Should There Be a Merger to a Single Primary Care Specialty for the 21st Century?

An Affirmative View

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Debating whether there should be a single or multiple primary care specialties should be nothing more than an exercise in reasoning. Logically, a united front in primary care could be a much more important force in American medicine than the present warring groups ever could be. Again, logically, there are characteristics of each of the existing primary care diciplines that could strengthen the others if they were combined into a single discipline.

Family practice can take a good deal of the credit for the current understanding of primary care and for the definition of current strengths and weaknesses in primary care training and practice. We would not even have this question to debate had our discipline not developed and challenged the other primary care disciplines. Would it not now be logical to improve medical training and medical care by combining the positive aspects of the three disciplines—family practice, internal medicine, and pediatrics—strengthening primary care in the process? Not only could a single primary care specialty provide improved training for practice in general medicine, but it could also eliminate the continued competition for status, money, and patients that characterizes the current relationships among primary care specialties.

Let me first make an important initial disclaimer. Despite a large literature, there is no convincing evidence that supports any one primary care specialty over any other. The bulk of the evidence is that outcome of care provided by family physicians and the other primary care specialists is similar, with neither family practice nor any other specialty showing consistently superior results.[1–10]

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COMMON BACKGROUND

The generalist origins of the primary care disciplines suggest that there may be emotional and professional support for a single primary care specialty which could make such a development easier to bring about than many presently think.

We know that family practice developed in response to the steadily decreasing number of needed general practitioners.[11] Many forget, however, that at the time the stirrings began which led to family practice as a specialty—the late 1940s to early 1950s—internal medicine still was a general medical discipline. Physicians who trained in internal medicine as late as 1960 believed in continuity of care, often worked closely in their training with social workers and psychologists, emphasized the importance of family members in at least the management of illness, if not in its genesis, and saw themselves as the central managerial physician in a medical care system that even then was becoming complex. Chairmen of departments of medicine insisted that their trainees were general internists first and specialists only later. Understandably, the leaders of internal medicine viewed the developing specialty of family practice as a threat.

The success of family practice should not make us overlook the viability of the current programs in general internal medicine, which are considerably more successful than many in family practice realize. According to the American College of Physicians (in conversation, January, 1989), there now are over 200 primary care internal medicine residency and fellowship training programs, and most departments of internal medicine have a formal division of general internal medicine. Some such departments have as many as 40 full-time general internists on their faculty participating actively in training and patient care. The problem of competition in primary care will not go away by our merely emphasizing family practice as the best pri-

mary care specialty, as some wish to do. Internal medicine in particular will remain a competitor for the minds of students, the business of patients, and the funds of the public.

Pediatrics, too, was committed to ambulatory care before family practice came into existence, and still considers itself the major primary care specialty for children. Indeed, it is only within the last decade that departments of pediatrics have come to be so subspecialized. The Society for Ambulatory Pediatrics, founded in 1960, now has almost 2000 members (personal communication, Barbara Starfield, June, 1989). Practicing pediatricians, too, do mainly primary care. Thus, like general internal medicine, general and ambulatory pediatrics represents a significant force in American medicine. What we are talking about here, then, are three strong disciplines doing similar things competitively.

It is the positive aspects of each specialty that we would seek to combine, and in the current primary care specialties, positive aspects are not hard to find, both in the characteristics and features of each specialty's training programs and in their practices. In general, all of the primary care specialties espouse the importance of training to assure intellectual curiosity and competence. Family practice, in particular, endorses specific primary care training in the belief that specialty training does not prepare one to do family practice or any other kind of primary care. Likewise, competent specialty care requires special training. Thus pediatricians are trained to provide more detailed and often higher quality child care over a wider range of patient problems, especially for seriously ill children. Internal medicine training emphasizes meticulous inpatient care of patients with complex illnesses. That family physicians use internists for consultation for our more difficult medical patients emphasizes the usefulness and importance of this extra inpatient training. Both pediatrics and internal medicine stress the biological basis of medicine over the social and behavorial components of patient care. Family practice emphasizes strong training in ambulatory care of common patient problems with a special weight given to the social and behavioral aspects of medicine. A combination of the three specialties would give us a physician well trained in both the ambulatory and inpatient care of adults and children, and in both the biological and the social and behavioral aspects of illness.

ADVANTAGES OF A MERGER

What would each discipline gain from combination? Some of the gains would be directly related to desirable improvements in training for medical practice. Others deal with political, fiscal, and organizational matters. Family practice would gain from consolidation by balancing its present important emphasis on ambulatory care with enhanced emphasis on the biological aspects of diagnosis and treatment and inpatient care of internal medicine and pediatrics.

The family practice resident's expected first allegiance to the ambulatory care patient makes his or her inpatient experience inefficient. Even the best of today's residents lack the sophistication in detailed physical examination, reasoning about diagnosis, and breadth of clinical acumen that characterized their earlier colleagues. Increased inpatient and specialty clinic experiences could help correct this deficiency. Further, internal medicine and pediatric faculty supervisors in family practice would be more likely to probe the primary care resident's knowledge and reasoning in the biological aspects of the patients' illnesses more effectively than current faculty, while family practice faculty would be much more likely to be successful teachers of the social and behavioral aspects of patient care.

Anyone from family practice, an already predominantly ambulatory specialty, could fairly ask why these same goals could not be achieved in the ambulatory instead of the inpatient setting. Medical care already is moving in this direction, and Steven Schroeder and I have made just such a suggestion.[12,13] The sheer volume of patients required in a primary care practice to yield several patients with specific disorders that usually are treated in the hospital or in specialty clinics, however, suggests that such training can still be the most efficient for some purposes. The extent to which internal medicine and pediatrics modify their standard programs over the years to move toward ambulatory specialty care of seriously ill patients will help determine the actual sites and content of any increased training in those disciplines.

A common primary care specialty would be stronger politically as well as medically. The competition among current primary care specialties for patients, money, and academic status could not exist if there were only one primary care specialty. Further, combining presently divided scarce training dollars could help raise support for primary care training to more adequate levels, both by making more efficient use of a single sum of money and by improving the persuasiveness of the argument for primary care in the halls of Congress and of academe. Not only would a voluntary solution made within our profession be respected, but it would be clear that we, as primary care physicians, have the welfare of the public at heart if we stop destructive infighting and unite to prepare a better physician.

A common primary care specialty would fare well financially in other ways as well. A new resource-based relative value scale to determine pay for physicians' work has been developed by Hsiao and his co-workers.[14] Their analyses provide support for the long-held view that the nonsurgical

work of family physicians, internists, and pediatricians has been compensated inadequately. Although new Medicare legislation will change reimbursement policies, the different primary care specialties can still be paid differently for similar services. A single specialty would not face this problem at all. In addition, a single primary care specialty would be a potent political force in maintaining these gains in the continuing discussions among the various specialties, which will lose income under the new system, and the federal government—discussions that are certain to follow initial implementation of the new payment system.

A common primary care specialty could also strengthen recruitment of future primary care physicians. Schroeder[15] and Colwill[16] have used recent data on entry level university and medical students, as well as analyses of the numbers of individuals entering primary care specialties over time, to document a leveling off and diminishing interest in primary care among current students. This serious problem deserves attention both from disciplinary and health policy points of view. Schroeder, in particular, has detailed the continuing imbalance between primary care and subspecialty physicians that characterizes our current medical educational and medical care systems. Even the success of family practice as a specialty and the resurgence of general internal medicine and pediatrics have not prevented this disparity from worsening.

The major influence medical school has upon career choice by medical students lies in the faculty role models students learn to emulate during their clinical clerkships.[15] Medical students are primarily exposed to specialty, inpatient-based faculty. Further, the academic stature of generalist physicians in medical schools is limited both by their relatively small number and by the entrenched biomedical science value structure of the majority of the faculty. Research emphasis in current medical schools is still strong, and even the growing research efforts of the primary care specialties are less well accepted by the majority of medical school faculty than is work in the biomedical sciences.

Having a single primary care specialty would result in increased effectiveness of primary care faculty in policy deliberations in each medical school even without increased numbers, as this faculty would all be working in a single discipline with concentrated exposure to students. In addition, a single primary care discipline would eliminate the competition that divides primary care faculty recruits into small, less-effective groups, and would represent a potent force for reorganization of medical education around primary care as a major clinical experience. The proportion of primary care faculty would increase, and subspecialty faculty would proportionately decrease. Students would see primary care role models in positions of authority in medical education and in patient care.

Finally, a single primary care specialty makes sense in light of recent changes in the organization of medical care. Primary care generalists are in demand as the central figures in physicians' medical service organizations. Unfortunately, particularly in staff-type health maintenance organizations, family physicians commonly are relegated either to an exclusively gatekeeper or combined gatekeeper-ambulatory care role, doing little or no inpatient care or obstetrics. Internists, on the other hand, have a greater generalist role in such organizations, both in the care of more complex patient problems in the ambulatory setting and in the hospital. A single primary care specialty would prepare physicians for a more complete role in medical care that could provide all the generalist functions needed in organized medical care systems, and provide it cost effectively.

EFFECTING A MERGER

First, we would have to overcome present unreasoned fears. I already have described the threat presented by the successes of family practice to internal medicine, both in numbers and in the image internists have of themselves as generalists who go on to specialize. Another, even deeper fear is that voiced by family physicians, who feel that family practice would be absorbed into internal medicine and would be lost. If we can recognize and examine the degree to which internal medicine and pediatrics have changed their primary care residency programs to emulate those of family practice, we should be able to put those fears at rest.

The entry of primary care trainees into internal medicine and pediatrics has fallen off even more than it has into family practice. Family physicians surely spend more of their time actually doing primary care than do even general internists. If any discipline was going to "lose its identity," it would be general internal medicine and pediatrics, since the new specialty would resemble family practice more than either of them. And if such a specialty were to have the strong characteristics of each existing specialty, then all three would lose their current identities in a new and better identity.

Fear of loss of subspecialty trainees is one reason some chairmen of departments of internal medicine oppose a common primary care discipline. A successful residency that resulted in the combination of present general medicine, pediatrics, and family practice would perforce play a central role in resident training. At the present time, departments of pediatrics and internal medicine depend upon their traditional residencies and on their primary care–general medicine programs for recruits into all the subspecialties. An increasingly successful primary care residency that was central to hospitals and medical schools

would gradually supplant these more traditional programs and become a major source of trainees for the specialties in addition to graduating the new primary care specialist. In time, the new primary care practitioner would also become a dominant generalist in medical practice.

From a practical point of view, several steps can be outlined that could lead in the directions proposed. First of all, a new residency program would have to be devised and approval obtained from all three existing specialty boards to sanction trainees from such programs. Second, several schools would have to be wiling to experiment with the new training program, setting it up either alongside or instead of existing programs. Such training programs would include more inpatient care and at least as much ambulatory care as current family practice programs, and would have to be the initial training programs for some physicians who want to specialize as well as those who wished to enter primary care. These training programs might be somewhat longer than the current three years devoted to primary care residencies, as well as more flexible. Already some programs are in place that represent first steps in this direction.[17,18]

Further, some decisions would have to be made about obstetric aspects of primary care training. Most agree at the least that obstetrics is an essential part of rural family practice in addition to being a superb model of family care for trainees. Much remains to be decided here, and the place of obstetrics in family practice overall is undergoing changes. The outcomes of these changes cannot now be predicted, but they will have to be dealt with and plans made for rural obstetric care in any new specialty.

Creatively designed training programs for a new primary care specialty would be exciting and attract inquisitive trainees. Overall outcomes would have to be monitored according to previously determined guidelines that would define levels of competence of program graduates and would monitor the content and breadth of their medical training. Finally, the outcomes would have to be accepted by the specialty boards, which would then be expected to amalgamate. These new training programs and their faculty would bear the burden of leading the changes in medical education and practice that would necessarily follow upon these initial steps.

Amalgamation might not be as difficult as it may seem. Changes already made have led to more similarities in the existing specialties than we might expect to find. Internal medicine programs now must provide one fourth of all their experience in ambulatory care settings, behavioral as well as biomedical aspects of medicine must be emphasized, and experiences in otolaryngology, dermatology, orthopedics, and office gynecology are strongly suggested. These requirements are remarkably similar to the experiences required in family practice training, and in time will make the differences between us smaller in actuality than they are in our minds. Even Dr. John R. Ball, Executive Director of the American College of Physicians, suggests that the concept of a merger of family practice, internal medicine and pediatrics makes sense (personal communication, October 1988).[19] It really is time to begin the spadework necessary to make this exciting and revolutionary development a reality.

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An Opposing View

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This is a difficult time for primary care physicians. Medical student interest in the primary care specialties of family practice, general internal medicine, and pediatrics has declined. Reimbursement inequities have made the procedure-oriented specialties quite lucrative, whereas primary care is at the bottom of the earnings ladder.[1] While there is a growing surplus of nonprimary care specialists, there is a shortage of primary care physicians in many areas. New managed care systems hold promise of a greater need for primary care physicians as gatekeepers or case managers, but often with increased financial risk and greater patient responsibility and without improved stature or economic reward.

These problems have led Geyman,[2] Colwill,[3] and now Perkoff[4] to propose a merger of family practice, general internal medicine, and pediatrics into a single primary care specialty. They use a strength-by-consolidation argument. They cite the growing similarities of training and practice among the primary care specialties and suggest that the American people would be better served by having a single type of generalist physician.

While this merger and unification idea for primary care has some conceptual appeal, its reality now or in the future in American medicine is unlikely and undesirable. Do Americans really want a single choice of primary care physician? In our pluralistic society, I think not. While many Americans embrace the concept and practice of family medicine, others clearly want to be cared for by an internist or an obstetrician-gynecologist and have their children cared for by a pediatrician. Many choose these specialists, not for their similarity to family physicians, but because of the distinct differences in focused expertise. Limiting the choice to some generic amalgamation of these specialists may not increase the power of primary care, as Geyman suggests; instead, it would likely have the opposite effect of restricting the potential power of primary care in the medical marketplace. The formation of a single primary care specialty would probably enhance the "hidden system" in primary care performed by other physician specialists and be a boon to other primary care health providers such as chiropractors and naturopaths. Americans like having choices and are likely to exercise that freedom whenever possible.

Does a merger of family practice, pediatrics, and internal medicine make sense from the perspective of these specialties? Most pediatricians have chosen that specialty because they want to focus their career on the care of children. Asking them to become primary care physicians for all ages is likely to result in widespread dissatisfaction. Are family practice and internal medicine enough alike to suggest a merger? Numerous studies have documented that family physicians and internists have markedly different practice styles with the same patient problems.[5–9]

Phillips[9,10] suggests that family practice and internal medicine have derived from very different medical traditions dating back to 18th century Europe (apothecaries vs physicians) and possibly even ancient Greece (Coan vs the Cnidian views of medicine). I suggest that in modern medical culture the internal medicine physician with a compulsive thirst for differential diagnosis remains quite different from the family physician with a focus toward pragmatic therapeutics. Attempting to merge these two specialties might make for interesting dialogue but is likely to cause considerable tension in practice styles.

Even if the American people would be better served by having a single primary care physician, and even if conceptionally an amalgamation of these specialties made sense, is such a merger organizationally or politically possible? In responding to the single primary care specialty ideas of Geyman and Colwill, Friedman,[11] an academic internist, states that merging internal medicine and family practice is impractical and unnecessary. Departments of internal medicine in academic institutions would never give up the general internal medicine component to an independent department. Departments of family practice, having struggled successfully for almost 20 years to gain an academic identity, would have to dissolve or transfer to some new primary care identity. In organized medicine, the single primary care physician concept has been virtually condemned by the American Academy of Family Physicians.[12]

A merger of the primary care specialties is unnecessary because most of the goals indicated by Geyman and Colwill can be achieved through greater interspecialty cooperation. Geyman suggests that competition is the alternative to a generic approach to primary care. While some interspecialty competition is inevitable and even desirable, a cooperation model is highly plausible for primary care.

Internal medicine and pediatrics do not generally compete, as the care is defined according to age. Family prac-

tice can compete with both and has, but more can be achieved by all three primary care specialties through cooperation. Friedman[11] describes five areas in which family practice and internal medicine are ready to cooperate: enhancing primary care training, developing primary care research, promoting academic viability of faculty, funding primary care programs and departments, and lobbying in the political arena. There are more than enough patient care needs to keep all primary care physicians busy. Working together, primary care physicians can promote reimbursement reform and improved professional status, which will make these fields more desirable to medical students. The American Academy of Family Physicians[12] has endorsed the idea of cooperation with other primary care fields. The concept of specialty merger or a generic physician seems counterproductive to improved relations among these specialties.

In summary, a merger of family practice, internal medicine, and pediatrics into a single primary care specialty is not appropriate, necessary, or practical. The American people like having choices, and having a single type of primary care physician is not likely to broaden public acceptance of primary care. The specialties of family practice and internal medicine have such different traditions, resulting in different practice styles, that a merger is probably impossible. Politically and organizationally a merger of these specialties would require compromises far too great to ever happen. Cooperation among the specialties is highly plausible and can achieve improved professional status and public acceptance for primary care. Let us stop this talk of merger and a common primary care specialty before such talk gets in the way of family physicians, general internists, and pediatricians working together to serve the American people; instead, let us promote academic achievement in primary care.

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