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that PCPs working in traditional primary care offices deal with clinical problems on a vastly broader, diverse scale than do retail clinics. Primary care offices, despite the growth of retail clinics, remain the most sophisticated, complete sources of care for patients, especially in the areas of chronic disease management and behavioral health care—two areas where rising demand is seen nationally. They also are the only viable primary care settings that can provide continuous care for patients with chronic conditions.

But what cannot be understated is that retail clinics provide basic, affordable primary care service delivery that is easily accessed and quickly performed. They serve a primary clientele that does not have allegiance to a particular PCP or primary care office, and one that might otherwise not pursue care without the clinic's presence. As a result, retail clinics will continue to fill service gaps that traditional primary care offices and PCPs have an increasingly difficult time filling, given large numbers of existing patients who clog the daily schedules, and the need to generate larger reimbursements from individual patient visits to cover the higher costs of physician-based care. They may also contribute to the shifting perception of generalist medicine within our society from a relationship-oriented brand of total care to a transaction-oriented series of compartmentalized visits that involve routine care. Ironically, it is the manner in which PCPs now work within their traditional office settings more than anything else that furthers this perceptual shift.

The Dysfunctional Primary Care Business Model

The halcyon days of generalist care, where PCPs alone determined the scope, substance, and economic value of all primary work has been replaced by an environment in which PCPs must make serious choices about which work to keep, which to jettison, and how to maintain job and patient satisfaction within a rigidly imposed reimbursement model that favors quick episodic care. The twenty-first-century U.S. health care system now pays PCPs less for the same type of care, ignores the practice of cognitive medicine that involves skills such as history taking and counseling, demands that PCPs see lots of patients in a given day to breakeven, motivates PCPs to give up low-margin parts of their business regardless of the personal or patient-related benefits derived from having PCPs engaged in that business, and increasingly buys the notion that other medical specialists are better suited to perform the more complex aspects of traditional generalist work such as different types of procedures and hospital medicine.

For most types of primary care, the fifteen-minute visit is now the normative standard. In the early twenty-first century, PCPs are professional piece-rate

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workers in the sense that they are paid on the basis that a face-to-face patient visit actually occurs, and less on what actually happens during that visit (that is, the actual diagnosis treated or addressed). Where the generalist of 1970 could spend forty-five minutes talking with a patient and be paid for that time, now insurers afix precise dollar amounts and time limits to different clinical diagnoses. This leaves PCPs little discretion to make their own judgments about whether or not more time is needed with a particular patient. But it also does not mean that the generalist's judgment about how much time to spend with patients in 1970 was good medicine. A forty-five-minute visit might have been unnecessary for treating the patient appropriately and may simply have been a way to generate adequate income without having to see too many patients in a given day.

PCPs spend the majority of their day in direct patient care. One recent survey found that the mean number of daily patients seen by a PCP was twenty-nine.[55] Almost all of them now spend a full day in the office setting, no longer doing work in the hospital, making house calls, or performing nonrevenue-generating activities such as committee work, at least during normal work hours. They cannot take time to do these other things. The typical workday of a primary care physician in the early twenty-first century is built on seeing as many patients as possible in the office in a given day.

Since fewer and fewer PCPs do procedures such as injections, biopsies, and cardiac stress tests in their offices, almost all of the primary care revenue within a practice now comes from reimbursement provided by the patient visit. Insurers financially motivate PCPs to keep patient visits brief. For example, a PCP may bill for visits that involve varying levels of complexity or length, but the relative additional dollars associated with complex or longer visits often does not justify the extra time and expertise needed relative to the simpler visit. In other words, it can be more profitable for a PCP to see four established, generally healthy patients who have basic acute problems in the course of an hour than seeing two established, sicker patients who require extended visits for services related to managing their chronic diseases. If patients have multiple issues, which many do, often the PCP cannot bill for treating both diagnoses in the same encounter but instead must bring the patient back for separate visits to address each of the issues in a way that provides adequate reimbursement.

This emphasis on both speed and numbers raises tensions in the practice of today's primary care medicine; tensions that never existed for the generalist of 1970. For example, as greater numbers of patients with behavioral health issues present in the PCP's office, and the PCP's reimbursement system is not set up to pay them adequately for this type of care, PCPs have four suboptimal

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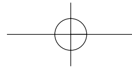
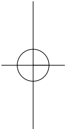
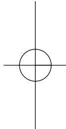


choices before them: either attempt to provide appropriate care by spending time with the patient, thereby sacrificing other office visits and earning less money for the practice; attempt to provide more complex behavioral medicine within the confines of fifteen- or twenty-minute visits that may produce low-quality care; offer "quick-and-dirty" prescription therapies to patients; or refer patients to behavioral health specialists who are in short supply causing delays of weeks or months before they are seen. It is often left up to individual PCPs to resolve this tension, and as a result the choice itself, made many times for patients over the course of a work week, can undermine the physician's job satisfaction.

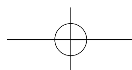
It is now also more accepted from a quality-of-care perspective that PCPs are not as appropriate for doing complex office procedures like colonoscopies and stress tests as gastroenterologists and cardiologists, for example. Instead, the argument goes, this type of work should be left to these specialists who do high numbers of procedures on a regular basis. Low-level procedures such as splinting sprained limbs or joints, or wound debridement and stitching, also now succumb to the whims of patients who may believe going to an urgent care center, emergency room, or specialist is faster and higher quality. And specialists desire to do as many of these simpler procedures as possible, since they pay well compared to the basic office visits in which they might engage with patients.





Most primary care practices now entrust care of their hospitalized patients to a new group of physicians called "hospitalists." The growth of hospital medicine as a separate specialty has accelerated over the past ten years. Since 1994, over 12,000 physicians nationally have taken up hospital medicine as a career field. It is the fastest-growing specialty in medicine, with the potential for over double the current number by 2010. Ironically, many of the doctors making hospital medicine a flourishing field would likely have been office based PCPs if the choice to become hospitalists had not been there. Three-quarters of hospitalists are trained in general internal medicine, and approximately another 15 percent in family practice or general pediatrics.

The need for hospitalists derives from the increased complexity of hospital medicine, combined with the economic realities of both hospital medicine and primary care today. Hospital reimbursement for primary care physicians is low. In addition, overall inpatient volume for the typical PCP at any given time is much less than in 1970 because of the health care system's enhanced ability to care for patients outside of the hospital and reimbursement incentives that encourage keeping patients in the ambulatory setting. As a result, PCPs earn greater reimbursement seeing patients in the outpatient setting during the same



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couple hours it might take to visit one or a few patients in the hospital. As PCPs do less and less hospital medicine, the appropriate standard of care from a quality point of view is that they do not perform this type of work but instead hand it over to the hospitalists who spend all day, every day doing nothing but caring for hospitalized patients.

These shifts in the work PCPs now perform, how they adapt to their work and get it done, and what it means for the workers and primary care are key foci in this book. For example, as PCPs have accommodated a reimbursement model that rewards speed over substance, how do they manage the demands imposed by sicker patients coming into their offices for care? For the multitude of patients with chronic diseases or behavioral health issues, are PCPs able to employ the necessary communication, listening, and history-taking skills in large enough quantities to produce high-quality care? Do PCPs enjoy practicing in daily environments where the work variety is lessened? What type of primary care field are patients left with after years of a business model where key services get financially undervalued, and the key knowledge workers providing these services adapt in ways that allow them to excel at completing customer transactions rather than building patient relationships?

Knowing More about the Everyday Experience of Primary Care Physicians

Anecdotes abound about the increasingly hectic, unsatisfying nature of primary care workdays across all types of settings, and about the dissatisfaction of primary care physicians. But to understand the current transformation of this field better, and how PCPs think and act within the transformation to shape primary care's future, we should know more about the everyday experience of being a primary care physician.

All workers make choices in adapting to developments thrust upon them. Work is restructured, sacrificed, and its pace modified by the individuals engaged in it. This is done to preserve control, income, prestige, and job satisfaction. But trade-offs are made by the workers themselves. For example, certain forms of autonomy get prioritized at the expense of lesser "luxuries" such as job variety and intellectual stimulation. In a primary care system where patient demand rises, and the business model rewards volume, PCPs engage work in a more transactional manner.

Pressures to meet production targets, in the form of patients walking through the door each day, require PCPs increasingly to emphasize the economic rather than social aspects of the customer encounter. Patients become "consumers" or "customers" and the interactions with doctors grow ever more

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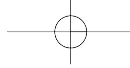
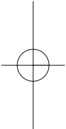
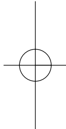


businesslike, streamlined, and impersonal. The drive to standardize, divide up labor, make work simpler, and pursue economies of scale in how things are done becomes a rational, expected motivator of behavior in a transactional system, which in turn shifts the expectations and values PCPs bring to their jobs.

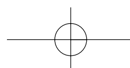
This study fills an important gap by exploring, from the perspectives of a variety of primary care physicians, the ways in which the field of primary care is adapting to developments affecting it. Extant literature has focused sharply on the developments themselves, and on external market responses such as the development of new occupational groups and primary care delivery structures. But much less attention has been paid to how individual doctors "in the trenches" are now coping with the everyday world around them. This sociological exploration can inform larger policy questions that relate to issues such as how to promote primary care to future generations of medical students, how best to intervene now in enhancing the experiences of existing PCPs and their patients, and what type of work and decision making should be advocated as purviews of primary care doctors and their traditional practice settings.





For example, most of the present discussion about the appropriate core of future primary care work and identity centers on the medical home concept, a concept envisioned by primary care professional associations as the means by which to reassert the primary care physician's importance and leadership role in the medical hierarchy. Through implementation of the medical home, PCPs would gain back formal recognition, through added payment, as care coordinators, overseers of health promotion and disease prevention in the clinical setting, and first-contact professionals that patients access first for care. NPs and PAs would be part of the "physician-led" team, but PCPs would retain the mantle of leadership in primary care settings. The traditional primary care office would be the legitimate focus for a patient's medical home, with emerging structures such as retail clinics providing supplemental basic care subservient to the care provided in the traditional PCP office.

The technical, idealistic vision of the medical homes as a savior for primary care cannot be fulfilled if PCPs find themselves in an everyday work setting where patient demand is still not easily controlled or predicted, where they are still forced to refer patients out quicker to specialists because of time or reimbursement constraints, where they are not adequately prepared for certain types of care, or in which their own scope of work still narrows toward an emphasis on highly routine, less complex care. These realities have already modified the way in which many PCPs think about their careers, clinical skills, and patients. And such modifications may not easily conform to what will be asked of them and their work in a medical-home role.



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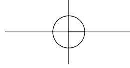

As a result, additional changes are needed beyond the much talked about reimbursement increases for PCPs or technological enhancements to make the medical-home model work. These additional changes once again involve transforming the social and psychological dynamics associated with physician-patient interactions in primary care. PCPs will have to readapt in thought and action to a workplace built not only on high-volume medicine but now also on care management and coordination. They will have to embrace new work and work roles, and think of other staff and patients in different ways. Yet having moved through one major form of adaptation over the past twenty years, in negotiating and making the best of a transactional business model in which all patients are customers or consumers, the field's enthusiasm and preparation for any new adaptation is not a given and remains a focus for empirical examination.

Focusing on the People Who Are Primary Care Physicians

The need for primary care to transform itself once again to maintain relevance in the twenty-first century American health system makes the primary care workforce a major sociological focus. For example, are younger PCPs better positioned to adapt to the medical-home model or other new external developments affecting their work than older colleagues? How do the value systems and expectations of younger PCPs, if different from older PCPs, shape what primary care work and the everyday experience look like, and what is possible in the future? These types of questions inform our ability to predict the trajectory of primary care as a set of careers. This trajectory will speak volumes about whether or not primary care work, for example, can meet the demands of a medical-home model by pulling back from increased routinization, faster pacing, ongoing skills erosion, and decreased autonomy on the part of PCPs. It will also help us predict the future prestige and place of primary care within the larger U.S. medical profession.

Younger physicians generally want a better lifestyle than their predecessors. More of them loathe thinking of medicine as a twenty-four-hour-a-day calling. Fewer take on the risks and rewards of owning their own practice, instead opting for salaried employment with regular hours, pay, and expectations. But their expectations and choices arguably align better with a primary care practice realm that treats its physicians less as independent professionals and more as labor inputs feeding into a production algorithm characterized by assembly-line medicine. If a new cohort of PCPs is to help save primary care, then it is important to know how their attitudes, behaviors, and experiences provide the grist for this salvation.

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Greater numbers of women and international medical graduates (IMG) now fill primary care physician roles. Family medicine, pediatrics, and general internal medicine all substantially depend on these two groups for their future survival, since U.S.-born, white male medical students now have a keen aversion to becoming primary care physicians. It makes sense to better understand how these emerging groups think and act in their careers, and how they differ from their cohorts who have traditionally filled primary care jobs. Anecdotally, it is thought that significant numbers of young female physicians choose general primary care because they believe it offers the lifestyle flexibility favorable to building a family and raising children. From the IMG perspective, primary care careers offer the best and often only hope to gain entrance into the U.S. medical profession and to work as a physician in this country. This has raised questions about their commitment to primary care careers.[56] These particulars merit exploration of these new groups in primary care, in order to see how easily they align with medical-home particulars and the current demands of a transaction-focused primary care delivery system.

These two demographic groups also experience different challenges and opportunities compared to their white, U.S.-born male counterparts. For example, women professionals have been shown to earn less consistently than their male colleagues in the same job.[57] In primary care fields specifically, this has been found to be true.[58] Increasingly in medicine, women physicians have been shown to earn less than men even when fulfilling the same work roles and responsibilities.[59] But evidence that women physicians bring different qualities and talents to their jobs compared to men, qualities and talents that may foster the type of patient-centered care envisioned by the medical home, means that women PCPs factor as a major part of the human resource solution to reinvigorating primary care medicine in ways that move away from transactional, customer-focused medicine.

International medical graduates (IMGs), especially immigrant physicians, also will shape the future of primary care as a viable field of medicine. IMGs are constrained to begin their primary care careers in less desirable practice settings such as underserved rural and urban areas. They bring different expectations about salary and job responsibilities to their roles. In exchange for the opportunity to gain access to a prestigious occupation and to live here, immigrant physicians may accept lower pay, longer work hours, and more fragmented work responsibilities, at least early in their careers. They may encounter unique difficulties in their interactions with American patients due to language and communication barriers.

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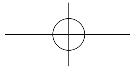
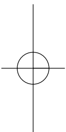
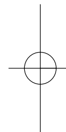


But because of where many IMGs are born, raised, and trained as physicians (outside of the United States and in resource-poor countries), they may appreciate how to interact with and deliver care to the uninsured patients in lower-cost ways that emphasize the ongoing honing of their decision-making skills through patient questioning, history taking, and the conduct of physical exams. These attributes, despite the language and communication barriers IMGs might face with some patients, can help achieve the ideal type of patient-centered care affiliated with the medical-home model: care that emphasizes the patient's voice and involves understanding the larger psychosocial contexts within which patients live and work.

Organization of the Book and the Physician Sample

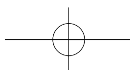
This book is organized into two major sections. The first section describes the current everyday primary care work setting and how PCPs think and act within that setting. Through the eyes of PCPs, it tells the story of how primary care has changed over the past couple of decades and how PCPs have processed and adapted to the changes. A key point supported by these findings is that PCPs have acted strategically to align their thinking and behavior to the current business model in which they practice. The richness of the description offered in these chapters, combined with the attention paid to the PCP perspective, yields insights for fixing primary care and implementing the medical-home model discussed in the later chapters of the book.





The second section of the book explores the three demographic groups that are taking over primary care specialties: young physicians, women physicians, and IMGs. A sociological analysis is incomplete without considering how worker biographies shape individual responses to events in the surrounding external environment. For example, not everyone has the capacity or interest to adapt in the same manner to the changes imposed on them. These three demographic groups are the future of primary care, given the large percentage of primary care physicians over the age of fifty-five and the current large influx of both woman and IMGs into primary care.[60] Exploring their collective capacities to navigate the changes in primary care, as well as the unique perspectives each group offers, can help tell us more about how the primary care physician workforce will think and act in the future.

The PCPs interviewed for this book come from a variety of different demographic backgrounds and work settings. As a result, the findings are representative of contemporary primary care physicians and workplaces. PCPs from the three primary care specialties—family medicine, internal medicine, and



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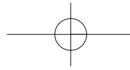
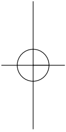
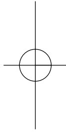


pediatrics—are significantly represented in the sample. A variety of PCPs at different age and career stages are included, as well as large numbers of both males and females. Residents, students, medical leaders in primary care, medical educators, and, most importantly, the "in the trenches" practicing PCP all have a voice in this study. The appendix at the end of the book describes this sample and the study design in greater detail.

The vast majority of primary care delivery in the United States is still performed in smaller group practice settings but increasingly under the umbrella of a larger corporate entity that assumes the administrative and business roles for the groups. Many of the practicing PCPs participating in this study work in these types of settings. While other primary care delivery settings do exist, such as urgent care centers and retail clinics, most PCPs still work in traditional primary care offices. In addition, the study also includes PCPs practicing in academic and health center or clinic-type settings, where there are sicker and more indigent patients, but where an increasing number of primary care services are provided.





This book is a snapshot, not a longitudinal study. It does not include the patient viewpoint, which is a necessary and important compliment to the view of providers. These are valid limitations, and the findings must be considered in light of them. But as a snapshot it gives an accurate look at today's primary care world, both generally and through a provider-focused lens. As such, it informs those who wish to know more about what things look like and where they might be headed. It incorporates developments in primary care and the larger health care system of which it is a part to identify current challenges, lost opportunities, and future adaptations that interact to shape primary care work and physicians in the future.

To begin an analysis that focuses on the work and workers of primary care, it makes sense to address two fundamental questions: What does the typical primary care workday look like at present, and how has that workday evolved over time?