The Future Of Primary Care

There are currently 400,000 primary care practitioners in the United States, 74 percent of which are physicians, 19 percent nurse practitioners, and seven percent physician assistants. Numerous studies have predicted a significant shortage of physicians in the coming decade, particularly in the area of primary care physicians. Healthy Living recently assembled several primary care physicians to discuss the future of primary care, the challenges facing both new and established physicians, and what drew them to primary care. Participants included moderator Philip Shaver, MD, Kinder Fayssoux, MD, David Ko, MD, Gregory Pecchia, DO and Peter St. Louis, MD.

Dr. Shaver: I'd like to ask each of you how you characterize your practice, and why you chose that model.

Dr. Fayssoux: I'm part of a large health group system associated with Eisenhower, Eisenhower Medical Associates, and I chose that primarily because of the flexibility. I didn't want to have a private practice; I wanted to go to work and be able to give my patients my full attention, and then be able to go home to my family and do the same for them. I don't have the time to worry about the business end of it [maintaining a practice] so I chose to work for an entity that completely handles this aspect of it. In addition to that, the group is part of the residency program [Eisenhower's School of Graduate Medical Education and Research] and I've always wanted to teach, so that influenced me.

Dr. Shaver: Peter, you've chosen a different path. You came here with a pretty standard practice, and that evolved into a concierge or boutique practice. Why did you make that choice?

Dr. St. Louis: Originally I had a very successful, conventional primary care practice. Just before 2003, it seemed to me that it was going to become more and more difficult to continue a high touch, personalized practice without making some kind of a fundamental change. That was in the early days of the concierge concept. A concierge practice seemed particularly suitable both for me and for my patients so that I could continue to practice in the style best suited for me and that I felt was the most beneficial for my patients.

Dr. Shaver: David, you have the unique position of having been a hospitalist and now you're in a traditional practice of internal medicine. It's a small group, fee-for-service, if you will. What was your pathway?

Dr. Ko: I did an internal medicine residency and then a geriatrics fellowship. When I came to the desert, I came as a hospitalist because it was convenient and I could hit the ground running and practice medicine. Ultimately though, my goal was to go into a traditional practice with my wife, with whom I had trained. We waited until our son was a little bit older before we started our practice. We have an office practice, take care of our patients in the hospital, and we also do house calls as part of the geriatrics component of our practice.

Dr. Shaver: Gregory, you have a similar situation?

Dr. Pecchia: I started in a private practice in Orange County 28 years ago — it was very successful, but unsatisfying in a number of ways, including the volume of patients that was required to maintain that style of practice. I was asked to look at the model here at Eisenhower, the Eisenhower Primary Care 365 program, which I would describe as kind of a hybrid between the pure concierge model and a typical traditional primary care model.

Dr. Shaver: Since the early 1990s, 21 percent of internists have left practice and only five percent of specialists have; that's for several reasons, mainly economic. Most medical students in general internal medicine believe there's more paperwork, they have to have a much broader knowledge than a specialist does, and there's lower income potential. In 2008, the average debt [from education] was $155,000, and I know when we get people joining our cardiology group, they will often have more than $250,000 in debt by the time they finish their residency and fellowship. It is a practical point that doctors are now concerned with what kind of debt they will have.

Dr. Pecchia: These are smart people that make it into medical school and it doesn't take quantum mathematics to reach the conclusion that typical primary care salaries and expectations of net revenue and primary care really don't match up well with that level of debt.

Dr. St. Louis: Something about having your own practice and calling your own shots is very gratifying, not just in practicing medicine, but also in the operation of a "small business." You can take steps in running that small business to offset some of the financial commitments required by your career and your education. Other "business" issues — the level of regulatory oversight, the focus on electronic medical records, hiring and firing employees, establishing a practice, insurance — all these things — can become overwhelming for young doctors. Still, I think there's a lot of satisfaction and reward in private practice, although it may soon become a thing of the past.

Dr. Ko: Certainly there's no class in medical school on how to run your own practice. It's something that you learn by trial and error unless you have a mentor to guide you along the way. When I was finishing my training, I found a fair number of the young medical students were planning to pursue careers where they would have more predictability. They wanted a stable salary and consistent schedule so they could finish their shift and enjoy a family life. Ultimately, it's difficult to maintain a private practice unless you're able to juggle many different things at once. There are pitfalls that can hurt your practice's financial health, unless you're able to think on the fly and put out fires quickly.

Dr. Shaver: By 2030, 20 percent of Americans will be over 65. In 2005, it was 12 percent. Geriatric fellowships are not filling at this time. They require additional training, and the hardest patients we take care of are the elderly with multiple problems. Twenty percent of them have five problems or more. But this is the segment of the population that is growing the most.

Dr. Ko: If you look at the statistics, the numbers of baby boomers heading into retirement age is overwhelming. It's true that these patients tend to be more challenging. I face this every day. I try to focus on the most important issues and not try to take care of every single issue all at once.

Dr. Shaver: How do you see future residency training with this dichotomy between hospital care and an efficient office practice? Do you think most family practitioners and internists will be trained in both, or in the future, should our patients expect to be treated by one physician in the hospital — for example, a hospitalist — and then return to his primary care physician for outpatient care?

Dr. Fayssoux: I think that's the unique thing about being part of a residency; that's the only arena where it is realistic to think that you're going to have the time to see patients, outpatient and inpatient, and still have that life balance which I think is the draw of family medicine. In terms of whether people should have specific training for hospitalist and outpatient practice, I think hospital medicine is advancing to the point where it's going to become a specialty, so trying to do both may not be realistic in the future.

Dr. Pecchia: I think the challenge is in how we train our physicians seeing patients on Medicare. Do we train them as outpatient, office-based executives who are managing a team of providers including mid-level pratitioners [nurse practitioners and physician assistants]? Do we separately train the hospitalists who may be in that same specialty, whether they come through family medicine or internal medicine?

Dr. Ko: Whatever model is involved, the real trick is going to be attracting talented people to primary care.

Dr. St. Louis: It's a slippery slope. Because all of a sudden you have physicians acting as "executives" who are just supervising a team of mid-level practioners. That may be the most cost-effective way to provide care, but is that the best way to provide care to an individual patient, and is that the most satisfying experience for an individual physician?

Dr. Ko: Patients want to see their doctor, first and foremost. Getting access to your doctor can be difficult at times. But I think if you manage your practice properly and if you are able to multi-task, you can focus entirely on your patient when you are in the room with them.

Dr. Pecchia: Another thing to be aware of is the growth of telemedicine, and closing the gap of the increasing demand for primary care and the number of primary care providers, whether it be a physician or a mid-level practitioner. That's where telemedicine comes in and that would include patient to physician e-mail systems and real time face-to-face encounters that are virtualized with Skype-type technology. For those of us who do some of this on a regular basis, we also see the importance of systems that can extend the outreach of a physician to patients, and be patient centered about all of this. For patients who desire the direct physician contact, that can be extended through secure online systems as well as telemedicine consultations. That will probably grow in response to the demand for access — that part of the patient population that really still desires and will pay for direct physician contact, but may not always be face to face.

Dr. Ko: I love technology — it helps me run my practice more efficiently. But in terms of patient communication, you can sometimes lose a lot of context in an e-mail. I prefer to call my patients.

Dr. Pecchia: Given the fact that all the desirable things about primary care medicine are time intensive, and therefore expensive, how are we going to accommodate 32 million more people being insured under the new health care plan? And I don't believe having health insurance is the same as getting care.

Dr. St. Louis: I love what I'm doing. The way I practice is very time intensive, and provides a high degree of personal attention, and as a result must be more expensive. Clearly, concierge medicine is not the solution to caring for a large population of patients, but I suspect it will continue to be desirable for people who choose to opt out of the standard systems of care.

Dr. Shaver: Do you think the practice of primary medicine in 10 years in this country will involve more mid-levels practitioners?

Dr. Pecchia: I think it's inevitable if it's really cost that's driving this and that is the only way to save money. The expensive training of medical students and resident doctors is prohibitive to have them only ultimately taking care of 2,000 patients, which is an extremely busy primary care medical practice. You have to have less expensive providers.

Dr. Ko: That's why mid-level practitioners are going to grow dramatically, because there are not enough doctors to do the primary care.

Dr. St. Louis: I think two things will evolve. First, there will be primary care doctors acting as physician executive administrators running these large groups of mid-level practitioners in a team approach. Second, I think there will be primary care doctors practicing at the very highest level of their medical skills. They will become primary care "sub-specialists," offering comprehensive care to patients with difficult, multi-system disease problems that require a physician's special training.

Dr. Ko: There's plenty of room for both models, because there are so many patients out there who need some kind of care. I really haven't set a limit on the size of my practice, but I told myself the first day I hung out my shingle that I was going to stop accepting new patients when I wasn't able to call them back that same day, or when I wasn't able to see them in a timely fashion when they were sick.

Dr. Fayssoux: I think there is definitely a place for mid-level practitioners. It will be a matter of trying to figure out what is the best way to utilize them, so both they and the physician still have job satisfaction.

Dr. Pecchia: I don't think primary care physicians will be replaced so much as augmented and that they will be assisted by those mid-level practitioners to manage a population on a technology platform that facilitates that.

Dr. Shaver: Do you think this team approach is the way of the future — that it will actually take hold and be the way you practice?

Dr. Pecchia: I do. With the growth of information technology to facilitate that, and then have the personal experience as a professional working in a system that is really built around that concept, and having some success with it, I'm absolutely convinced that this is where this is going, and needs to go.

Dr. Ko: I'm going to do what I'm doing now for as long as I can…I really think that there's something to be said for the direct, personalized, tactile interaction with your patients. I don't want to lose that.

Dr. Shaver: People still want to go into medicine, but they want to be specialists or they want to be hospitalists. What would you tell a group of medical students about why they should go into primary care?

Dr. Pecchia: I'd say the first thing that you should understand if you're interested in going into a primary care specialty is what type of primary care physician you hope to become. Are you looking at the Marcus Welby version, someone who would see the patient through thick and thin in every possible setting in which they have their care delivered? Or, are you a population-based type individual who understands that a great number of people need to be served, or are you a face-to-face, one-on-one individual who really needs to be there intensively for the patient in their greatest time of need?

Dr. St. Louis: I think primary care, general internal medicine, is one of the most challenging and rewarding medical disciplines. The patients that I see in a day can present with all sorts of problems, from minor ailments to emergency, life-threatening crises — an ingrown toenail, high blood pressure, a skin rash, emphysema, depression, a heart attack, an infection, or, more often than not, a combination of many such diverse problems…you have to know a lot about a lot. It cannot be only disease-focused but must focus on the whole person. Perhaps the only discipline more difficult would be family practice because family practitioners have to be a "jack of even more trades." I would say to new doctors, that, in primary care you really have to have a love for people, you have to have a strong curiosity about science and the human body, and you have to be willing to accept that you're inserting yourself into somebody else's life in the most intimate way — it's really something very special.

Dr. Ko: I think if you're going to go into primary care, that decision predates medical school, it predates college — it comes down to all the factors that shaped you as you were growing up. I think in spite of all the financial pressures when you come out of medical school, you have to put all that aside if you want to go into primary care. Don't go into primary care expecting that you're going to be the highest compensated person out there. Don't go into primary care expecting that you're going to have set hours all the time. Choose it if you honestly want to make a significant difference. The need is there.

Dr. Fayssoux: I would say, go into primary care because it is gratifying. I chose family medicine because I love the diversity of patients I get to treat in a single day. A typical day may have me going from a well baby check to an asthma exacerbation to a pap smear to an ingrown toenail removal. I also love that I have the opportunity to treat multiple generations of a single family (a child, her mother and father, and her grandparents) and thus, really get to know my patients. Due to this connection with them, I can be a more effective physician, not only because I know what their diseases are, but how their particular environment might be affecting those diseases. With this knowledge I can then tailor treatment and advice about lifestyle adjustments specifically to what motivates them as an individual. And ultimately, being able to help people live healthier — and make better choices — is all the more gratifying when I feel like I have a personal connection with the patients I am helping.

To find a primary care physician, call 760-568-1234 or visit emc.org/physician

There are many options for primary care; below is a list of what Eisenhower has to offer:

Concierge Care
Larger Annual Fee
• A concierge physician is always on call for you, 24 hours a day, seven days a week by phone or in person.
• A concierge physician will see you throughout your hospital stay.
• Concierge physicians take care of between 200 and 600 patients. Fewer overall patients translate into more time with your physician.

Eisenhower Primary Care 365
Modest Annual Membership Fee
• You have direct and continuous online communication with your chosen physician 365 days a year. An Eisenhower Primary Care 365 physician will respond within 24 hours to routine communication. In case of an emergency, a physician is on call.
• An Eisenhower Primary Care 365 physician will become involved with your hospital stay, but will usually rely on a hospitalist to take charge of your primary management.
• Eisenhower Primary Care 365 physicians will take care of up to 900 patients, depending on age and complexity. Fewer overall patients translate into more time with your physician.

Regular Primary Care
No Annual Fee
• Regular primary care is delivered through scheduled appointments. Your communication goes through the office and is triaged to your physician or the staff, including a nurse practitioner or physician assistant.
• A regular primary care physician will become involved with your hospital stay, but may rely on a hospitalist or another physician to take charge of your primary management.
• Regular primary care practices take care of 1,800 patients or more.