Lifestyle Trumps Money

New FPs *from page 1*

dents are shying away from family medicine residencies. With medical students facing student loan debt of $150,000 on average, it's tempting to choose to train in higher-earning specialties, said Dr. James King, AAFP president.

Over the last several years, family medicine has seen the percentage of U.S. medical graduates filling family medicine slots remain at about 42%. In 2007, only 88% of the 2,603 family medicine residency positions were filled, and only 42% were filled by U.S. medical graduates. The 2008 results from the National Resident Match Program are expected this month.

International medical graduates have been filling the gaps, Dr. King said, but even with that influx of manpower, family medicine residencies aren't producing enough physicians. The number of graduating family medicine residents needs to increase by about 1,000 a year to meet demand, based on the growing population, he said.

A new data analysis from the U.S. Government Accountability Office (GAO) found that from 1995 to 2006, the number of physician residents in family medicine, internal medicine, pediatrics, or combined primary care training programs increased by about 6%, about 2% less than other medical specialties.

At the same time, the composition of primary care training programs has changed, GAO said in testimony to the Senate Committee on Health, Education, Labor, and Pensions in February. The GAO found that while allopathic U.S. medical school graduates continue to dominate training programs, there were about 1,655 fewer allopathic U.S. medical school graduates in primary care residencies from 1995 to 2006. During the same time period, the number of international medical graduates rose by 2,540 and the number of osteopathic graduates rose by 1,415.

AAFP has been working with nonprofit organizations and government agencies to increase the number of loan repayment programs for physicians who commit to working in underserved areas. Those groups are also working with public and private payers to increase reimbursement for preventive health care services and coordination of care in an effort to close the income gap with other specialties.

The good news is that the demand for family physicians has never been higher, said Travis Singleton, vice president of marketing for Merritt, Hawkins & Associates, a national health care search firm that specializes in physician recruitment.

Family medicine was the firm's top search in 2006-2007. But that also means that practices have to offer more to entice new physicians. For example, the average baseline salary in family medicine rose from $145,000 during 2005-2006 to $161,000 in 2006-2007. And signing bonuses, which were once a nice incentive, have become standard offerings.

Mr. Singleton advised practices to consider what specific incentives appeal to the candidates in the marketplace. For instance, the new crop of family physicians, which includes large numbers of women, is looking for part-time work, flexible hours, or shift work.

For the new generation of physicians entering medicine, it's often not about the money, said Dr. Albert Ray, president of the San Diego County Medical Society and a family physician working at Kaiser Permanente.

"They're more interested in lifestyle and their family life," Dr. Ray said.

When they hire new doctors at Kaiser, the new physicians usually say that they aren't interested in earning a lot of money, but would like to work 3-4 days a week and do only outpatient work.

When they hire new doctors at Kaiser, the new physicians usually say that they aren't interested in earning a lot of money, but would like to work 3-4 days a week.

Kaiser has been successful in recruiting family physicians, Dr. Ray said, but only because they have been willing to be flexible by offering partnership tracks for less than full-time work.

Recruiting new family physicians in an increasingly competitive environment is especially challenging in rural areas in which family physicians must have a broader scope of practice, take more calls at the hospital, and are farther from large cities, where it may be easier for a spouse to find a job.

Dr. John Adams, who works in a large, multispecialty practice in Danville, Ill., said he struggles against misperceptions about the area. Since he practices in a blue-collar community without a major university, people assume that the education won't be as good or that there won't be things to do.

The solution, Dr. Adams said, is to give residents a more realistic sense of the local community and the advantages they can gain living outside of the large, urban centers.

Dr. Terry Cahill agrees. He is currently the only family physician in a clinic based in Blue Earth, Minn., a rural area about 2 hours from Minneapolis. About a year ago, there were four family physicians and the clinic has had as many as six in the past. The challenge is conveying to new physicians that they can still have a reasonable lifestyle working in a small town. "That's a hard sell," he said.

Many residents also get used to having instant access to subspecialists during training and worry that they won't have access to consults in a rural area. They are told in medical school that the family physician's job is too hard, Dr. Cahill said.

The specialty as a whole needs to work on getting new messages to medical students and residents, he said.

"We need to start convincing medical students that there is value in primary care," Dr. Cahill said. ■

POLICY & PRACTICE

Better Appeals Process Needed

Analysis by the Government Accountability Office has pointed out deficiencies related to Medicare Part D. The watchdog agency says that the Centers for Medicare and Medicaid Services has improved its efforts to inform beneficiaries about sponsors' performance, but its oversight of sponsors is hindered by poorly defined reporting requirements. To improve the process, CMS should allow independent reviewers to conduct reviews without the standard "appointment of representative" form, and also should provide the plans with standardized definitions for data that they must provide, the GAO report said. A bipartisan statement from Senate Finance Committee members said that the lawmakers back simplification of the process. "Patients and their doctors should not have to navigate an impossible maze of bureaucratic red tape in order to get the prescription drugs they need," said Sen. Jay Rockefeller (D-W.Va.) in a statement.

FDA Issues Food Co. Injunction

Two food companies and their top executives have signed a consent decree that effectively prohibits them from manufacturing and distributing any products that claim to cure, treat, mitigate, or prevent diseases, the Food and Drug Administration said last month. The consent decree against Brownwood Acres Foods Inc., Cherry Capital Services Inc., and two of their top executives is the result of unapproved drug claims and unauthorized health claims such as "Chemicals found in cherries may help fight diabetes," the FDA said. Eastport, Mich.–based Brownwood Acres Foods, and Cherry Capital Services, which is based in Traverse City, Mich., manufacture and distribute various products, including juice concentrates, soft fruit gel capsules, fruit bars, dried fruits, liquid glucosamine, and salmon oil capsules.

Copays, Caps May Reduce Use

Copayments and caps on drug expenditures—common methods used by drug plan sponsors to control costs—may discourage patients from using those drugs, potentially leading to adverse health effects, a new review of existing research showed. The Cochrane Library review of 21 studies that looked at a variety of prescription drug payment policies found that, among insurers that tried to keep costs down through copayments and caps, "reductions in drug use were found for both life-sustaining drugs and medications that are important in treating chronic conditions," said Astrid Austvoll-Dahlgren, a research fellow with the Norwegian Knowledge Centre for the Health Services, in a statement. Although the review did not provide clear evidence that patient health suffered under the cost-sharing policies, plans designed to make patients shoulder some of the cost of prescriptions reduced both the amount of medication used—including life-sustaining drugs—and medicine expenditures. Ms. Austvoll-Dahlgren suggested designing policies in which people pay directly for only nonessential drugs, or in which exceptions are built in to ensure that people receive needed medical care.

Medco Launches e-Rx Drive

As Congress considers legislation that would tie physicians' Medicare payments to their use of e-prescribing technology, Medco Health Solutions Inc. said it was launching a national initiative to assist physicians of Medicare Part D patients in switching to electronically generated prescriptions. The pilot program also will be used to study the effect of e-prescribing on patient safety, increased generic drug use, and formulary compliance, the prescription drug manager said. Initially, the study will include 500 physicians currently treating enrollees in the Medco Medicare Prescription Plan. Medco will provide these physicians with free e-prescribing software and training, and Medco will compare the physicians' rate of generic drug dispensing, formulary compliance, and generated safety alerts with that of a control group. Ultimately, 2,000 physicians—mostly primary care doctors—will participate in the e-prescribing program, Medco said. Estimates have shown that e-prescribing could save up to $30 billion in the Medicare program, and Medco said it hopes its study will help to quantify how much the technology actually will help reduce medication errors and lower costs.

CVS Caremark Settles Suit

CVS Caremark last month agreed to a $38.5 million settlement in a multistate civil lawsuit that accused pharmacy benefit manager Caremark Rx of engaging in deceptive business practices. Caremark encouraged doctors to switch patients to different brand-name prescription drugs and represented that the patients and/or their health plans would save money by switching, according to the complaint, which was filed by attorneys general in 28 states. But Caremark did not adequately inform doctors of the effects that switching would have on costs to patients and health plans, and did not clearly disclose that rebates would be retained by Caremark and not passed directly to health plans, the complaint said. Under the settlement, Caremark must significantly alter the practices it uses to ensure that patients, physicians, and health plans have the information needed to make the most cost-effective purchasing decisions, said Illinois Attorney General Lisa Madigan, who led the investigation with Maryland Attorney General Douglas Gansler. Caremark also is prohibited from soliciting drug switches under a variety of circumstances.

—Jane Anderson