

- Family physicians have **huge** patient loads.
- They earn **far less** than specialists.
- Will a doctor be **there for you**?



# Where Have All the Doctors **Gone?**

By Patricia Barry

When Donna and Larry Bry moved from Oregon's coast to its capital city, Salem, in May 2006, they started looking for a new primary care doctor. It took two years to find one.

At first it didn't matter much. Though beyond retirement age, the Brys were healthy, and when they needed prescriptions filled every three months they drove back to their old home on the coast—a round trip of about 160 miles. But one day the side of Larry's face swelled up so badly that it closed his eye, and he went to the emergency room. He had a severe case of shingles. He needed a neurologist. "But nobody would see him unless we had a primary care doctor, and we couldn't find one," Donna says. "We pounded the phones day after day, going through the whole list [of primary care doctors] in Salem. But everyone who accepted new patients would not accept people on Medicare."

## The number of doctors going into primary care medicine has fallen by half.



**T**he Brys' experience is not an isolated case. At least 56 million Americans, almost one in five of the population, are now "medically disenfranchised"—having inadequate access to primary care physicians because of shortages in their area—according to "Access Denied," a county-by-county study by the National Association of Community Health Centers and the Robert Graham Center, a research group that focuses on primary care.

Among Medicare beneficiaries, about 3 percent—more than 1.3 million people—have difficulty finding a new primary care physician, a government survey found last year.

As the population ages, with the first wave of the nation's 78 million boomers due to turn 65 in 2011, experts say the shortage of primary care physicians—those trained in general internal, family or pediatric medicine—is already a crisis. It's a factor that's often overlooked in the growing demand for universal health care. "Ensuring everyone has health insurance without ensuring them a regular source of primary care," the "Access Denied" report warns, "is like providing currency without a marketplace."

Most people living in areas where shortages are most acute actually have insurance, the report found. So did most of the *AARP Bulletin* readers who shared their problems trying to find physicians. Californian Judy Johnson, for example, had insurance but couldn't get in to see a doctor until she lucked into a referral. [See sidebar on Johnson's experience, page 14.]

**S**o where have all the doctors gone? "The pickle we're in is that [primary care doctors] of my generation are stopping practice early and the young people are not choosing it as a profession," says Jeffrey Harris, M.D., president of the American College of Physicians, which represents 126,000 internists. "To say that primary care is collapsing is not hyperbole."

The reasons why primary care doctors are retiring early and new doctors are not replacing them are pretty much the same, Harris and other physicians say. Their earnings on average are half or a third of those of doctors in many specialties, yet their workdays are longer and their overhead higher. Hours spent on paperwork and phone calls for prior authorizations demanded by insurance companies reduce the time spent with individual

patients—so does the pressure to take on as many patients as possible to stay in business. New medical school graduates realize this: The number going into family medicine declined by more than half from 1997 to 2005. By 2006 only 13 percent of first-year residents in internal medicine said they intended to pursue it in general practice.

The experience of one small-town primary care doctor sums up what is happening. Fred Ralston Jr., M.D., is an internist in Fayetteville, Tenn., where his family settled 120 years ago. The practice has seven physicians, a nurse practitioner and more than 30 others on staff. He personally has 2,000 patients, sees 20 a day in his office and others at the hospital and nursing homes. His world is totally different now from when he started practice in the 1980s, he says. "There were plenty of primary care physicians, and we had time to see and get good relationships with patients," Ralston says. There was little paperwork, and the practice's overhead was "less than 40 percent of every dollar we took in." Now, he says, it's around 65 percent, of which at least 40 percent is spent dealing with insurance companies. "It's a very large part of our expense."

**D**espite his own job satisfaction, Ralston doesn't blame young doctors for not going into primary care when they can choose other specialties with defined hours, higher salaries and less hassle, especially when they have huge debts from school and young families. But he can see the effects. "Every neighborhood in the country is one doctor away

**'Every neighborhood in the country is one doctor away from a crisis.'**

from a crisis," he says. "If I go away and my 2,000 patients are let loose on the market, there are not enough doctors to absorb them."

Because fees are fixed by Medicare and insurers, the only way primary care doctors can generate revenue is to take on more patients, which means spending less time with each—often no more than 15 minutes. "The commonest complaint you hear from patients is: 'I don't have enough

time with the doctor,'" says the ACP's Harris. "They're right. You can't take good care of people with chronic conditions in 15 minutes."

A recent ACP study compared the U.S. health system with those of 12 other countries and analyzed why the latter had better medical outcomes for far less funding. "The take-away message," says Harris, "is that systems with primary care as a cornerstone are less expensive and have better quality." The American system needs new strategies, he says, starting with medical school training, which currently favors overspecialization. Among many proposals for improving the situation is forgive-

**Donna and Larry Bry spent two years trying to find a primary care physician who would take them as Medicare patients in Salem, Ore.**



ness of medical school debts for graduates who go into primary care, restructuring the way those doctors are compensated and, above all, establishing “patient-centered medical homes.”

**T**he point of a medical home is for patients to have an ongoing relationship with a personal physician who leads a team that coordinates care. The approach would allow more time for patients, especially those with multiple chronic conditions. The doctor's compensation would be tied to meeting certain standards and bundled into a “care coordination” fee for each patient. Patients would be able to ask questions by e-mail or phone and schedule appointments on short notice.

That at least is the ideal. As yet, only two practices—in Maine and Maryland—meet all the standards for a medical home set by the National Committee for Quality Assurance. Medicare, Medicaid and some insurers are already experimenting with pilot projects. Some members of Congress are working on legislation to make medical homes more feasible.

In the meantime, though, the access situation is likely to become worse before it gets better. Donna and Larry Bry finally found primary care 30 miles away, from a husband and wife newly graduated from medical school, on a tip from another doctor's receptionist. Judy Johnson found hers through her grandson's new basketball coach. His family had just moved to the area, and his wife was a rare find—a primary care doctor looking for new patients. □

### Insurance, Yes. Access, No.

**H**aving health insurance doesn't guarantee access to physicians. **Judy Johnson** (left), for example, says she had “insurance up the ying yang”—primary employer coverage, secondary Medicare coverage and medigap supplementary insurance—and still couldn't get in to see a doctor last year after noticing a mole on her arm “doing weird things.” It turned out to be melanoma, a potentially deadly cancer.



Having just moved from the San Francisco area to 50 miles north of Sacramento, Johnson, 68, didn't have a new primary care physician who could make a referral. So it took months to see a dermatologist—typically those she called said they couldn't schedule an appointment for three or four months. “I can't tell you how many times I was in tears, just over trying to coordinate insurance, doctors and care,” she says.

It was seven months before she had surgery to remove lymph nodes. Now the melanoma has spread to her lungs. “If I'd gotten in to see somebody sooner, like right away, it might not have spread so far,” she says. “But it's turned into a big mess.”