

Is the Primary Care Doctor Obsolete?

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During the Great Depression, we had a family doctor. Most were general practitioners who took care of adults, delivered babies, took care of them, as well as their brothers and sisters, set bones, and did surgery. They were the primary care doctors of that time. Today, family doctors may be board certified specialists who do not deliver babies nor do surgery. They are nonetheless regarded as primary care doctors.

What is a primary care doctor?

In the 1970 and 1980s, there was a debate as to who qualified as a primary care doctor. Some insurance companies excluded all but the certified family medicine specialists. Finally, general internists and obstetric-gynecology specialists were included along with family doctors.

A primary care doctor is the first one that the patient should consult regarding any medical concern. That doctor is the first to assess the patient's needs and to manage any needed medical care. The primary care doctor focuses on the essence of medical care, and the patient should be at the center of that care. This may seem obvious but most doctors no longer practice this way. They focus on the disease and its treatment, often ignoring the personal needs of the patient.

Today, many doctors regard medical care as the applied science of statistically derived, evidence-based medicine founded on practices shown to be effective for the majority of a group. This is actually herd-based care that treats an individual as a statistical integer and not as a person.

Medical care today is still referred to as the "practice of medicine." As Osler, the highly regarded physician of a century ago, said, it is, "an art based on science." It is based on the care of the patient as a person, not as a member of a herd care.

Medical care should be more than individual care. It should be personal care. Individual care defines a person in terms of measureable characteristics, such as age, weight, height, blood pressure, blood sugar levels, cholesterol, hemoglobin, genetic makeup, and many other measurable characteristics that can be defined through testing.

Personal care, on the other hand, includes not only measurable characteristics, but other important factors that lend themselves less readily to measurement, such as cultural background, education, training, likes, dislikes, view of health and disease, and other biases. These factors have been proven to have a significant impact upon the effectiveness of disease management, yet they are almost completely ignored in herd care.

I want to further emphasize that personal medical care should not be confused with the recently advocated personal-*ized* medical care, a term that was hijacked by geneticists and deceptively used by some starting 10 years ago. This type of care focuses on genetic markers to target diseases and care methods, such as susceptibility to certain drugs. This genome-based care alone may help provide more precisely targeted treatment, but it is no more personal than a fingerprint. It's just another term for individualized care, treatment based solely on measurable characteristics.

Primary care physicians focus on truly personal care, and studies have shown that health systems that include primary care physicians at the center of patient care have better outcomes at a lower cost than those without them.

Is the primary care doctor obsolete?

While not completely obsolete yet, the primary care doctor is certainly an endangered species. This important type of doctor is the victim of a medical system that now largely focuses on costly technology in the treatment of diseases.

The challenge today is to not only prevent primary care physicians from becoming extinct, but to place them, once again, at the center of patient care.

What happened to primary care?

In trying to get to where we want to be, it helps to know how we got to where we are. Since just after World War II when I started practicing medicine, the technological advances in medical science have been absolutely stunning – and it's only the beginning. But these advances have come at a cost. First, there is the real dollar cost. Technological care does not come cheap. Second, our sense of social compassion has extended medical benefits to more and more people, gradually making this new technological care an entitlement. This compounds the cost.

Lastly, patients today have removed themselves from personally allocating and spending their own medical dollar, a form of self-rationing. They have turned their medical purse and decision-making over to a third party, an insurance entity or the

government. As a consequence, people tend to want and to pursue more care than they actually need for good health.

These third-party entities determine how to spend that dollar based upon the needs of the group, the herd, not necessarily based upon the specific needs of the person. In an attempt to control the skyrocketing cost of care, personal care has suffered more than technological care. The focus on technology has victimized the primary care practitioner.

I have personally observed these trends over the past 60 years, and have detailed them along with my interpretations in my book *Time To Care: Personal Medicine in the Age of Technology*.

Before World War II, few people had medical insurance. Visits to doctors were restricted to very serious complaints. Medical care was primarily a family matter. My mother had two large volumes dedicated to home health care remedies. I had my share of iodine gargles, mentholatum chest rubs, chamomile tea, and cod liver oil. Somehow, I was spared the springtime castor oil purge. Until my teens, the only time I went to a doctor was for a dog bite. But, our doctor made four or five house calls to see me for fevers or rashes, the usual contagious diseases that most of us had.

Hospitals were few and distant in rural areas. One of my medical school preceptors in Northern Wisconsin told me of kitchen table surgery he had done in the early Twentieth Century, in his early days of practice. Babies were delivered at home, many by mid-wives, even in the big cities. I was one of them in Chicago. My professional obstetrical experience a number of years later was derived as a University of Wisconsin senior medical student doing home deliveries in the slums of Chicago out of the Maternity Health Center.

Many hospitals had no emergency departments, or emergency rooms as they were called in the few hospitals that had them. In 1934, my dad took me to visit my mother and new baby brother in a Milwaukee Hospital after 8:00 p.m. The hospital doors were locked and unattended. We had to go in through a service entrance off an alley.

Up until mid-century, financial responsibility for medical care belonged to the patient. Payment of doctors was out-of-pocket, or occasionally in rural communities, with produce. Only a minority of people had medical insurance. My dad had it through his insurance company job in the late 1930s, when I had to be hospitalized for bilateral hernia surgery. Of the 16 days there, I was kept bedfast for 12 days. I walked bent over like Groucho Marx for a week. It cost my dad \$9 out of pocket.

Blue Cross was started largely in the 1930s and 1940s, often by radiologists, pathologists, and surgeons. Medical insurance only covered in-hospital charges, diagnostic procedures, and surgeons' fees. In Kansas City, by 1947, Blue Cross gave in

and started covering outpatient diagnostic x-ray charges. Patients had costly unnecessary admissions to the hospitals only for x-ray procedures, for one day, then for three days as the rules changed.

During World War II, many companies started to provide employees with medical insurance. It helped maintain the work force and control inflation at a time when more money than goods was available.

As hospital insurance was too expensive for most people, more affordable insurance coverage of specific diseases such as poliomyelitis, stroke, or cancer was promoted, largely using fear.

With the introduction of Medicare and Medicaid in the mid-1960s, private insurance expanded to cover most out-patient as well as in-patient services.

At the time, legislators had no idea how much office, clinic and inpatient charity care was contributed at no cost by doctors and hospitals, nor did they seem to care. Initial wariness of Medicare by doctors and patients in the first several years was replaced by enthusiasm for the program. Now, providers were being paid for what had been charity work. More extensive, private insurance coverage was offered then for out-patient services as well as in-patient care. Providers, the hospitals and doctors, did not adjust their charges for the payments they now received for what had been charity work.

The flood gates were open. Medical inflation soared. The impact of Medicare on hospitals was considerable. Cost control efforts of hospitals resulted in the elimination of their clinics and nursing schools. Medicare and Medicaid did not reimburse for these non-inpatient charges which hospitals had included as part of their in-patient overhead.

Certificates of Need permission became a requirement for major hospital expenditures for such as new rooms, laboratories, and special x-ray equipment. After 1984, the impact of Medicare's diagnosis-related groups was considerable. These DRGs reduced and fixed the lengths of stay in the hospital for each diagnosis at a fixed reimbursement.

Insurance carriers regarded sick people as clients, not as patients. Further cost-control measures decreased the reimbursement amounts for primary care doctors' out-patient services, or "cognitive care," as the personal interaction between doctor and patient came to be called. Insurance carriers shifted the emphasis from payment for the treatment of patients to reimbursement for the use of technology in treatments.

This had unintended, unappreciated, and adverse consequences for primary care doctors and consequently for their patients. Based upon time involved, there has always been an overcharge for procedures and an under charge for the time with a patient whose perception was that, "He didn't do anything. Asked me a few questions and poked around on me a little and then charged me too much," no matter what it was. To

supplement their declining incomes, primary care doctors learned to do technological procedures, such as proctoscopies, that they had been referring to other doctors.

Office procedures did not prove to be an adequate financial remedy to meeting primary care practice expenses. More importantly, it was not enough to change perceptions of medical students, as most were graduating with large debts. They saw that the average income of primary care physicians was not only relatively lower than that of specialists' but increasingly so.

Consequently, medical students became less interested in primary care, intending to become specialists. Forty years ago, 80% of freshmen medical students were altruistic about the practice of medicine and most wanted to practice general medicine. That percentage dropped to 25% by the time they graduated.

In the past 10 years, however, freshmen students' interest in primary care has declined to 50%, and this drops to 10% by the fourth year. An increasing number of students today become hospitalists who restrict their practice to the technical care of hospitalized patients. This requires less interaction with the patient, and they see no need to treat the patient as a person. The time commitment is lower and the income more rewarding.

As the third parties, in the name of cost control, stopped paying doctors for personal care, volume, not quality, of care, became the watchword. Also as a result, doctors started referring the more time-consuming patients to specialists in order to reduce their own work load and, incidentally, also their medical liability. Some refer to these as turnstile practices.

As a result, increasingly, patients have become dissatisfied with being treated as a number and seeing their doctors for only a few minutes. They, in turn, have bypassed the primary care doctor and started going directly to the more expensive specialist of their choice without a doctor's referral. Also, as expectations of the wonders that technology can provide have become unrealistic, many people bypass the primary care doctor for what they perceive as better care, to say nothing of those who judge the value of medical care, like everything else, on its cost.

With less reassuring personal care and supervision by a trusted primary caregiver, people have become less trusting and more litigious, increasing the cost of liability insurance.

In free market medicine, many medical specialists are more apt to provide the more highly remunerative diagnostic or therapeutic procedure that, at times if not often, is unnecessary. They are more likely than primary care doctors to refer patients unnecessarily to another specialist.

This reduces their liability. It's easier to defend against a law suit over a complication from an unnecessary test or treatment the doctor performed for a condition that never developed, than it is to defend against a suit over the omission of a test or procedure for a rare condition that was undetected, and that then did develop with serious consequences.

While unnecessary testing may reduce doctors' legal liabilities, it is very expensive. A recent study of Pennsylvania orthopedists found that unnecessary, defensive imaging, including x-rays and MRIs, accounted for 20% of total tests and that defensive medicine – unnecessary tests and procedures – overall was responsible for 35% of health care costs for their patients.

Medical technology is wonderful!

Some diseases, such as small pox and polio, are not only cured but have been all but eliminated. With this has come an unreasonable increase in expectations and hopes. People expect and want testing to detect even the rare condition, especially a cancer, as early as possible.

This attitude appears to make sense, but in some situations it is actually counterproductive. Find the cancer before it becomes incurable, but this may lead to the wrong diagnosis and unnecessary treatment that can be more harmful than waiting till a condition actually becomes more evident. Screening for prostate cancer is the most notorious example where the harm can exceed the benefit. A new book, *Overdiagnosis, Making People Sick in the Pursuit of Health*, by H. Gilbert Welch, a Dartmouth medical professor, and others, addresses this growing problem.

Now, instead of having a primary care doctor, many people consult, not their family medical reference book like my mother used to do, but medical references on the internet. There were 160 million medical web searches last year. The internet is rife with misleading information including medical. On the basis of this misinformation or because they don't fully understand it, people often bypass the primary care doctor and select a specialist that at times is the wrong one.

A little medical knowledge can be a dangerous thing. When students in various medical fields learn about the various diseases, many become unduly and unnecessarily anxious that they have one of the diseases they read about. We used to call this, "the sophomore syndrome."

Part of the traditional appeal of a doctor visit is that the doctor utilizes the important "laying on of hands" to examine a patient. This can have a reassuring, healing impact, though it is actually a placebo effect. Doctors do much less of this now, and

some turn it over to assistants. Testing tends to replace the laying on of hands required by physical examinations.

This contact accounts in part for the popularity of some so-called alternative care practitioners who make such contact. For example, in one study, a chiropractor relieved neck pain in 66%, massage relieved it in 50%, and a primary care physician with exercise advice and a prescription relieved it in only 35%.

Since the 1980s, there have actually been fewer visits to traditional allopathic medical doctors than to alternative-care practitioners of complementary medicine, such as chiropractors, herbalists, homeopaths, acupuncturists, reflexologists and those using massage, hypnosis, biofeedback, imagery, and energy healing, to name but a few of the several dozen types. In addition, there are traditional practitioners from other cultures in which some people have more confidence than western medicine.

Basically, American doctors are allowing themselves to be turned into technicians who focus on using procedural techniques to diagnose and treat diseases, rather than being doctors who use these procedural techniques in their management of patients with disease.

The abandonment of personal care is most evident in the hospital where a doctor of record who is legally responsible for a specific patient's care while in the hospital may call in multiple consultants. Often, today, no one doctor is actually coordinating the care. The admitting doctor used to be the patient's primary care doctor, but this is increasingly not the case. With fewer primary care doctors caring for their own patients in the hospital, there has been a progressive problem, not only with coordinating care in the hospital, but also with continuity between the care in the hospital and care after discharge.

For example, recently, Medicare records show that half of the patients discharged from the hospital after treatment for congestive heart failure had to be readmitted prematurely at an unnecessarily high rate. They were prematurely discharged or had not gotten back under the care of a doctor.

This is much worse than it used to be, despite the more numerous types of communication devices now available to doctors. When the introduction of the diagnosis-related groups (DRG) in 1983 set a shortened length of stay for in-hospital care of patients with congestive heart failure, Medicare administrators were concerned that premature discharges from the hospital would increase. I was one of a number of doctors who reviewed charts of Medicare patients who were readmitted within 30 days of discharge to determine whether this was the case for congestive heart failure. It wasn't a problem then.

But by the 1990s it had become a big problem, which continues today. This is due, in part, to the increasingly poor or delayed communication between hospital-based doctors and primary care doctors, or because many patients did not have a primary care doctor.

In order to avoid reimbursement penalties, hospital administrators responded to these medical staff deficiencies by creating a non-physician patient navigator position. Depending on the hospital, these navigators may have different names, such as case worker or care navigator, and more extensive duties than the traditional discharge nurse. But most of these positions were created to ensure the shortest length of stay in the hospital to maximize reimbursement, and seem to be more disease-focused than patient-focused.

Since they are not physicians, many of these navigators may not understand both the technical and personal needs of a particular patient who may well have other medical problems that need care. Non-physicians may not recognize conflicts in drugs and other aspects of management between the different physician specialists, and may not be able to get them resolved.

What's so important about primary care?

The coordination of care by a trusted personal doctor creates not only greater patient satisfaction but also greater efficiency of care at less cost. World Health Organization data show that in those countries, including the USA, where patients have a primary care physician, there is as much as a 19% lower mortality at up to a 35% lower cost.

Fortunately, the concept of *humane, patient-centered care* is coming to the fore, once again. The importance of primary care is recognized by a movement that regards primary care as the basis for good medical care. One such model is referred to as the *Patient-Centered Medical Home*. This concept was first proposed in the late 1960s by the American Society of Pediatrics. More recently, the medical home concept has been endorsed by a number of medical societies.

The medical home gives primary responsibility for patient care to a personal primary care doctor who provides the patient with continuous quality of medical advice, care, coordination, and integration with various specialists, health providers, and services within the community.

This is similar to the way medicine was practiced within the hospital staff prior to the insertion of third-party payers between patients and their doctors. But comprehensive medical care of the individual as a person is certainly more complicated

and demanding now and requires more coordination. This style of practice is also being promoted under the rubric of “integrative medicine.”

Sixty percent physicians today are employed by health systems rather than being paid directly by their patients, and this ratio is increasing. This creates a conflict-of-interest for the doctor. When a patient goes to a doctor, there is a tacit contract between the patient and the doctor. Ethically, the patient’s needs and concerns must take precedence over the practitioner’s. If a patient has ceded the medical purse and decision-making to a third party, the requirements of the health system may trump the patient’s best personal interests. When the doctor is an employee of the same system, this conflict can be compounded, especially where free market medicine flourishes. *Caveat patiens*, let the patient beware.

If physician practitioners are to continue to be part of this re-emphasis on primary care, they may benefit from less training in technology and more training in human relations. Unless the emphasis in medical training changes, more and more primary care will be delivered by nurse practitioners and doctors of nursing, as well as physicians assistants, care navigators, and patient advocates. And, they may prove *more effective*.

The health reform bill (PPACA) of 2010 addresses this in part by providing special funding to medical schools that promote primary care physician training. Also, funds are provided for setting up systems of patient-centered care like the Medical Home. If the compensation for the time of the primary care doctor is not increased, this will be too little, too late. Doctors will be replaced by nurse practitioners, as is already happening in many places.

As the wonders of technology continue to fascinate us, demanding a disproportionate share of the medical dollar, adequate compensation for primary care will continue to be difficult. The US life expectancy has risen from 46 years in 1900 to 78 years today, an increase of 70%. At birth, it is slightly longer in Japan and European countries. However, at age 80 years, the life expectancy in the US is 8-9 years and in these other countries it is 1-2 years less, and this has not changed since 1860! The fact that the population in the USA is less culturally homogenous than in most other countries is one factor.

Does technology offer a discomfort-free, disease-free life of indefinite duration?

Some in science regard death as a disease with which we were born that should be studied, just like any other condition with the object of cure. Rather than technology saving money, however, the cost of care has done nothing but increase from about 5%

of the GDP in 1950 to nearly 18% at present. We still die in increments, despite preventive care and technology.

In the USA 10-20% of the people incur 60% of all medical costs, and at least 40% of this is in the last months of life. Prevention and technology defer the major cost of care to our final stage in life. The cost is shifted from for-profit insurance companies to Medicare. It's only the beginning. The improvements in medical technology already in the pipeline are mind blowing.

Technology will continue to consume a disproportionate share of the medical care cost. According to the Congressional Budget Office, "About half of all growth in health care spending in the past several decades was associated with changes in medical care made possible by changes in technology." It expects to pay for this in part by the reduction of doctors and hospital reimbursement. Improved, more efficient delivery of less personal, individualized care will just be temporizing.

What is the purpose of Health Care?

The cost of health care is widely discussed, but the product is undefined and the goal assumed. We tacitly assume that the goal is that health care should create a disease-free and eternal life for everybody. Given that assumed goal, government-funded medical care like Medicaid and Medicare or Universal Health Care cannot be equitably controlled. If we define the true goal of our health system, we can then determine what features of medical care that a government funded system offers. Defining the goal will require use of the difficult ethics of distributive justice, the just allocation of resources known pejoratively as *rationing*.

Actually, health care has always been *rationed*, is now rationed, and always will be rationed but this is more covert today. Drug formularies are an example. People accept it and don't discuss it as long as it's called regulation, not rationing, or as long as they perceive that it's not happening to them.

Medical care now uses nearly 18% of the GDP. What limitations on medical care will we accept? What percent can the country afford? If everybody in this country received the health care to which they want and feel entitled, it would eventually consume the entire gross domestic product, much like the health system in Dr. George Fisher's book, *The Hospital that Ate Chicago*. It grew bigger and bigger until it occupied and employed the entire city. If we continue in the direction we are headed, we will eventually have, "The Health System that Ate the USA."

In order to address the rationing issues there should be agreement on the purposes of medical care. The consensus is that the purposes include the prevention of death

that's not inevitable, the relief of pain and suffering, the treatment of disease, and the restoration of health. But do purposes also include comfort care, the promotion of health, and the prolongation of life? For the country as a whole is the purpose of health care more than the prevention and control of contagion and matters of hygienic management of food, water, sewage, air, and other environmental matters? Does it also include population and work force vigor, maintenance of and protection by the military, drug non-dependency, and others?

These are just a few examples of potential purposes where the consensus breaks down. In the US, we have not agreed upon a definition of the term, "good individual health." The World Health Organization defines it as the complete physical, mental and social well being as defined by each individual, not just the freedom from disease. Some diseases or conditions are syndromes, that is a combination of symptoms and physical findings usually of unknown cause that in some instances are statistically defined to the point of absurdity. This could get worse if individual variations in genetic coding are defined as disease. Then everybody might be considered diseased. This, of course, is reduction to the absurd.

Upon what factors should health care be based?

In order to determine the purpose of our health system, we need to define the differences among our rights, our needs, and our wants.

Life is a *right*, as stated in the US Declaration of Independence. The question is how much life, what quality of life, and how long a life is a person entitled to? Is eliminating the threat to life from disease considered part of the right to life, and if so, how do we define a threat? Does this only apply to an immediate threat, such as that from a heart stoppage for which cardiopulmonary resuscitation is triggered? Does this apply to curable conditions such as infections? If the right applies to less immediate risks to life, how big a risk and a risk over what period of time – hours, days, weeks, years?

Should medical *needs* be based only on the health of the public, the collectivist needs, the needs of the herd? Or should need be based only upon a third party's definition as to the needs of an individual as a member the herd?

Should securing medical *wants* be considered a personal goal, based on the ability to pay?

What is the social goal of health care? Prolonging life at all costs for those who can afford it or are fortunate in the rare treatment lottery such as heart transplants? Medicare

has a code for death, a fatal disease with which we're all born. Is death a disease medical science is looking to cure or is it inevitable?

In the past decade 70% of medical care has been for comfort care. Cost per hospitalization for the aged has been only \$53 more than younger people, but they have 7-8 times the number of hospitalizations. In the long run it probably costs less to treat an 80-year-old with coronary artery surgery than a 40-year-old.

Some form of rationing of care is necessary.

In many countries, much of rationing is overt by age, queuing, geographic access and financial coverage. In this country, rationing is covert, and it's not a topic of general discussion as such. We complain about managed care, but what should we expect when we have turned over our health care dollar to third parties that are "herd managers," where an individual's health care needs may be secondary to the herd's financial needs, and where the physician is expected to serve two masters in an unethical conflict of interest.

In order to establish the goals of our public health system, the use of medical resources must be discussed openly – whether you call it rationing or the just the prudent allocation of medical resources. It is absolutely necessary to reduce arbitrary decisions based on competitive political influences. The system is in dire need of rationality if rationing is to be equitable. We need to determine and separate what is universal necessary care, from what is individual needed care, and what is personally wanted care.

What does this all have to do with the primary care physician?

Our health system, based upon free-market medical care, is a unique experiment in the world, but it is seriously flawed. Its technological skewing and our avoidance of hard choices to correct it are threatening the elimination of the primary care physician, the system's keystone of economical, compassionate and effective care. We should stop avoiding the necessary debate and the hard choices.

No, the primary care doctor is not obsolete. But this core specialist will become obsolete unless we demand that the imperfections and technological bias in the system be more seriously addressed.

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