

Gardeners Versus Mechanics: A Case for Primary Care

BY KEVIN P. GLYNN, MD

George F. Kennan, the diplomat who devised the policy of "containment" to fight communism, was asked if he resented not being a celebrity like Henry Kissinger while he was in the State Department. He replied resignedly that he knew himself to be a "gardener"—with a quiet, persevering, style—while Americans prefer "mechanics," flamboyant individuals who solve problems and fix things.

Primary care physicians are the gardeners of medicine, who take care of people unobtrusively. But specialists, especially surgeons, capture the imagination of the public and reap the economic rewards. All of us want a kindly personal physician—one who reminds us of our grandfathers or grandmothers—until we think we might be sick, and then we want immediate access to the most experienced specialist and the latest technology.

How did this dichotomy come to be? What should be done about it? Is fragmented care inescapable, considering our values and attitudes?

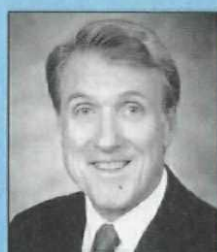
In the United States, primary care is praised in the abstract, but devalued in the concrete. The media herald new developments in biomedical technology. The heroes of the profession are single-minded investigators intensely exploring such fields as organ transplantation. Everyone knows who performed the first heart transplant, but how many know the name of the doctor who founded hospice?*

It is no wonder young doctors opt for careers in narrow specialties.

MEDICAL SCHOOLS FOSTER SPECIALIZATION

The medical profession and the public must collectively share responsibility for the gardener-versus-mechanic phenomenon. The government has supported medical research not just to exploit technology, but to train more physicians by increasing the size of medical school faculties.

*Christaan Barnard and Dame Cicely Saunders, respectively.



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Medical school applicants are compulsive, goal oriented, and left brained. Most major in biomedical sciences and are selected by faculty with similar personalities and worldviews.

Medical schools offer few role models in primary care for students to emulate. Studying exotic diseases is more exciting than seeing people with colds and rashes. It is no wonder that we graduate doctors who are expert technically but have little interest in humdrum human encounters.

Medical schools as they currently exist cannot be expected to train physicians for primary care. Many state legislatures, frustrated by problems of cost and access, are making plans to force state universities to turn out primary care doctors. This approach will change the incentives, but the progress will be slow.

Academic physicians have spent their lives in laboratories and at tertiary care hospitals, and universities see themselves as existing primarily to expand human knowledge. Such institutions are poorly prepared to turn out primary care doctors. Focusing resources on physicians' assistants and training physicians to supervise them may be more effective, but no one knows. This is a fruitful area for study.

CARE: AN ABSTRACT NOTION

The public and its doctors today vibrate in a gridlock of frustration, demoralized by unfulfilled expectations and fragmented care. To a nation of mechanics, operating and scanning appear to be more valuable services than reassuring and educating sick people.

Physician reimbursement through Medicare and most insurance plans is pegged to "procedures." It is easier to document that an operation has been performed, an x-ray obtained, or a test made, than that care has been given. As a result, the income gap has widened between surgeons, pathologists, and radiologists, on one side, and internists, pediatricians, and family doctors on

Continued on page 71

the other. Surgical specialists have come to earn three or four times as much as those who provide general care. It is no surprise that the ablest medical graduates want to specialize.

PUBLIC INSISTS ON SPECIALISTS

Some specialists, particularly internists and obstetricians, do provide primary care for their patients. As late as 1967, a survey revealed that most internists, even those with special interest in subspecialties, still spent at least half their time in primary care (W. W. Engstrom, "Are Internists Functioning as Family Physicians?" *Annals of Internal Medicine*, March 1967, pp. 613-616). To meet the needs of their communities and to make a living, they had to.

Times have changed. Those who suffer from serious chronic diseases such as cancer or emphysema insist on being followed by a specialist rather than by their family doctor. In addition, people nowadays regularly sue their doctors. One way to limit liability is to limit responsibility by specializing. It is no wonder that only one out of six medical school graduates now chooses a primary care field.

Internal medicine used to attract the top medical graduates and is still the largest medical specialty, but it is in danger of dying, carved up into an array of subspecialists who focus on one disease or organ system. Some assert that the most efficient use of internists and family practitioners would be as supervisors for frontline platoons of nurses and physicians' assistants. The public is used to having a doctor as the point of entry into the healthcare system, but as cost containment becomes a priority, patients may need to be willing to see a nurse or physician assistant for routine problems.

MULTISPECIALTY GROUPS ARE ATTRACTIVE

Is the country doomed to "one-minute-techno-nerd" doctors? No. Organizing care around large, multispecialty medical groups offers the best way for the public to get what it wants. Kaiser Permanente is the largest multispecialty group in the United States. More than half its doctors are in primary care and earn nearly as much as specialists. This system attracts payers and patients because it provides all services securely and predictably. Kaiser is criticized for using nurses as primary contacts, but in most communities, it signs up patients as fast as it develops facilities.

If we nurture primary care doctors, we will get more primary care doctors. Congress, state legis-

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latures, and insurers need to make laws and policies that press physicians to form large multispecialty groups. The various proposals for health-care reform currently being debated often use the term "medical groups," but devote little attention to how those groups should be organized for the public good. Careful attention to the structure and function of the large multispecialty physician groups that must evolve over the next 10 years can have a major influence on whether society gets what it needs.

Hospitals are a major component of the health-care system and valuable community resources. Individually (through their governing boards) and collectively (through their trade organizations) they should also be pressing their medical staffs to form large multispecialty groups. Hospitals are forming management service organizations to support their doctors. Some are creating tax-exempt foundations as a step toward integrated delivery systems where physicians and hospitals collaborate as partners. The more quickly this happens, the sooner the country can get on to the tasks of managing costs and increasing access to care.

Physicians in clinical practice need to join together in multispecialty groups and distribute revenue more evenly between primary care doctors and specialists. The temperament of the senior practicing physician, articulated by organized medicine, is individualistic to the point of being destructive. With the wide gap in income between "generalists" and "proceduralists," intraspecialty tensions leave doctors vulnerable to being exploited by outside forces. Even apart from responsibility to focus on what is best for their patients, physicians must rethink their views on independence and how they are rewarded, if they are to flourish in the future and attract capable new people to medicine.

RESPECT AND REWARDS FOR GARDENERS

Changing these values is difficult, since Americans are socialized to believe that the solution to all our problems is to hire mechanics. We can best meet our needs in healthcare, however, if we respect and reward gardeners as much as mechanics. □

EDITOR'S NOTE: Beginning with this issue, we will be alternating "Final Say" with "The Human Element." We welcome submissions for either column.