Full Testimony to the Senate Health, Education, Labor, Pensions (HELP) Committee field hearing in Anchorage

Richard Neubauer MD, FACP

2/20/07

I'm pleased to give testimony regarding physician workforce shortages. While there are shortages in many specialties of medicine, it is the shortage of primary care doctors and specifically general internists that concerns me the most. In my view these fields of medicine are near collapse and are critically threatened unless prompt actions are taken to reverse current trends.

When I graduated from medical school at Yale University in 1976 and did my internship and residency in internal medicine at the University of Michigan from 1976 to 1979, the majority of my classmates wanted to pursue a career in internal medicine or an internal medicine sub-specialty. That situation is totally different now, and the majority of medical school graduates want to pursue careers in radiology, ophthalmology, anesthesiology and dermatology due to the kindlier lifestyle, better pay, and perceived better prestige in these areas of medicine. This is especially tragic since with an increasing elderly population, the need for skilled general internists who can manage complex multiple medical problems is increasing and will continue to increase.

After leaving residency training and completing a scholarship obligation with the Indian Health Service in Wyoming, I came to Alaska in 1981 and have practiced here since. When I began my career, I typically cared for 10-15 patients in the hospital daily, took many admissions from the emergency room and worked full time in my office as well. Over 25 years of practice, I have watched as many of my general internist colleagues have retired, moved away, or moved on to other pursuits. With few exceptions, as these physicians have left, they have been unable to find young physicians to replace them and have thus simply closed their doors and scattered their patients to the wind. Nowadays, when this happens here in Anchorage, these patients, especially if they are covered by Medicare, are unable to find a physician to care for them. This is because they have complex medical problems, take a lot of time to care for properly, and the reimbursement for seeing them does not even cover the overhead costs of running an office. These patients are destined to use the emergency room for their "primary care" which is expensive and inefficient. They may neglect their problems until they have become far advanced and are thus harder or impossible to treat.

Right now, there is virtually no financial incentive for a young primary care internist to start a private practice here in our city. The remuneration for their efforts would simply not be enough to justify the work involved and the overhead of operating an office. Starting in the mid 1990's the advent of hospitalists – internists who only work in the hospital – changed the dynamics of care even further in Anchorage and around the country. In general, internists coming out of training programs are only interested in

hospitalist practices and not office based practice. This is due to the high overhead of office practice, the burden of unreimbursed work in the office, the threat of punitive audits, the long hours and constant need to be on-call, and the low compensation for this work in our current reimbursement system. While the ascendancy of hospitalist practice has in some ways benefited the functionality of inpatient care, it has come at the expense of promoting a further critical decline of interest in the long-term management of ambulatory "outpatients". Right now in Anchorage, by my count there are about 18 general internists working in office settings, and for comparison about 30 cardiologists. This is not a healthy mix. A sad truth is that if I, at age 57, were to become incapacitated or otherwise have to leave my practice, it is highly likely that no one would be around to take my place, and my patients would be without a physician.

Let me present an example from my own practice of how coordination of care of a patient by a primary care physician can result in better outcomes and lower costs but is not reimbursed by the current system. I currently care for a man in his 50s who tragically has had a series of strokes and heart attacks at a young age. He has congestive heart failure as well, but with modern medical management has lived with these conditions for years. He also has diabetes, hypertension, and psychological issues that have complicated his care. I share his care with a cardiologist, but for a while he was visiting the emergency room on a regular basis with chest pain and was often admitted to the hospital at great cost and with no additional benefit to his care. By a combination of allowing him open telephone access to my nursing staff and physician assistant and having him come to my office for frequent reviews of his medications with my staff we have been able to avert most of the emergency room visits. Most of this was done with low cost office visits and unreimbursed time in person and via telephone contact with myself and my staff. On the other hand, the monetary savings to the system were tremendous.

What can be done? Both here in Alaska and nationwide, a further study of the manpower needs for primary care services is needed. In my view, the current methods that CMS uses to track access to care are blunt tools that do not reflect reality. It is my view that a robust primary care presence in our country will require restructuring of the payment system in a way that reflects the importance of primary care services, with recognition that much of what primary care specialists do is un-reimbursed in our current system. Management fees above and beyond traditional fee-for-service reimbursement would recognize the value of primary care of the patient, and need to be strongly considered.

New models of care such as the Advanced Medical Home proposed by the American College of Physicians also have promise to increase the attractiveness of internal medicine as a career. This model relies heavily on Electronic Medical Records to improve the functionality and accountability of practices and improve delivery of preventive care services, but implementation of this technology has been hampered by high cost and difficulty deploying this new technology in busy offices.

Medical training programs need to be re-designed to encourage students to consider careers in primary care, but that has not been happening in a concerted fashion due to

entrenched interests and perverse incentives. This needs to change. Students are burdened with so much debt coming out of medical training that they are pushed into high paid specialties by necessity. In an effort to fill positions that graduates of American Medical Schools are not interested in, we are robbing other countries of their own talented physicians by importing foreign graduates. This is not a good long-term global strategy.

In summary, we stand at a critical time in the design of delivery systems within our medical communities. Inaction at this time will have predictable results: a lopsided supply of physicians in high paid specialties coupled with access to care problems for patients who seek the guidance of a physician to coordinate their medical care. There are things we can do to positively shape the future but this will require courage and conviction.

I conclude by asking the HELP committee to require a study and report on ways that the federal government can increase the attractiveness of primary care, including consideration of programs to eliminate or reduce student debt for those who go into primary care, redesigning federal support for medical education to expose medical students to well-functioning models of community-based primary care, and changes in federal reimbursement policies to support the value of primary care. Thank you for the opportunity to testify.