Solving Our Primary Care Crisis by Retraining Specialists to Gain Specific Primary Care Competencies

That this country now has a full-blown crisis in its primary care physician work force is hardly disputed.[1-3] Simply stated, other developed industrial countries for many years have practiced medicine with roughly 50% of physicians in primary care and 50% in specialties and subspecialtics.[4] In the United States, however, we train and employ about 32% primary care physicians (general practitioners, family physicians, general internists, general pediatricians, and some obstetrician-gynecologists and emergency medicine physicians) and about 68% specialists and subspecialists.[4] Health indicators show that comparison countries do as well as or better than the United States at providing care at much lower cost, whether cost is measured as the amount spent per capita per year or as a percentage of the gross national product. If that news isn't bad enough, the situation in the United States is rapidly getting worse. The percentage of physicians graduating from US medical schools who are declaring generalist fields has drastically declined during the last decade, from 36% of the graduating class in 1982 to only 14% in 1992.[4]

On examining the 50:50 specialist-to-generalist ratio desired and the existing 68:32 ratio, one finds a shortfall of approximately 100 000 generalist physicians and an oversupply of 100 000 specialist and subspecialist physicians.[5] Moreover, existing models of managed care show that if the federal government, individual states, or the private marketplace creates health alliances or accountable health partnerships for everyone, we will need a work force that more closely approximates 35% specialist and 65% generalist physician distribution (J. Sokolov, MD, oral communication, May 1993). Using such models and some basic arithmetic, one can demonstrate a shortfall of 200 000 generalist physicians between current physician supply and what may be needed in the near future.

Innumerable articles over the years have documented these problems and proposed erudite as well as practical solutions.[2,3,6] But, with isolated exceptions, the situation has continued to worsen. There appear to be four general options for fixing the system:

1. Immediately and greatly increase the number of medical school graduates who actually enter generalist fields. Many students enter medical school intending to practice in primary care, but due to various social, economic, and psychological pressures, they change their minds by the time they graduate and decide instead to practice in a subspecialty. While focusing on medical school graduates is important and necessary, this strategy implemented alone will take 20 to 30 years to correct the disparity.

2. Immediately and sharply curtail the number of resident physicians in specialties and subspecialties and increase the number in primary care fields. Although there is a surplus of residency positions available nationwide, only 40% are allotted to primary care, and many of these remain unfilled, while 60% are for specialty positions.[7] Reducing the overall number of residency positions and reducing slots can and should be done, but attaining the desired, needed balance will still take about 20 years.

3. Do not directly address the oversupply of specialists and subspecialist physicians. Simply allow primary care to be provided by those physicians currently in the fields and those who result from options 1 and 2. Let the remainder of care be given by nurse practitioners, physician's assistants, homeopaths, naprapaths, chiropractors, and other non–allopathic physician providers.

4. Recognize that the only way we can remedy the imbalance in the short run is to create a system of incentives and disincentives that encourages a huge shift of practicing specialists and subspecialists into primary care.[8] Such a system would require a massive program of continuing medical education and retraining for a displaced work force of physicians, most of whom would probably be very unhappy students.

The Competency-Based Curriculum for Primary Care

During the past 3 years, the Pew Health Professions Commission, a national body examining the changing context of health professional careers, has identified several specific competencies that the physician of the future will need to embody.[9,10] Many of these skills, values, and attitudes are particularly relevant for the practice of primary care; they included the ability to do the following:

- Provide contemporary clinic care. Practitioners should possess up-to-date clinical skills to meet the public's health care needs.
- Participate in coordinated care. Practitioners should work effectively as team members in organized settings that emphasize high-quality, cost-effective integrated services.
- Ensure cost-effective and appropriate care. Practitioners should incorporate and balance cost and quality in the decision-making process.

Dr Lundberg is the Editor of *JAMA*. Mr Lamm is the Director of the Center for Public Policy and Contemporary Issues, University of Denver (Colo).
Reprint requests to *JAMA*, 515 N State St, Chicago, IL 60610 (Dr Lundberg).

- Practice prevention. Practitioners should emphasize primary and secondary preventive strategies.
- Assess and use technology appropriately. Practitioners should understand and apply increasingly complex and often costly technology and use it appropriately.
- Manage information. Practitioners should manage and use large volumes of scientific, technological, and patient information.
- Understand the role of the physical environment. Practitioners should be prepared to assess, prevent, and mitigate the impact of environmental hazards on the health of the public.
- Provide counseling on ethical issues. Practitioners should counsel patients when ethical issues arise and participate in discussions of ethical issues that impact society and health professions.
- Accommodate expanded accountability. Practitioners should be responsive to increasing levels of public, governmental, and third-party scrutiny of the shape and direction of the health care system.
- Continue to learn. Practitioners should anticipate changes in health care and respond by redefining and maintaining professional competency throughout their practice life.

Actions Needed Now

We call on the leaders of family medicine, general internal medicine, general pediatrics, obstetrics-gynecology, and emergency medicine to study existing competencies, to review the Pew Commission's suggested competencies, and to establish standard primary care competencies for each of these fields. We also call on these leaders to develop methods for assessing the extent to which practicing specialists and subspecialists possess the new competencies and thus would not require further education in order to practice competent primary care. Further, we encourage primary care leaders to develop curricula for specialist and subspecialist physicians who will need more education. Planners must determine what primary care physicians should know and be able to do and develop targeted curricula for achieving these competencies. Curriculum planners must recognize, however, that it takes different lengths of time and types of educational experiences for different people to achieve competency. People learn at varying rates and have different knowledge bases on which to build. Continuing medical education or intensive retraining programs, therefore, should be flexible when applying any new curricula to individuals.

Other Avenues for Change

It will also be necessary to change academia so that it recognizes, honors, and rewards primary care. Academia must provide role models for the best and brightest medical students to enter this field. Academic health centers may, for example, use methods that have recently been delineated by Bulger[11] and Wright.[12]

Recently, Johns[13] proposed that national health service be mandatory for US physician graduates. We support this idea and believe that Congress should dramatically increase the number of people entering the National Health Service Corps. Work at the community level greatly enhances the competencies of practitioners, while exposing them to the common health problems of communities. We know that people who work in the corps may not remain where they were originally assigned,[14] but during their stay they will certainly learn valuable lessons and, at the same time, provide much-needed care. Linking national health service to tax-supported education is legitimate, as the education of all US medical school graduates, even those in private medical schools, has been supported in large part by taxes, Medicare, and Medicaid funds. This economic reality applies to every US-trained physician since 1965.

With such massive reforms in mind, it is not an overstatement to call this educational challenge a "revolution." While economics and politics will determine whether proposals such as these succeed, health system metanoia will occur in the relatively near future. We hope that physicians can and will accept the new reforms and continue to function effectively in the fundamentally changed system.

George D. Lundberg, MD
Richard D. Lamm

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