad base of experience. I served as a medical director for a fairly large hospital system. I have been able to testify before Congress and the Senate quite a number of times. I’ve done a considerable amount of clinical research, and of course, I have practiced Family Medicine which has been very gratifying to be a part of families growing, developing and maturing in a healthy manner. I have also had the honor of being a Clinical Professor for my entire medical career and teaching young doctors is truly rewarding. But, the circumstances under which we all practice have changed considerably. Because of the insurance system and government interactions with the medical world, we spend a good deal of time being patient advocates,making sure our patients get the care they need.

Dr. Shaver: Dr. Abbasi, you were also trained as an internist. Did you ever go into primary care practice, or did you want to be a hospitalist from day one?

Dr. Abbasi: I started my residency in 2002. The term hospitalist was coined in 1996. It refers to a physician who focuses on hospitalized patients, inpatient care.At that point I already had friends who were doing this.After my second year as a resident, I made the decision to definitely just do inpatient care only.

Dr. Shaver: I am a supporter of the hospitalist program here at Eisenhower. I think it has improved patient care. An example is the availability of having a physician “in house” 24/7. This leads to an effective early response team which has been shown to decrease the incidence of cardiac arrest in recent studies.

Dr. Abbasi: What I like about hospital medicine is having an opportunity to work with a variety of specialists on a day-to-day basis. One hour, you’re discussing a patient’s care with nephrology; the next, neurology; the next day, with the cardiologist — so you are constantly engaged with all the specialists. That is something that I thought I would miss if I spent the bulk of my time in an office.

Dr. Shaver: Do you feel you might be giving up this “emotional income” Bob and I were talking about, getting no longterm relationship with patients or families?

Dr. Abbasi: That is absolutely correct. The one downfall with what we do is that you don’t get to know people for a very long time.

Dr. Waterbor: I’ve always thought, unless you see inpatients and take care of them in the hospital, you lose your edge as a physician seeing outpatients.

Dr. Shaver: If you were told today you were going to do an internal medicine residency, but you basically would be doing predominantly ambulatory care, and your hospital patients would be going to the hospitalist. That wouldn’t interest you?

Dr. Waterbor: Not at all. I don’t know why you would do an internal medicine residency if that were the case

Dr. Abbasi: With a hospitalist, a patient comes in to the hospital and is admitted to the hospitalist, who is usually an internist. The internist then calls in the specialists and coordinates the patient’s care.

Many physicians, either internally or as a group, identify one person to act as their hospitalist. They admit for them. There’s less and less people like Dr.Waterbor to come and do the inpatient/outpatient as Bob does — to go to all three settings, office, hospital, nursing home. That’s not that common anymore.Now,more than half the hospitals in America have hospitalists that act in that capacity.

Dr. Shaver: To have a physician at the bedside, to me, at 2:00 in the morning is invaluable, and I think adds to the quality of care at Eisenhower.

Dr. Abbasi: We will be there to see the patients at their bed side at two a.m. The number of hospitalists is increasing nationally. But, there is always going to be primary care, because everyone needs it.All patients want and need to have someone to see continuously in the community for their day-to-day needs. The only question is, who is going to provide this primary care?

Dr. Gaede: A more fundamental issue is the supply of physicians versus the supply of patients. Between 2000 and 2020, we are going to have 87 million new patients (37 million previously uninsured and an additional 50 million in population growth) in the United States health care system. The country needs 200,000 more primary care physicians to meet present demand.As of 2020, we will need an additional 236,000 physicians to be able to provide the same access to care that we have at the present time.

Dr. Shaver: Do you think enlarging our student population in medical school is an answer?

Dr. Gaede: We’re a net importer of physicians, but how are we going to make them go into primary care?

Dr. Waterbor: Do we increase the number of foreign medical school graduates?

Dr. Gaede: That is already happening. This past year, 37 percent of the residency slots and 43 percent of the internal medicine slots were assumed by foreign or international medical graduates.

Dr. Abbasi: I have also found that patients are quite accepting of a good physician assistant or nurse practitioner as their primary contact for medical care.

Dr. Waterbor: Patient attitudes about their primary care physician can vary. I have some patients who will see a specialist if they have to, but their preference is for me to make the final decisions about their health care. I have others who only view me as a conduit for getting them in to see a specialist, and they really don't care about my opinion.

Dr. Gaede: A generalist can have an impressive array of knowledge.You can grow and expand your capabilities in medicine, particularly in primary care. I think that is the wave of the future.You want your best and brightest on the front lines. The problem is those best and brightest may not be going into medicine.

Dr. Waterbor: Is it every bright kid's dream to be a doctor when they are in high school? I don't think if you went into high schools now you'd find anything like that.

Dr. Gaede: When students look at the return on investment in their education, they see that you can go through four years of college, four years of medical school, three to five years of residency, or you can spend two years on a Harvard Masters of Business Administration [MBA]. The return on your investment with an MBA is roughly 10 fold what it is as a physician.

Dr. Shaver: Dr. Gaede, where do you think we'll be in ten years?

Dr. Gaede: I think, with guidance from the 200,000 practicing primary care physicians, as well as the 800,000 practicing physicians, we can maintain, and in fact, enhance the presence of primary care in the United States.We have the potential to redefine how primary care is delivered.Who better to do that than physicians?

Dr. Shaver: I think the shortage of primary care physicians is a problem, and one in which our readers should involve themselves. They have a say in how they want to spend their health care dollars, and they can ask their government representatives what they plan to do to address this issue. As a specialist, I admonish my patients to obtain a primary care physician.

If there is not a change in the present system, there is little impetus for medical graduates to practice primary care. Their importance as the "hub of the wheel," in other words, the coordinator with the specialists as the "spokes" must be recognized and rewarded, not only financially, but also with the appropriate respect they deserve.

Dr. Abbasi: I think the trend we're seeing nationally in recruitment for hospital medicine is that the bigger markets are saturated, and the smaller markets are also filling up slowly. So, the number of active hospitalists will level off. This will allow for more internist/family physicians to be available for primary care. Then, the economics of the system should change to allow primary care physicians to have more office staff and nurse practitioners. I think primary care has a bright future down the road.

Dr. Shaver: Urgent care facilities also help fill a void. There are times when a primary care physician says he or she can't see you today, but they think you need to be seen. Rather than go to the emergency room for everything, patients at Eisenhower have the option of going to three Eisenhower Urgent Care locations.

Dr. Gaede: Patients who access Eisenhower Urgent Care do have contact with Eisenhower primary care physicians, which provides patients with a continuity of care within the Eisenhower system.And, that will be developing throughout the valley, both with Eisenhower Primary Care 365 — which is a membership program that looks beyond office visits and creates an ongoing relationship between primary care physician and patients using the latest in current technology — as well as Eisenhower Primary Care.