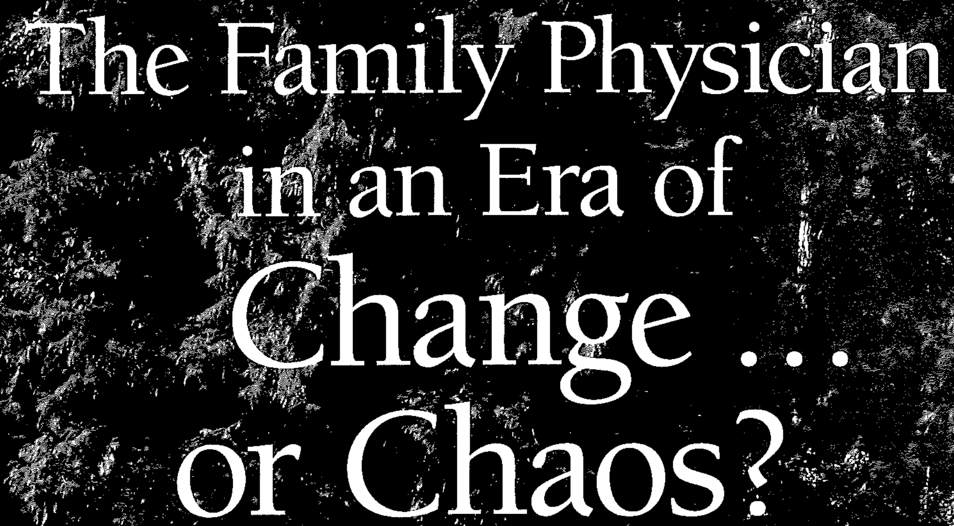
The Family Physician in an Era of Change ... or Chaos?



SUPERSTOCK

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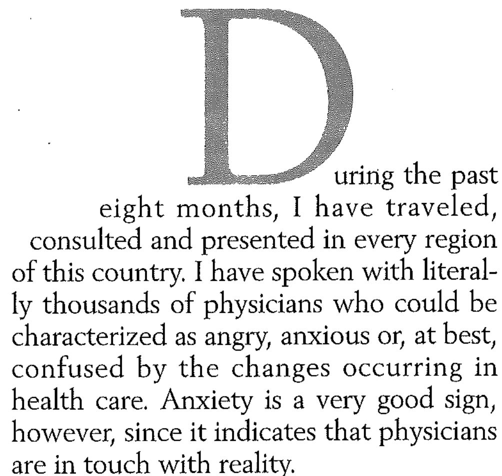
If you see only the risks ahead, you may be missing a golden opportunity.

William J. (Terry) Kane, MD



During the past eight months, I have traveled, consulted and presented in every region of this country. I have spoken with literally thousands of physicians who could be characterized as angry, anxious or, at best, confused by the changes occurring in health care. Anxiety is a very good sign, however, since it indicates that physicians are in touch with reality.

Marcus Aurelius might almost have been thinking about our health care system 1,800 years ago when he wrote, "One thing hastens into being, another hastens out of it. Even while a thing is in the act of coming into existence, some part of it has already ceased to be. … In such a running river, where there is no firm foothold, what is there for man to value among all the many things that are racing past him?"[1]

If you are among those family physicians who feel too much is "racing past" in health care today, my advice is to stay focused on the big picture — what is best for your patients and the American public. With this in mind, I offer the following observations in hopes of adding some perspective and some enthusiasm for the challenges and tasks confronting the medical profession in general and family physicians in particular.

Reasons for the momentum

The health care system is undergoing radical change and restructuring, and there are very compelling reasons for this activity. The United States has the most expensive health care per capita in the world without the health outcomes to justify the expenditure.

We have been told repeatedly that industry and business in the United States must compete internationally and that health care costs must be controlled for them to remain competitive. These arguments have met with skepticism. However, in the past year the bipartisan Commission on Entitlement and Tax Reform of the United States has released data indicating that by the year 2011, if there are not significant cost reductions, the federal government will use its entire revenue to fund entitlements and interest on the national debt. This will mean

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SPEEDBAR

▶ The United States has developed a sophisticated health care system, but has failed to make it accessible to all Americans.

▶ Because the country has not found a solution to the health care crisis, the marketplace may impose one.

▶ While primary care physicians are now in demand, it is difficult to project manpower needs for the future.

▶ Greater competitiveness has led to a surplus of specialists and hospital beds, more purchasing cooperatives and larger practices.

no funds for education, defense, infrastructure or any other discretionary spending.

Medicare and Medicaid expenditures are major costs in these calculations. Clearly, this year-2011 scenario will never happen. Recent congressional actions and debate indicate the direction that is going to be taken with regard to federal health care expenditures.

The United States has the best physicians, best technology, best research and best health care facilities in the world. However, with the exception of primary care, we have far too much of everything and still leave more than 40 million Americans without health insurance. There has to be a better way! This is the motivation behind much of the reform activity.

Yet there seems to be no way to reach consensus on how to solve the health care issue. I fear that America will address the problem just as it has addressed other noncompetitive, inefficient aspects of our economy — in the cruel, impersonal marketplace.

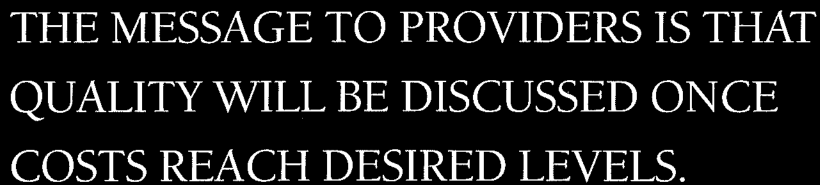
The competitive environment

Consider the current environment. Several characteristics of the marketplace call for responses from us:

Primary care physician transition. While the primary care physician is now in demand, I question whether any significant shortage exists. I believe that we are in a period of transition. Future medical group organization coupled with capitation may change manpower requirements in primary care.

Specialty physician surplus. The specialty physician surplus is real, very significant and apparently an insoluble problem. Physician needs of staff-model and group-model health plans with defined numbers of enrollees are dramatically less than our current norms, and if we continue to move in the direction of those highly managed models, the demand for physicians in each specialty in the community at large will drop significantly below supply.

Hospital bed surplus. Hospital utilization is decreasing throughout the United States, and California levels of less than 200 days per 1,000 population and one acute bed per 1,000 population will eventually be the norm everywhere. One of the biggest obstacles to reforming the health care system is the continuing enchantment with hospitals. As Ian Morrison of the Institute for the Future notes, "What killed the railway system was not the automobile, the interstate highway system or liberalized trucking regulation. What killed the railways was that they were run by people who really liked choo-choos. This also is the Achilles' Heel of hospitals. They are run by people fascinated with big buildings and all they contain."[2]



Purchasing cooperatives. Government-oriented and business-oriented purchasing cooperatives continue to grow in number and size. Some have been able to achieve significant reductions in health insurance premiums, reductions that are quickly passed to providers. Providers will assume risk for cost and outcomes, and the message to providers is that quality will be discussed once costs reach desired levels.

Capitation. I prefer to use the term "fixed reimbursement system" since the word capitation so often engenders a negative emotional response from physicians. Capitation will be the predominant reimbursement mechanism and, for most family physicians, it will result in better reimbursement than continually discounted fee-for-service payment.

Health care "superstores." The corner hardware store, neighborhood pharmacy and mom-and-pop grocery store are vanishing. We are even seeing banks charging

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▶ The medical profession must be willing to admit that more research is needed to make critical allocation decisions.

▶ Massive changes in the industry necessitate that family physicians change with the times or risk losing control of their practices.

▶ Collectively, physicians have chosen to complain about their circumstances and to blame others for unwanted changes.

▶ Constructive action begins with acknowledging that more common-sense approaches to health care produce healthier people.

to see the teller, giving a clear indication that multiple bank branches will give way to electronic banking. Physician offices will also be converted to large group practices with more efficiency, expanded hours and more services on-site. Just as the American public has accepted superstores in other industries, they will be very comfortable with the move to larger practices.

Ambiguity, uncertainty and overexpectation in medicine. This is the most difficult of the issues confronting us. We simply do not have the knowledge required to make critical allocation decisions in medicine. Much more health-services research will be required to fill in the void. In the meantime, as a profession we might be better off if we were honest with the public about our lack of knowledge. At the same time, steps must be taken to curb malpractice claims and plaintiff attorney rewards.

Our gut reaction

How is the physician doing in this environment? In a book titled *To the Greater Good: Recovering the American Physician Enterprise*, The Advisory Board acknowledges that the impact of change is being felt in every practice model and that even the most celebrated systems are suffering (see "Winds of change"). The message is clear: We cannot continue to practice the way we did 20 years ago, not when the changes taking place in this country are so extensive. Change must be met by change.

Well, are we meeting change with change? What do you think? In fact, physicians' collective reaction to current changes is to complain:

- Business and government only care about cost, not quality and the art of medicine.
- Physicians are losing control of the practice of medicine.
- The quality of patient care is decreasing because of health plan interference.
- Managed care is limiting the hospital and procedural activities of family physicians.
- Savings are not going anywhere except to stockholders and managed care executives.

Do you find yourself agreeing or echoing these statements? On the surface, they seem valid. But what good does it do to hold on to this thinking? We are not going back to the days of old!

Let me offer another possible viewpoint.

The central problem

As a family physician, you know that health care costs are too high, that we have too much technology in medicine, and that we can produce a much healthier population through common-sense approaches and policy such as that conceived in Oregon (see "Kitzhaber on

Winds of change

According to The Advisory Board, the turbulent nature of the marketplace presents unending challenges to physicians:

- Over time, there is no perfect shelter for physicians from the storm; relentlessly, impersonally, a rationalizing market will drive toward equilibrium in number of physicians, mix among specialties and levels of compensation.
- No setting for physician practice can sustain physician income, artificially, against market forces; winds of change are felt in every model — solo practice, group practice, multispecialty group practice, PHO, IPA, staff model, foundation model, equity model and academia.
- Some models (some specific groups and systems) are markedly advantaged in the competition of a contracting market; that said, for the moment even the most progressive, most celebrated California health systems and groups — icons of the past five years — are suffering in heavy seas.

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► The greatest challenge facing providers is to meet health care needs with limited resources.

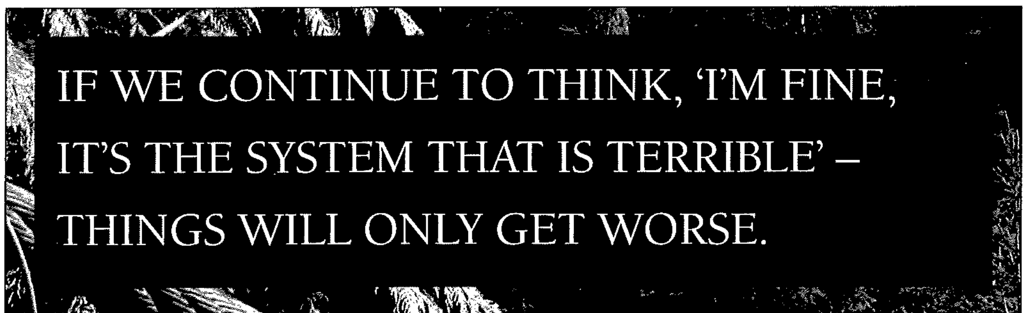
► Ambivalent and negative reactions to managed care have enabled government and business to continue to drive the system.

► Restructuring can lead to more accessible and more effective care, but not without further reductions in facilities and manpower.

► As changes continue to occur, the real question is whether the system will deliver the best care.

Reform: Right Direction, Wrong Road," *Family Practice Management*, February 1994, page 26).

Clearly, we are faced with unique challenges. Richard D. Lamm, former governor of Colorado, points out the core problem for our society: "Infinite needs have run smack into finite resources. A new world of tough, agonizing decisions faces American society. We have invented more health care than we can afford to deliver to everyone, and we must start a dialogue on how we allocate limited health care resources."[3] Naturally, this problem implies a special challenge for us physicians: "The moral question is no longer whether to participate in cost containment (that would be like asking shall we abide by the law of gravity?) but how to do so in morally credible ways."[4] That is, how can we participate in cost containment while still upholding our responsibility to our patients? "There is a very real conflict in a physician's responsibility to a patient-centered ethic and other competing responsibilities to preserve society's resources."[5] Clearly, we are between a rock and a hard place.



The effect of our collective response to this challenge — which I would characterize as ambivalence at best and negativism at worst — is bringing us more pain, more dissatisfaction and more suffering than we have ever experienced. Preauthorization, external utilization controls, gatekeeping, lower and lower reimbursement and multiple contracts and rules from every health plan pose greater and greater obstacles to our professionalism.

If we continue to act as victims — if we continue to think, "I'm fine; it's the system that is terrible" — I believe things will only get worse. Why? Our collective reaction so far simply has the effect of leaving government and business to drive this system restructure based on price alone. We are allowing insurers to turn this into a power struggle, pitting one health care provider or system against another to the probable detriment of the public and the profession. Business and government can manage money. Only physicians can manage care. If we do not join the process, business and government will continue to manage cost and reimbursement to get the changes they desire — changes that are, in fact, needed.

A different strategy and focus

So what is the desired outcome? I believe these will be long-term measures of success for the restructuring now under way:

- Organized, properly sized systems of care, competing on outcomes, patient satisfaction and cost.
- Public policy developed after engaging the public and the medical profession in an honest dialogue concerning the distribution of health care resources.
- Re-engineered clinical processes based on multispecialty clinical guidelines defining necessary care and the specific impact of the criteria on health and cost.
- Population-based health care with incentives for preventive care and health promotion leading to the improved health status of the community at large.
- All Americans insured, with access to basic health care benefits.

There will, however, be a downside to these accomplishments. We will close one-third of our hospitals with all the turmoil that involves, and thousands of our specialty colleagues will seek other work or retire. We cannot change that inevitable outcome, just as the auto and computer industries could not prevent their downsizing and restructuring. The real question is how excellent, scientifically based and personally satisfying will the resulting patient care be?

Why should family practice accept

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▶ A strong case can be built for family physicians assuming a leadership role in reforming the health care system.

▶ Recognizing that family practice is vital to managed care, more medical schools are establishing residency programs.

▶ The future success of family practice will depend on the willingness of its leaders to rethink priorities based on the needs of the public.

▶ Family practice has served as a change agent in the past, bringing about changes in medical education and delivery of care.

WHAT DOES FAMILY PRACTICE HAVE TO DO TO SUCCEED IN A LEADERSHIP ROLE?

the challenge and assume a leadership role in these changes? The answer is obvious — it is our heritage to be a change agent. There is no other discipline with the size, credibility and togetherness to even consider taking on the task.

In 1982, Gayle Stephens, MD, wrote a book titled *The Intellectual Basis of Family Practice.* In a section called "Family Practice and Reform," he identified four crucial questions facing American medicine:

> • Will medicine become a vast technocracy institutionally based, mechanized and automated? If so, who will control this technocracy?
>
> • Will medicine delegate or abandon its historic identification with caring in favor of an obsession with curing, an obsession that is ultimately destined to be frustrated by the ecologic limits of the Earth?
>
> • Can physicians retain or develop any qualification to serve as counselors to society in matters of health?
>
> • Will medical education enhance the role of physicians as experts in interpersonal communications or will it ignore and allow to atrophy whatever inherent communicative skills the medical student may have?

Stephens went on to say:

> We have had to settle for less than we had hoped for. We hoped for everyone to have access to a personal physician — we've discovered that not everyone wants or can utilize a personal physician properly. We hoped to produce compassionate physicians — we've had to settle for producing less cynical ones. We wanted to educate patients — we often found that we ourselves lacked the education to do it. Perhaps our unfulfilled hopes are less remarkable than that we hoped at all.
>
> We have a good beginning but our future success depends on a number of factors over which we have no control. My hope is that we can find leaders who are willing to rethink priorities on the basis of the medical needs of the public rather than on the basis of preserving the professional self-interest of organized medicine.[6]

That was and is our challenge. I grew up in a specialty that was not afraid of change; that overcame obstacles from without and within to achieve Board status and academic respect. Today, family practice is the foundation of managed care, and even those medical schools that until recently were afraid to breathe the words, "family practice" are seeking approved residency programs.

In the 1970s and 1980s, family practice functioned as a change agent, fostering the return of the generalist to medicine, inclusion of humanism in medical education, recognition of the role of behavioral science in ambulatory curriculum, emphasis on ambulatory care research and development of the multidisciplinary team approach. Our success in the last 25 years, in both education and practice, was the result of a willingness to rethink our priorities on the basis of the needs of the public, just as Stephens espoused.

Opportunities and liabilities

Now we are faced with one of those infrequent opportunities to make a quantum leap to lead the health care revolution in this nation for the next decade. What does family practice have to do to succeed in this leadership role? We must, I believe, undertake the following activities:

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➢ Family practice must lead the way in finding creative ways to deliver ambulatory care, to use specialists and to increase resources.

➢ Lobbying efforts must focus on development of public policy to guide the ethical distribution of health care resources.

➢ Overconfidence must not prevent family practice from reexamining its processes and practices in changing times.

➢ Since restructuring will continue, it is extremely important for family physicians to possess good leadership and management skills.

- Reinvent the ambulatory care process through the development of innovative, cost-effective, science-based guidelines and pathways;
- Develop creative strategies to engage specialists in the care process and define the specialty referral process;
- Commit resources to organizations, such as the National Committee for Quality Assurance, that are involved in database development and quality indicators;
- Advocate immediate reductions in medical school enrollment and specialty residency programs;
- Foster public-private partnerships to increase the resources allocated for practical health services research and disease management;
- Lobby for public policy to guide the ethical distribution of health care resources. We need enlightened public policy because simply assigning a percentage of the GNP to health care and expecting the various participants to fight it out is cruel and foolish. Physicians cannot be expected to ration care at the bedside, one patient at a time.

THE SEVEN LAST WORDS OF A DYING ORGANIZATION: 'WE NEVER DID IT THAT WAY BEFORE.'

As we approach this decade of change, we as a specialty also have liabilities to consider. We run the risk of overconfidence that family physicians are in short supply and indispensable. We must reevaluate our feelings of protectionism with regard to the role of other professionals. We must take care that ambivalence and "raging incrementalism" don't rob us of the opportunity to lead. We must not allow an emphasis on inpatient and procedural skills to detract from the importance of ambulatory management and leadership. And we must make sure that our residency programs and curricula do not reflect the status quo, mortgaging the specialty's future.

In my career, I have often reminded my management team of the seven last words of a dying organization: "We never did it that way before." Family practice must be willing to constantly re-examine its processes and practices while remaining constant in its values and purpose.

The current restructuring and downsizing in health care is not going to slow or stop. It is driven by the harsh realities of foreign competition and the necessity for our government to live within it means.

We have the option to go along, kicking and screaming, doomed to accept our fate at the end and perhaps forever forfeiting medicine's leadership role. Or we can accept the challenge and opportunities I have outlined.

We need physician leaders at all levels of health care willing to bring about dramatic change in how we practice medicine and commited to marked improvement in outcomes and efficiency. We will need to develop the educational programs to ensure family physicians have the management skills to succeed.

We are the specialty positioned to lead this transformation — based on our past performance and dedication to personal, sensible primary care for all Americans. I have every confidence we will rise to the occasion.

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