

Why We're in the Mess We're In

Three forces are making it difficult to be a family physician today, but there are reasons to be optimistic.

Robert D. Gillette, MD

It's well known that health care in the United States is in a state of disorder and dissatisfaction and that family physicians are in an uncomfortable and unstable spot right in the middle of it. Overall per capita expenditures for medical services in the United States are dramatically higher than those in other industrialized nations¹ and are projected to rise still more in coming years.² Polls have repeatedly shown that Americans are less satisfied with their medical care than are citizens of comparable nations.³ The number of individuals totally without health care coverage exceeds 40 million and continues to rise.¹

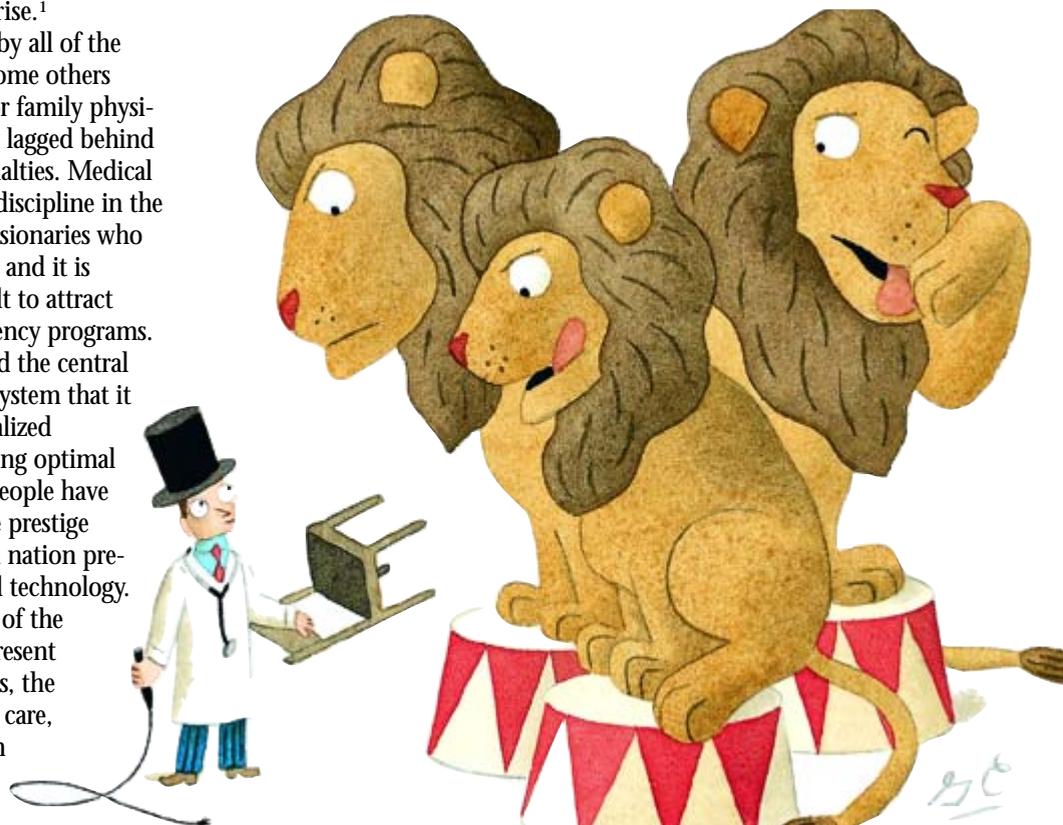
Family practice is affected by all of the foregoing problems and has some others of its own. Reimbursement for family physicians' services has consistently lagged behind that for more glamorous specialties. Medical students haven't pursued our discipline in the numbers anticipated by the visionaries who defined it several decades ago, and it is becoming increasingly difficult to attract strong applicants to our residency programs. Primary care has never reached the central position in the U.S. medical system that it serves in many other industrialized nations. Our focus on providing optimal care for the needs that most people have most of the time receives little prestige and gathers few headlines in a nation preoccupied with innovation and technology.

This essay highlights three of the multiple factors driving the present situation – economic pressures, the inherent complexity of health care, and ongoing tensions between community-centered

family practice and academic family medicine – and suggests some appropriate responses.

First, though, you should know where I'm coming from. I've been watching American medicine for more than a half century. My father was a physician with a keen understanding of patients as people. My own professional experience includes 15 years as a small-town, solo family doctor, followed by two decades of teaching and practicing in family medicine departments and residency programs. I have lectured to medical students about the American health care system (or non-system, if you prefer).

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Health care as a percentage of the gross domestic product exploded to 12 percent in 1990, leveled out for several years and is now trending upward again.



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Far too often, costly innovations have been adopted without adequate validation of their usefulness.



To survive in today's environment, physicians must be open to innovative, cost-effective practice styles.

None of this qualifies me as an authority, but it has provided some insight and historical perspective that may be of use to readers who want to understand where we are and where we need to go.

Money and medicine

Seven decades have passed since the total annual cost of health care in the United States was first calculated and expressed as a percentage of the gross national product (GNP, more recently expressed as gross domestic product, or GDP), which is an approximation of all the goods and services made and sold in our country. In 1929 it amounted to less than 4 percent of a depression-era GNP for medical services that were primitive by today's standards.⁴ By 1970 people were living longer and medical care standards were higher, and the cost exceeded 7 percent of GNP. Medical technology and care standards grew at an increasing rate in the next two decades, and by 1990 the cost had exploded to about 12 percent of GDP, which is more than we pay for education and national defense combined.¹ It leveled out for a few years, largely in response to pressures generated by the business and government entities that now pay most of the bills. However, the curve is trending upward again as our population ages and increasingly expensive new medical interventions come on line.²

The consequences have been far-reaching, although not always obvious to the casual observer. Inexorable rises in state Medicaid costs crowd out funding for education and important social programs. Small employers react to sharp increases in health insurance costs by hiring more part-time workers who receive no health care benefits. Individuals go without medicines and medical services that they can no longer afford. And, of course, physician morale and professional satisfaction continue to erode in response to multiple exogenous pressures.

As costs have increased, the profession's ability to influence the economics of health care has diminished sharply. This can be attributed in part to federal regulations that have undercut the ability of "organized medicine" to speak out against fee gouging and other abusive practices, but doctors have responded to the problem with little more than table-pounding (does anyone remember the AMA's feeble "Voluntary Initiative"?) and stern, dogmatic warnings against tam-

KEY POINTS

- As health care costs approach 14 percent of gross domestic product, family physicians must continue to strive for "lean but not mean" practices.
- Complexity is not always desirable. At some point it becomes necessary to simplify your work as a family physician.
- The value systems and world views of academicians and of community family physicians are profoundly different, but the two sides can and must work together.

pering with "the world's best medical care." Far too often, costly innovations have been adopted without adequate validation of their usefulness, and medical decisions have been based on the assumption that "nothing but the best" (usually meaning "nothing but the costliest") will do – assuming, of course, that the patient is well insured. Valid but costly procedures such as MRIs are often ordered for patients who have almost zero probability of benefiting from them. The managed care people know all of this, and they have little reason to think of physicians as their natural allies in controlling costs.

The companies now dominant in American health care are awesome in size and power. *Forbes* magazine's 2001 list of America's largest companies (see www.forbes.com/forbes500) listed 18 of them as each doing more than \$10,000,000,000 (that's ten billion dollars) of business annually. Legislators, regulatory agencies, major employers and the administrators of large health care systems also influence the course of health care, not always for the better.

The bottom line: With our population of senior citizens increasing steadily, a deluge of expensive new drugs and technological interventions arriving each year, and the business people in control, the tensions between exploding demand for services and the nation's finite financial resources can only get worse. Some form of political explosion seems inevitable in a few years as health care costs approach 20 percent of GDP, but those now at the top of the pile have the power to stay there for the short term. Family physicians must live with the hard fact that the good old days are not coming back. Surviving in today's environment requires us to stay ahead of the curve

by evolving ways to “work smarter” and to soften the system’s rough edges for the benefit of our patients. This means being open to the need for and possibilities of innovative, cost-effective practice styles.

We must be “lean but not mean”: There can be no “fat” in our professional work, no futile diagnostic procedures or worthless treatment methods (evidence-based medi-

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cine, here we come!). There must be a clearer distinction between what patients need and what they simply want. The common assumption that it is somehow immoral to consider the cost when writing patient care orders must go. Ditto for the belief that social and emotional factors are irrelevant in this technology-driven age (we have all seen instances where a doctor – usually not an FP – ordered a \$1,000 MRI that didn’t help the patient, rather than taking a \$100 comprehensive history that could have). At the same time, we must remain faithful to our roots in terms of seeing our patients as valued and respected human beings who deserve our best professional care.

The heavy hand of complexity

A century ago some researchers working with mice discovered what they called the Yerkes-Dodson law, which goes something like this: If the little critters receive almost no stimulation, they do very little. As they are confronted with increasing challenges (running a maze, perhaps) they perk up and respond more effectively. However, at some point increasing stimuli become overwhelming and performance drops off. (See the graph at right.) A similar phenomenon in the world of economics is called the Laffer curve, in which rising taxation rates bring increasing revenue up to a point. Eventually,

as taxation becomes excessive, tax-avoidance strategies are pursued vigorously and total revenue falls.

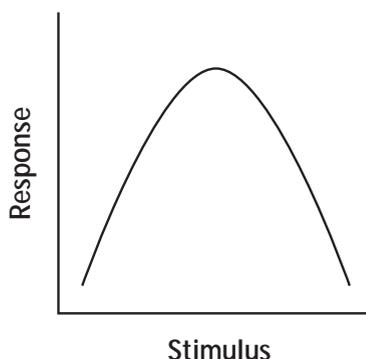
It’s the same with people, including doctors and patients, except that each of us has a unique Yerkes-Dodson response. Some of us can tolerate a lot of complexity, while others hit our peak performance at a less demanding point. This has important but little recognized implications for medical care. For example, the folks who set health care standards tend to like complexity, while the majority of us “in the trenches” can do our jobs better if we are permitted to focus on what’s really important without being inundated with a flood of unusable data. Also, patients have widely varying abilities to retain and use the information we give them in the examining room.

Ignoring these facts is having a serious negative impact on American health care. Consider, for example, the matter of preventive care. The concept of picking up potential problems before they become irreversible makes sense, but we unnecessarily add to the complexity of the patient visit when we begin advocating interventions that sound plausible but only increase costs without helping patients much. In many cases, we are trying to do too many things, with the risk that we will do none of them well.

Complexity has other adverse effects, not the least of which is the rising rate of potentially dangerous medical errors that is receiving so much attention in the news media. This problem has been with us for years, but pressures associated with rapid technological change and the economic demands of

THE EFFECT OF INCREASED COMPLEXITY

The Yerkes-Dodson curve, shown here, illustrates how an increasing stimulus leads to an increased response, but only to a point. This phenomenon is applicable to the current health care environment, where physicians struggle to maintain their productivity and professionalism in the face of increasing complexity.



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According to the Yerkes-Dodson law, an increasing stimulus leads to an increasing response, but only to a point.



Increasing complexity in health care leads to more productive physicians, but only to a point.



The majority of doctors “in the trenches” do their jobs best when they can eliminate needless complexity and focus on what’s truly important.



Complexity should be questioned if it only increases costs without helping patients much.



At some point it becomes necessary for physicians to simplify their work and consciously decide what to utilize and what to ignore.



Family physicians have both the right and the obligation to be selective in their scope of practice, basing the boundaries on what is best for their patients and on their own abilities.



To better manage the complexities of medical practice, family physicians should delegate tasks that do not require their attention.

managed care are making it worse. Stressed, overworked employees seldom pause to analyze their work and take steps to improve it. The use of information technology promises to help, but at some point overload is overload whether it exists on paper or on a computer screen. It's still "noise" and it still gets in the way of clear thinking and efficient action.

The bottom line: It's time to abandon the notion that complexity is always good and simplicity is always suspect. At some point it becomes necessary to simplify our work and consciously decide what to utilize and what to ignore. For family practice, this means addressing society's many health care needs only to the extent that we can do so without compromising our focus on "uncommonly good care of common health problems." We are obligated to provide exemplary care for people with diabetes, allergic rhinitis, musculoskeletal pain, depression and other disorders that confront us daily, as well as providing preventive services of proven value. We have both the right and the obligation to be selective in addressing less common conditions, basing the boundaries on what is best for our patients and on our abilities. To help us manage the complexities of medical practice, we must also let go of things that do not require our attention. It's time to do better in teaching patients to manage common respiratory infections and other self-limited problems themselves, and to delegate more

repetitive chores (such as tracking immunization schedules) to other members of our practice staffs.

Much of the needless complexity, or "noise," in our professional lives comes from sources other than patient care, primarily the payers and the regulators. We must continue the good fight of keeping these people at a proper distance.

Family practice vs. family medicine

The February 1976 issue of the *Journal of Family Practice* featured a series of articles on "The Virginia Study," a massive project describing the content of patient encounters documented in various family practices

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throughout the state of Virginia. As a family physician then making the transition from private practice to a teaching career, I couldn't see the point of the paper. At a national meeting I asked one of the authors why he and his colleagues had spent so much time and energy documenting the obvious. Didn't everyone know what family doctors do all day? He replied that the publication filled a political need, that people in the

WILL POSTMODERNISM SAVE US?

"Every reform, however necessary, will ... be carried to an excess, that itself will need reforming." These words of Coleridge anticipate the present-day intellectual assault on "modern thinking," the use of disciplined analysis of objective data to solve human problems. The modernist approach has been marvelously effective in advancing medical knowledge and the treatment of biological diseases, but it has been less helpful – indeed, it is sometimes counterproductive – in the care of ill patients and the management of disorders such as chronic benign pain that have important social and psychological elements. Modernism asserts that everything of significance can be quantified and that anything that can't be measured is trivial, vaporous or irrelevant. This is one reason that family medicine, which inevitably deals with patients whose problems and needs often defy precise measurement, continues to rank low on the academic prestige ladder.

Postmodernism, a new concept in recent decades, can be thought of as a reaction to the rigidity, complexity and depersonalization found in "modern" society. It is a developing construct that means different things to different people, but in general terms it challenges the notion of objective

reality and promotes a subjective, individual-oriented view of "truth."

The bad news is that enthusiasts have carried postmodernism to an extreme that says all systems of belief are equally valid ("one person's truth is as good as another's") and that modernism is dead. The good news is that a more modest postmodernism can free us from the excesses of rigid biomedical dogmatism and let us return to listening to and valuing our patients as individuals and as members of families. This was foreshadowed by Einstein's dictum that, "Truth is what stands the test of experience." Quantitative analysis is part of truth, but much of experience cannot be quantified.

Our challenge as family physicians is to sort out the reasonable from the absurd and to utilize the sound parts of both modernism and postmodernism, fully aware that both will evolve and mature over time. Evidence-based medicine and subjective narrative must share the stage as we address the real problems in real patients. As William James put it, "We have to live today by what truth we can get today, and be prepared tomorrow to call it falsehood."

academic world needed to understand that family practice was a definable, functional and important part of health care. Over time it became clear that he was absolutely correct, as the document proved to be a useful tool in negotiations and discussions with colleagues, both family physicians and others.

The truth was, of course, that “everyone” didn’t know what family doctors do all day, and many in the academic world still don’t today. What’s more, the values that we in family practice stress – comprehensive, top-quality, patient-centered care of common health problems – are foreign to academicians. The technological side of medicine advances by breaking itself into smaller and smaller subspecialties, while family medicine recognizes the importance of a comprehensive approach to meeting our patients’ needs. Fragmented, discontinuous treatment is all that many academicians have ever experienced, while our discipline understands and supports the value of continuity-oriented care.

Family medicine academicians thus find themselves attempting to negotiate and function at the interface of two very different medical cultures. The value systems and world views of academia and of community family physicians are profoundly different, but we can’t let that deter us from working together. We need access to medical students and credibility in their eyes. We also need the scientific knowledge and the intellectual discipline that the academic system offers. The situation brings to mind the old tale of the blind men and the elephant, in which each man is touching a different part of the animal’s body as they try to identify the object before them. The one holding the tail thinks the beast is a rope, the one feeling a leg conceives of it as a tree trunk, and so on. Only by communicating effectively and synthesizing their observations can they arrive at a coherent view of the whole.

Thomas Schwenk, MD, of the University of Michigan’s family medicine department, has stated this problem in clear and unmistakable terms: “University medical centers are basically places where ideas and principles compete with one another – and they compete in an aggressive, merciless and sometimes amoral fashion Many of the most critical issues facing family medicine, including student interest, residency capacity, research development and government funding, depend on our visible,

assertive participation in academic medicine power structures.”

The bottom line: Community-based family physicians must support our academic colleagues if our discipline is to remain viable in coming years. First, it is essential to seek common ground between the academic and community-practice worlds. Be tolerant of differences in outlook and practice styles and supportive of family medicine clinical research. Second, get involved in the education process, perhaps by inviting medical students into your practice for family medicine clerkships or by serving as a preceptor or lecturer at a family practice residency program.

Half full

Family medicine educators are reporting with increasing frequency that some community family physicians are so unhappy and pessimistic about the present and future status of family practice that they are actually discouraging students from becoming family physicians. From the perspective of several decades of medicine watching, I’m persuaded that this makes no sense. We can now do so much more for people than was possible a half century ago. Patient care can and should be a real joy. Income for family physicians may lag behind the more prestigious specialties, but it’s infinitely better than what my dad made as a physician in the 1930s. There are still a few diseases we can’t cure, and still people who die despite our best efforts, but the proverbial glass is much more than half full. Be proud of who you are and what you achieve as a family physician, and pass it on to the next generation. **FM**

Send comments to fpmedit@aafp.org.

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Many in the academic world do not understand the work of family physicians or the values of family practice.



Academic and community family physicians must find ways to work together to uphold the specialty and to attract medical students.



Some family physicians are so unhappy and pessimistic that they are actually discouraging students from entering the specialty.



Family physicians should be proud of who they are and what they achieve and should pass those feelings on to the next generation.