



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 13, 2008

THE FUTURE OF PRIMARY CARE

The editors asked several experts to share their perspectives on the crisis in U.S. primary care. Their articles, which address this crisis from six different angles, follow. We also brought the five U.S. contributors together for a roundtable discussion of the problems and potential solutions for training, practice, compensation, and systemic change. A video of the discussion and reader comments can be seen at www.nejm.org.

The Need for Reinvention

Thomas H. Lee, M.D.

Primary care has been one of the best jobs in medicine, and it can be again. In fact, primary care must recapture its attraction for the next generation's best trainees — or the chaos and inefficiency of U.S. health care will only worsen.

The challenges are formidable, for there are so many reasons for young physicians to go into other fields. Many physicians graduate from medical school with staggering debts, and procedure-oriented specialties offer higher potential incomes. The work of primary care is itself overwhelming. Primary care physicians often go home worried that they may have made mistakes, or dispirited because they did not complete their work.

But as Treadway's story reminds

us, failure is not an option. Throughout their lives, but particularly at the end, patients want and need physicians who focus on the people who have diseases, not just the diseases that they have.

And when people want and need something, the market usually gives it to them. Right now, patients throughout the United States are having difficulty finding primary care physicians, so incomes for such practitioners will probably rise as health care organizations struggle to meet the demand for primary care. At the delivery system where I work, we are actively discussing questions such as how high primary care salaries need to be, where the money to pay them will come from, and how quickly higher incomes might work to expand the primary care pipeline.

These questions are difficult to

answer, because money is only part of the problem and therefore can be only part of the solution. We have to figure out how to make the job of primary care doable once again. We have to learn how to surround primary care physicians with teams that help them care for their populations of patients, as Bodenheimer argues in his article, and we have to equip them with systems such as electronic medical records to help them manage the flood of information that moves through their offices every day. And, as Goroll suggests in his article, we have to develop payment policies that make these innovations sustainable.

Many organizations have found that when they increase payments to primary care physicians, the physicians respond by reducing the number of patients they see. These physicians, it turns out, place a higher

priority on trying to do a good job and having a sane life than on making a higher income. The message they're sending is that more money will not be enough to revitalize primary care.

Revitalization will take something more like reinvention, and it will demand creativity and flexibility from all parties — including primary care physicians themselves. These physicians need to learn to work in teams and adjust to the notion that much of primary care can be delivered by nonphysician team members, some of whom are located in nontraditional settings, such as limited-service clinics in retail stores.

In this collection of articles, Starfield describes some of the major policy issues that must be addressed as the U.S. health care system develops a stronger primary care focus, and Roland suggests that there are some features of primary care in the United Kingdom that might warrant adaptation. As we test new concepts in the years ahead, primary care will undoubtedly change dramatically. But if we are successful and wise, these changes should allow key aspects of being a primary care physician to remain the same.

Primary care doctors should once again feel a deep sense of satisfaction when they leave their offices or patients' homes after helping people through difficult times. They should be able to leave work thinking not of their income, or of unanswered phone calls, or of test results that they might have overlooked. They should go home thinking, "This is what I was meant to do."

No potential conflict of interest relevant to this article was reported.

Dr. Lee is network president at Partners Health-Care System, Boston, and an associate editor of the *Journal*.

Copyright © 2008 Massachusetts Medical Society.

Sustaining Relationships

Katharine Treadway, M.D.

"A growing chorus of discontent suggests that the once-revered doctor-patient relationship is on the rocks."

New York Times, July 29, 2008

With its combination of care for acute, undiagnosed illness and complex, multisystem disease, as well as the provision of extensive preventive care, all in the setting of a long relationship built on mutual trust and knowledge, primary care has long been a deeply rewarding profession. But in recent years, this once-extraordinary specialty has seen its ranks diminish as doctors struggle with an increasing amount of paperwork, the explosion of therapeutic options, and a dramatic expansion in preventive care responsibilities. Care is

increasingly fragmented, leaving patients angry and doctors frustrated. The time demands have exploded, which has eroded everyone's ability to develop the personal, long-term relationships that are a great source of satisfaction for providers and comfort for patients. Such relationships can be instrumental in providing effective and efficient care.



My 12-year relationship with one patient and her family had a profound effect on care at the end of her life. When I met Mrs. C, she told me, "I am

Continued on page 2088

Transforming Practice

Thomas Bodenheimer, M.D.

Overstressed by large patient panels, many primary care practices are performing below par. In one study, patients explaining their problem to a physician were interrupted after an average of 23 seconds. Fifty percent of patients leave office visits not understanding what the physician has told them. It would take a primary care physician 18 hours per day to provide all recommended preventive and chronic care services to a typical patient panel. As a result, only half of evidence-based care is actually provided.¹ These disturbing findings can be attributed primarily to the overburdened 15-minute clinician visit.

Two solutions come to mind: Re-

duce the panel size to allow more time per patient — the concierge model — which would aggravate the impending shortage of primary care physicians. Or reorganize primary care into a team-based endeavor, off-loading many functions from the 15-minute visit — a solution requiring fundamental payment reform that uncouples reimbursement from the clinician visit and creates incentives for team building.

The latter approach involves a fundamental paradigm shift: rather than spending all day in traditional patient visits, primary care physicians must analyze their patient panel and manage it so as to keep all patients as healthy as possible. To do so, practices need a registry (database) that gives them access to their patients' diagnoses, key clinical data (e.g., blood pressures and cholesterol levels), and

Continued on page 2089