

Trends That Will Affect Your Future . . .

Where Can I Find a Family Doctor? An Unintended Consequence of Health Reform

| By Stephan A. Schwartz |

The SchwartzReport tracks emerging trends that will affect the world, particularly the United States. For EXPLORE, it focuses on matters of health in the broadest sense of that term, including medical issues, changes in the biosphere, technology, and policy considerations, all of which will shape our culture and our lives.

When I was a boy, my father, who was an anesthesiologist and professor of medicine, in response to my questions, took me along to a research conference in Cincinnati, where we lived when I was young. It was only for the end of the morning and a bit of the afternoon, as I remember; part of my father's gentle recruitment program in that long ago world of the 50s. I was about 12, I think. At lunch a number of the doctors retired to a delicatessen near the medical school, and over borscht and roast beef sandwiches whose height was measured in inches, I sat there on best behavior and absolutely silent unless spoken to. I listened to my father argue that physicians should get behind a single-payer private-practice universal coverage system, before the corporations moved in and "docs will be reduced to employees with limited practice authority." The response to this was, "Abe, the AMA would never permit it, we have too much influence with Congress for that to ever happen."

Well, it happened, and since Richard Nixon we have labored under the illness profit industry that has emerged. Now, as reform is finally taking shape, a wide range

of flaws in the system will become crises, and we need to know that and interpret them correctly when they occur. One of the most immediate: the growing need for family doctors.

I have a dear friend who, after years as a master carpenter, decided to live out his dream and become a physician. Almost two decades of labor followed as his children grew, too much on the periphery of his vision to suit him, and debt piled up. And finally he became a doctor. One HMO dominated the city in which he lived, and the area beyond. Newly launched, he was thrilled to be asked to join a prominent family practice, with seven other physicians, physician's assistants, and nurse practitioners. It is in every way an iconic representative of a modern family medicine practice. Notably, the clinic has more insurance clerks than nurses.

Now seven years into his practice, Henry is successful, oppressed, and unsatisfied. After the years of training that left him \$250,000 in debt, he is paid \$172,000, provided he sees an average of 460 patients a month. That's less than the national average of \$186,740.¹ He could see fewer patients, but there would have to be a downward readjustment to his income. Equally as irritating to him is that the company where he is an employee places limitations as to what he can order. In the Illness Profit system, Henry is an *uber*-technician and employee. Henry individually is an iconic representative of modern family medicine.

Individually and collectively, this is the medicine produced by the Illness Profit

model of healthcare. Patient coverage is only one failure of this system. Physician dissatisfaction is another.

In 2010, the United States has 352,908 primary care doctors. The Association of American Medical Colleges estimates that 45,000 more will be needed by 2020.² Will they be there? They will not. Our health-care model is precariously balanced because it is so unnaturally structured. As we are about to discover, even the small changes made in the recent health reform legislation are going to stress the system dramatically, and in ways that the overheated rhetoric that marked the debate hardly considered. The act of extending coverage to 30 million people is wonderful at one level; much has been made of that. Less was said about the fact that with the over-65 population doubling, as American Association of Medical Colleges Chief Advocacy Officer Atul Grover, MD, PhD, observes, "it will be difficult to meet care needs, and more people coming into Medicaid rolls and insurance exchanges will exacerbate that." Grover explains, "We currently train about 25,000 doctors a year, and will need another 5,000 or so per year if we are going to meet the needs of the next decades."²

Yet we face an already active decline in the number of primary care physicians. "The number of medical-school students entering family medicine fell more than a quarter between 2002 and 2007 [emphasis added]."¹

One of the biggest reasons family physicians give for their dissatisfaction is the

ever growing paperwork and micromanagement imposed on them. Henry works from 7:30 AM to 7:30 PM, and most Saturdays because electronic records mean he is also his own clerk; each patient visit means he has a data entry task to complete. He stays late to keep it current and works over the weekend to catch anything he missed. Henry is far from alone in his unhappiness over the seemingly endless record keeping he is required to do. On the Medscape Physician Connect, a physician-only discussion board:

“The intrusion into medicine by third-party payers (better known as the insurance industry, Medicare, and Medicaid) has been coming since the '60s, but this effort to control costs has really become burdensome over the last 15 years, and it has not controlled costs and has not improved quality.”³

Another contributor remarks, “Every visit has its own catch-22, whether that’s a prior authorization, a formulary, a HIPAA rule—it never ends.”³

At the front end of medicine, the family doctor living a world of 15-minute patient visits, interminable paperwork, a night sweat debt burden, amounting to a second mortgage and, if the physician is in private practice, the malpractice costs, seems close to overload. The model of medicine he is forced to practice conspires to create an unsatisfying career, which is why fewer and fewer young doctors are taking it on.

This confluence of a diminishing supply and a society with increasing needs almost inevitably is going to mean longer delays, more difficulties getting appointments, and more stress on everyone. It will take at least a decade, and could take longer, to get through this, and it is a crisis that should not be happening. It is the wholly predictable outcome of the health-

care system it represents. An approach that places its principal emphasis on profits not health. Moreover, the lack of available professionals encourages the development of adjunctive professionals, usually at a lower pay level, who take up the slack, and this has its own unintended consequences, for both doctors and patients. Sociologist Andrew Abbott describes the process: “a profession whose jurisdiction is excessive must increase its productivity or expand its numbers.”⁴ The present system has reached a productivity threshold that can hardly be raised. Thus, as Abbott points out, “when a powerful profession ignores a potential clientele, paraprofessionals appear to provide the needed services.” In Henry’s family practice, the lack of MDs has resulted in an increase in the number of physicians assistants and nurse practitioners. From the insurance perspective, a mixed clinic such as Henry’s, and thousands like it, is a better financial deal because part of the client load is carried by personnel who do much of what physicians do, but for a lower cost.

It is interesting to consider the dysfunctional reality of family medicine with the pharmaceutical success at creating medications for hither to unknown conditions those family physicians and their paraprofessional colleagues can be encouraged to dispense. Medical writer Martha Rosenberg makes the point: “When The Medication Is Ready, The Disease (and Patients) Will Appear. Who knew so many people suffered from restless legs?”⁵ As the healthcare reforms kick in over the next four years, this family physician crisis will be but the first of several such. We need to prepare ourselves for antichange advocates pouncing on the extended wait times and delayed appointments that will arise, and which they will claim are the result of

the changes, not—as in truth they are—an unintended consequence of trying to create a real healthcare system in the United States.

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