The primary care doctor is a rapidly evolving species — and in the future could become an endangered one. As the United States grapples with the dual challenges of making health care more widely available and reducing the national price tag, it’s hard to say how primary care physicians will fit into the delivery models that emerge. Will they be increasingly replaced by nurse practitioners and physician assistants? Will they become partners or leaders on multidisciplinary teams, spending more time supervising others and less interacting with patients? Will most become employees of large health systems, as solo and small-group practices disappear? Will having a primary care physician become a luxury, available chiefly to people who can pay a premium to enroll in a concierge practice?

Even the question of whether the country faces an impending doctor shortage is debatable: groups of experts have reached opposite conclusions depending on their assumptions about who will be delivering care in the future and how. The report of a conference held in May 2011, sponsored by the Josiah Macy Jr. Foundation, cited estimates predicting a shortage of more than 100,000 physicians by the middle of the next decade, with primary care specialties most affected.\(^1\) That report, however, stated that such providers are profoundly maldistributed, resulting in severe shortages in rural areas and among underserved populations. It noted that nurse practitioners are the fastest-growing group of primary care practitioners, their numbers having grown by an average of more than 9% per year relative to the population in the 6 years ending in 2005.

Changes in Doctors’ Work

The doctor’s duties are changing, influenced by advances in medical knowledge and technology; the increasing use of computers, handheld devices, and electronic...
satisfied with their work, and said they were somewhat or very dissatisfied. The surveys also fail to show any consistent change since the mid-1990s in the percentage of physicians indicating that they don’t have enough time to spend with patients.

David Mechanic, a professor of behavioral sciences and director of the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, reported a decade ago that despite the widespread impression among physicians and patients that medical visits had gotten progressively shorter, the average visit length increased by 1 to 2 minutes between 1989 and 1998. However, in recent years, the pressure on physicians to move quickly and accomplish multiple goals during a visit has intensified, Mechanic said. In surveys, many patients describe their doctors as hurried and unresponsive, whereas nurse practitioners are viewed as “much more willing to take time, talk to the patient, and answer questions,” he added. In one study, researchers who videotaped outpatient physician–patient visits and audiotaped patients afterward found that the most highly satisfied patients perceived the visit as having lasted 3 minutes longer, on average, than it really had.

Observers of medical practices report striking changes in how doctors work. Physicians Christine Sinsky and Thomas Bodenheimer visited 23 primary care practices during the past year for a project, sponsored by the American Board of Internal Medicine Foundation, focused on ways of sustaining primary care doctors’ joy in practice. Sinsky, a primary care internist at a large multispecialty group practice in Iowa, commented that the electronic health record, despite its obvious benefits, has been “an enormously disruptive innovation,” altering the practice environment and the daily tasks performed by physicians and other health care workers.

“What I’ve really seen is a lot of waste within the health care system at the level of utilization of physician skills,” she said. “I think two thirds of many physicians’ days are spent on documentation, administrative tasks, paperwork completion, rote inbox management, data gathering, and data entry... It’s something that’s hard to recognize when you’re the one doing it.”

Sinsky noted that some innovative practices have responded by assigning much of the responsibility for data entry to other staff members. For example, in one more collaborative model of care, a nurse or medical assistant accompanies the physician during each visit, enters the findings and treatment plan into the computer, and prepares prescriptions and instructions for the patient.

Abraham Verghese, a professor of medicine at Stanford University, believes that the ubiquity of computers in clinical settings has contributed to a decrease in face-to-face interactions between doctors and patients and an erosion of physicians’ skill in the physical examination. Teams of residents may conduct rounds by checking test results on a computer and entirely omit examining patients. Often during patient encounters, “the physician’s back is turned because he or she is entering data into the computer,” he noted. Yet for patients, talking with a doctor and being examined has both ritual and therapeutic value, in addition to its importance for gathering information.

“I love technology, but I think
we're discovering that the physician–patient relationship is timeless,” Verghese said. “It cannot be abandoned because we have better tests and can do away with the human interface.”

Verghese has been campaigning to expand the teaching of bedside diagnostic skills during medical school’s clinical years and argues that newly trained physicians should have to undergo a “high-stakes clinical examination,” similar to those required in some other countries, as a condition of board certification in internal medicine or family practice. Medical schools now routinely evaluate students’ communication skills. A Chicago couple recently donated $42 million to the University of Chicago Medical Center to establish an institute to improve the doctor–patient relationship. Even when encounters are brief, “you can actually train physicians to do interpersonal things that make patients feel they’re more committed to their welfare,” said Rutgers’ Mechanic.

Some evidence suggests that primary care doctors’ scope of practice is narrowing. In a recent survey of family practice physicians by the American Board of Family Medicine (ABFM), 80 to 90% reported spending no time on preoperative, postoperative, or maternity care; 60% said they spent no time on office surgery; 55% said they spent no time on mental health; and more than 25% said they did not see children. In a letter e-mailed to members of the specialty to report these findings, Warren Newton, the ABFM chair and vice dean for education at the University of North Carolina School of Medicine, noted that the data were preliminary but prompted the question, “Why is it happening and what should we do about it?”

Newton explained in an interview that the data are drawn from online surveys that the country’s 70,000 board-certified family physicians must regularly complete to maintain their certification. He noted that the proportion of family physicians who report caring for children has declined sharply in recent years, a trend that may be related to the increase in the number of doctors employed by integrated health systems. Since general internists are in shorter supply than pediatricians, health systems are more likely to deploy family physicians to care for adults, he said. He suggested that the survey’s findings may underestimate the proportion of family doctors who treat mental health problems, because physicians may assume that the question doesn’t include the prescribing of drugs to treat depression.

With the proliferation of hospitalists and the rapid expansion of medical knowledge, the scope of practice of many internists has also narrowed, Sinsky noted. “In my own practice and others, there may be early referrals for things that could be managed locally with stronger channels of communication,” she said. Sinsky added that she has tried to maintain breadth in her practice by learning to perform procedures, such as joint injections and endometrial biopsies, and by cultivating relationships with specialists whom she can call for advice, enabling her to manage more conditions without referral.

EMPHASIS ON TEAM-BASED CARE

The health care reform law has focused national attention on the patient-centered medical home and the concept of team-based care. For several years, Colorado’s family practice residencies have been training young physicians in team-based care, especially by having them collaborate with mental health professionals and pharmacists, said Frank deGruy, professor and chairman of family medicine at the University of Colorado School of Medicine. More recently, the state’s family practice programs have also expanded their focus on practice design and
management, teaching “how you put together your care team so the people who you have available are practicing at the top of their license, communicate well, and collectively create a practice that continuously measures and improves its level of quality,” he said. Trainees have responded enthusiastically to the new approach.

“I would say the morale of the family doctors out there in the field is pretty much in the toilet, whereas the morale of the residents . . . and the newly minted family doctors is good,” deGruy said. “We’ve got people coming out who think they can change the world.”

Team-based care is the norm in some of Colorado’s large urban health systems, such as Kaiser Permanente and Denver Health, deGruy said. However, in private practice settings, the economics of the reimbursement system and a shortage of medical specialists and other services in rural areas make it difficult for physicians to apply the team-based model even when they have been trained to do so. “The biggest problem” for primary care doctors entering practice is that “it’s still really hard to make it financially,” deGruy said. Primary care physicians are “trying to do the right thing in the face of very strong incentives to do the wrong thing.”

Faced with an aging patient population with mounting medical needs, North Carolina internist Douglas Kelling radically reinvented his own practice in 1994, becoming a pioneer of the team-based model. At that time, Kelling was a solo practitioner in Concord, North Carolina, employed by the local hospital, which supports his practice. Today, he leads a greatly expanded practice that includes two other physicians, six physician assistants, and two doctors of pharmacy, as well as a case worker, a discharge planner, and other staff. In the past, it has also included nurse practitioners. He sees patients 4½ days a week in his office, manages the care of hospitalized patients, and spends his evenings and weekends developing and updating the written protocols that specify the practice’s standard treatment plans for various medical conditions. When accepted national standards exist, he applies them. When they don’t, he does the research necessary to devise an evidence-based protocol.

“We’ve found that 98 or 99% of all the patients, with our systems and pathways, can be managed by the physician assistants and nurse practitioners,” he said. “They’re empowered to go ahead and do the obvious. That frees me up to do what I enjoy most — . . . to take care of patients where there’s a gray area, where there’s no best way to handle it.”

Whether a patient sees Kelling or a physician assistant as a primary care provider, each visit is also likely to include interactions with other team members. For example, a patient taking warfarin would see a doctor of pharmacy for monitoring and adjustment of that medication, and patients with hypertension might speak with a nurse who’s trained to counsel patients on following the Dietary Approaches to Stop Hypertension (DASH) diet. Another nurse assists uninsured patients in filling out enrollment paperwork for programs that provide free prescription medications. “It’s an encounter with the system,” Kelling said. “Although obviously seeing me is important, there are certain other aspects” of each patient’s care “that other staff members can handle better than I can.”

A fourth-generation physician, Kelling is proud of his practice’s effectiveness in caring for a large population, including patients with multiple chronic conditions. He said most residency training is “training to be the Lone Ranger, where one person goes in and is supposed to be all things to all people.” His own approach is “to make medical care more like NASCAR,” with the doctor as the driver and other team members responsible for the fuel and the tires. “You as the doctor are in charge, but unless you allow other people to do what they do best, you can never be successful.”

REFORMS IN EDUCATION
Producing the number and kind of primary care physicians that the country needs will require recruiting more diverse medical students — including more from underserved areas and populations — and reforming the system and expanding the settings for training health professionals, predicted George Thibault, president of the Macy Foundation. Thibault, a former professor of medicine and medical education at Harvard Medical School, recalled that last year a resident in primary care medicine at Massachusetts General Hospital told him that she wouldn’t be comfortable going into outpatient practice because she didn’t feel she’d learned the skills needed for ambulatory care. “We probably should be using the Kaisers and the health centers of the world more than we are now” as training settings, Thibault said. If residents “never leave the ICU . . . they’re never going to have
Mental Illness — Comprehensive Evaluation or Checklist?

Paul R. McHugh, M.D., and Phillip R. Slavney, M.D.

The debate over revising the Diagnostic and Statistical Manual of Mental Disorders (DSM) is of more than intramural interest, for the way in which the promised fifth edition (DSM-5) resolves the debate will shape the nature and scope of psychiatric services for years to come. Now established as the master reference work for U.S. psychiatrists, the DSM initially emerged, like the companion volume for internists, the International Classification of Diseases, with a public health interest in the incidence and prevalence of illnesses. But with its third edition in 1980 (DSM-III), the DSM began prescribing how clinicians should identify psychiatric disorders.

The editors of the DSM-III justified this move by noting that the likelihood of diagnostic agreement between any two psychiatrists about the same patient was scarcely better than that achievable by chance. They attributed much of the difficulty to sectarian discord among proponents of psychodynamic, behavioral, and neurobiologic explanations of mental illness. And they concluded that the diagnostic muddle could be cleared up if psychiatrists put aside disputes over causes and instead identified disorders by their symptoms, signs, and clinical course.

The DSM-III produced a revolution in psychiatry. The manual identified every condition with lists of diagnostic criteria; its editors presumed that causes, mechanisms, and rational treatments of the conditions would emerge through investigative efforts that, supported by these reliable definitions, drew from the boundless explanatory resources of the biopsychosocial body of knowledge. Revolutions solve some prob-