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The Collapse of Primary Care

Disaster looms as medical students abandon family practice for higher-paying sub-specialties.

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On the first day of my internship in primary care internal medicine at the Massachusetts General Hospital in 1981, one of the gastroenterology professors had a welcoming party for the new interns at his home, a beautiful manor located on several acres of land, in one of the wealthiest suburbs of Boston. In-between bites of the gourmet food he provided, one person asked the professor, "How are you able to afford all this?"

"Scoping for dollars," he replied. He spent much of his time performing endoscopies, a then new procedure in which a fiber-optic scope is threaded down the esophagus of a patient, thereby allowing the doctor to visualize the stomach, duodenum, and other parts of the upper gastrointestinal tract.

"But can't most patients with ulcers be diagnosed just on the basis of their symptoms and history?" one intern asked. "What's the added value of doing an endoscopy?"

"What's the value of not knowing?" he replied.

I chose primary care medicine because many of its leading advocates then, mentors such as Mass General's Dr. John Stoeckle and Dr. Alexander Leaf, saw it as part of a larger social and political movement toward more equitable health care. Also, as I conducted research showing what a powerful difference counseling patients to eat healthier, manage stress, quit smoking, and exercise could make in their lives, primary care provided the ability to follow patients over time and support them in making healthier choices.

However, at that time, anyone choosing to enter one of the primary care fields such as general internal medicine, pediatrics, geriatrics, or family medicine was looked down upon as having less prestige and power than those entering a sub-specialty such as gastroenterology or cardiology. Since then, it's gotten even worse.

A study just published in the Journal of the American Medical Association found a strong, direct correlation between the starting salary of physicians in a specialty and the percentage of medical school

graduates choosing those specialties. Because those in primary care fields are the lowest paid—the average salary of a family physician ($185,470 for working 60-70 hours/week) is less than half that of an interventional cardiologist or surgeon—it's not surprising that the number of interns and residents choosing a career in primary care has decreased by more than 60 percent in the past decade, whereas the number choosing to be sub-specialists has increased by almost 40 percent. Already lower to begin with, salaries for primary-care doctors actually decreased 10.2 percent between 1995 and 2003.

This study was directed by Dr. Mark Ebell, a professor at the University of Georgia. He conducted the research to draw renewed attention to the role of salary disparities and the primary care shortage and to encourage policymakers to enact meaningful reforms to increase the percentage of primary care physicians. "The problem of salary disparities is not something that anyone is going to solve locally," Ebell said. "This is something that will require reform at a national level."

Why should you care about this? Studies have linked a lower percentage of primary-care physicians with higher infant mortality rates, higher overall death rates and more deaths from heart disease and cancer. Even worse, the system of primary care is about to collapse.

A recent report from the American College of Physicians has the ominous title, "The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care." According to this report, "Primary care, the backbone of the nation's health-care system, is at grave risk of collapse due to a dysfunctional financing and delivery system. Immediate and comprehensive reforms are required to replace systems that undermine and undervalue the relationship between patients and their personal physicians. If these reforms do not take place, within a few years there will not be enough primary-care physicians to take care of an aging population with increasing incidences of chronic diseases. The consequences of failing to act will be higher costs, greater inefficiency, lower quality, more uninsured persons, and growing patient and physician dissatisfaction."

Similarly, as Dr. Thomas Bodenheimer of UCSF wrote in an essay entitled "Primary Care-Will It Survive?" in The New England Journal of Medicine, "Primary care is facing a confluence of factors that could spell disaster." As reimbursement for primary care decreases, these doctors have to see more patients in less time. This is profoundly unsatisfying for both patients and their doctors. Because of this, 63 percent of physicians would not recommend a career in medicine for their sons or daughters, and 25-40 percent are seriously considering leaving the profession.

Why are specialists paid so much more than primary care doctors for the same amount of work? Thirty minutes spent performing a diagnostic, surgical, or imaging procedure often pays three times as much as a 30-minute visit with a patient with diabetes, heart failure, headache, and depression. Why are procedures valued more than thinking, even though there is so much more information to master in primary care than in a sub-specialty? In part, because health insurance first began in order to help people pay for hospital-based surgical procedures which were much more expensive than going to the family doctor.

Incentives are often perverse. For example, insurance companies pay more than $30,000 to amputate a diabetic foot even though most amputations are preventable by scrupulous foot care organized by a primary care doctor for a few hundred dollars and which is often not even covered by insurance or Medicare. A cardiologist who performs an angioplasty gets paid several thousand dollars for the procedure despite clear evidence from randomized controlled trials showing that angioplasty does not reduce the risk of a heart attack and does not prolong life in patients with stable coronary heart disease, i.e., 95 percent of those who receive it. When I was an intern, Dr. Roman DeSanctis, who was chief of cardiology at the time, said, "If cardiologists were paid $50 rather than $5,000 to perform an angioplasty, most of them would not be done."

In other words, despite all the talk about evidence-based medicine, much of medicine is reimbursement-based. Let me make it clear that most doctors I know are driven primarily by a passion for service, not money. There are many ways of making money that are much easier than being a physician. But if we are trained to use procedures and reimbursed to use procedures, then it's not surprising that many medical school graduates are discouraged from primary-care careers and are choosing sub-specialties that use a lot of procedures-especially since it's not unusual for a recent graduate to owe more than $250,000 in student loans that need to be repaid.

In short, we doctors do what we get paid to do and we get trained to do what we get paid to do. Therefore, if the system of reimbursement changes to value the work of primary care doctors as much as sub-specialists, then this trend can be reversed—if leaders at the highest levels of government make this a priority. As Dr. Bodenheimer warned, "Whoever takes up the cause of primary care, one thing is clear: action is needed to calm the brewing storm before the levees break."

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