North Coast Physician

In This Issue:

Cover Photo
"TAI CHI AT THE FARMER'S MARKET 2009"
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The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

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What Doctor Shortage?

STEPHEN KAMELGARN, M.D.

In the December 4, 2013 New York Times, I came across a little op-ed piece entitled "No Their Wills Be a Doctor Shortage," by Scott Gottlieb and Ezekiel J. Emanuel. The thrust of Drs. Gottlieb and Emanuels' thesis is that the projections made by the Association of American Medical Colleges of a 130,000 shortfall in the number of physicians in the US by 2030 is wrong.

While they don't dispute the assumptions made by the AAMC: increasing medical demands from an aging population and increasing numbers of insured people from ACA (Obamacare), they feel that the increased demand for medical services will be more than offset by improved efficiencies in how we take care of patients.

We're already seeing the effects of less invasive surgical procedures, less toxic and shorter courses of cancer chemotherapy, shorter hospital stays. In other words, medical care is becoming less resource intensive, and this is a good thing.

However, they also feel that we should be making more use of non-medical personnel. They state:

"Other medical personnel can also expand the reach of physicians to care for a larger population. Nurse practitioners, health aides, pharmacists, dietitians, psychologists and others already care for patients in numerous ways, and their roles should expand in the future. The rise of nonphysician providers will enable more team care.

". . .That means expanding the scope of practice laws for nurse practitioners and pharmacists to allow them to provide comprehensive primary care;

" . . .Instead of building more medical schools and expanding our doctor pool, we should focus on increasing the productivity of existing physicians and other health care workers while incorporating new technologies and practices that make care more efficient."

I know the move in medicine is to move toward "team-based care," with an army of non-medical and paramedical personnel taking over tasks that were formerly performed by physicians: teaching, routine wound care, ordering screening studies, etc.

I've made my feelings about the word, "productivity" abundantly clear in prior screeds. (See "Productivity: The Industrialization of Medicine" in North Coast Physician, February 2013.) So I don't see this as an avenue to improve patient care.

Ever more of our patient interactions occur via email, which chains the doctor to the computer ever more so.

While all this "brave new world" may make us more efficient, it also makes us a bit more robotic and a little less human. We "manage" while we direct patient "traffic" to the appropriate paramedical person: the patient as assembly line commodity. With me acting as a glorified traffic cop: go here, see her for more education, I'm not sure exactly what my role is supposed to be, and how patients heal as they navigate the maze.

Primary care, in particular, truly demands that we interact with the patients. As I stated in last month's rant: "It is in the taking of the history, and in the advising and treating that we practice our art form." This is a process that can't be speeded up, nor can it be delegated to paramedical personnel. This is what takes the time during that famous seven minute office visit. This is what separates the doctor from the health care provider.

If we expand the roles of pharmacists, nurse practitioners and other non-physician personnel, what happens to the costs we all claim to be concerned about? There have been hundreds of studies documenting how valuable in extending "physician reach" mid-levels have become, whole swathes of rural America would have no medical care at all if it wasn't for mid-levels practicing out in "the boonies," today. Unfortunately, there are very few studies documenting relative "cost per patient" between mid-levels and physicians. The few studies I could find seem to indicate that costs to the healthcare system are higher (increased referrals to specialists, increased use of routine blood draws) with the use of mid-level practitioners, and that they don't order screening tests (colonoscopies, in particular) as frequently as physicians. And I could find NO studies documenting if there is any differences in outcomes between patients managed by physicians as compared to patients who are shunted to a variety of paramedical personnel for their medical care.

As we involve more people in the care of patients, the chances for error, mis-communication, scheduling foul-ups increases dramatically, and we must ask ourselves, is the patient really being better served by having all this increasing fragmentation.

If we don't wish to train the extra 130,000 physicians, we'll need to spend (probably) an almost equal amount of money training an army of nurses, pharmacists, mid-levels, educators, technicians, etc. Anyway we slice it, training personnel costs money and taking care of people takes time, whether those people are seeing a physician or a diabetic educator. Isn't it better for us, as physicians, to demand that we get to spend our time with the patients, rather than on the phone to some robotic bureaucrat explaining why we need the time, and we truly are "cost-effective." §

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