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Can't Find a Doctor? You're Not Alone

By Nancy Shute

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Amber Meiwes is happy to tell you what's wrong with primary care in America: It's hard to get any, and when you do, it's a health risk.

During a long struggle with recurring stomach pain, Meiwes got used to waiting three weeks to get in to see a doctor—and then being hustled back out in mere minutes. "They had way more patients than they really can see," says Meiwes, 29, of Piedmont, Okla. "They would say, Take an antacid and go home." When she fell ill on weekends, her only options were an after-hours clinic or the emergency room. It took three years of office visits and ER visits before she got a diagnosis: inactive gallbladder. "I got to the point where I wouldn't even go to the doctor anymore."

It's not supposed to work that way. A primary-care doctor is supposed to be the go-to doc for almost every ailment from ingrown toenails to suspicious breast lumps—the trusted guide to the system who knows the patient, her medical history, her family. Any time the patient must navigate the bumpy and often frightening path through specialty care, it's these internists and family and general practice doctors who make sure that nothing critical falls through the cracks. Indeed, study after study has shown that patients fare better in areas of the country not overpopulated by medical specialists and where primary-care physicians handle the bulk of care. Yet increasingly, the system is fraying. Consider:

- Twenty-nine percent of people with Medicare said they had trouble finding a doctor who would take that insurance in 2007, up from 24 percent the year before. That's 11.6 million people.
- Two thirds of Americans say they have a hard time getting medical care on nights, weekends, and holidays, according to 2007 survey by the Commonwealth Fund.

- Just 30 percent of Americans say they can get in to see their doctor on the same day—putting the United States second to last among industrialized countries, ahead of Canada, according to the Commonwealth Fund survey.
- In California, almost half of emergency department patients surveyed in 2006 by the California HealthCare Foundation said they thought their problem could have been handled by a primary-care physician. Two thirds of those people said they couldn't get an appointment with their doctor.
- In Texas, 24 counties now have no primary-care doctors at all.
- In Alaska, not one of the 749 private-practice physicians was taking new Medicare patients for primary care in November 2007.

The shortages don't reflect a lack of doctors; the number of physicians per capita rose 77 percent between 1970 and 2000. But given the choice, most new doctors simply reject primary care. A specialist performing a procedure—a colonoscopy, say—is commonly paid three times as much for 30 minutes as a primary-care physician who spends that time talking with patients about how to manage their heart failure or diabetes. An internist or a family-practice physician might start off making \$100,000 to \$150,000 a year, but specialists make about twice as much on average, says David Dale, a Seattle internist who is president of the American College of Physicians. And a typical medical student graduates with \$130,000 in debt.

As a result, the number of grads choosing residencies in family practice, internal medicine, and pediatrics fell 7 percent from 1995 to 2006, according to congressional testimony from the Government Accountability Office in February. And while half of residents in internal medicine chose to go into primary care in 1998, now just 20 percent do. In the past few years, many have instead chosen to join the growing ranks of "hospitalists," a new genre of internist who manages the care of patients while they are in the hospital. Hospitalists may make \$200,000 a year to start, with fewer hours than a private practitioner and none of the start-up costs or managerial headaches.

Those who remain find themselves struggling to make money even though they can't meet demand. "The waiting list to get a physical with me is 14 months," says Kate Atkinson, a family-practice physician in Amherst, Mass., who does home visits, answers patients' E-

mails within a few hours, and prides herself on being the kind of doctor she'd like to go to. Atkinson sees 25 to 30 patients a day, yet she's barely staying afloat, largely because of the cost of staff she needs to keep up with insurance paperwork and Massachusetts's combination of low insurance reimbursements and a high cost of living. "It's very frustrating," she says. Her salary is supposed to be \$110,000. But one month last year, she wasn't able to pay herself at all.

Yet Bay State docs are so busy that just 51 percent of internists were accepting new patients in 2007, down from 66 percent in 2005—this in the state that in July 2007 became the first to require that residents have health insurance. Bruce Auerbach, president-elect of the Massachusetts Medical Society and head of the emergency department at Sturdy Memorial Hospital in Attleboro, often sees people coming in with out-of-control asthma or with severe dehydration due to stomach problems. When he asks them, "Why did you wait so long?" the answer is almost always that they couldn't get in to see their doctor or that they have no primary-care physician at all.

No guarantees. People who think that their problems will be over when they qualify for Medicare may be in for a nasty surprise. In some places where Medicare reimbursements have slid below those of commercial insurers, particularly in the South and West and in rural areas, more and more doctors are refusing to take new seniors—and even dropping longtime patients when they turn 65. In Oregon, for example, the number of primary-care doctors who no longer accept Medicare almost doubled in two years, from 13 percent in 2004 to 22 percent in 2006. Robert Gluckman, an internist at Providence St. Vincent Medical Center in Portland, has some patients who were dropped at 65 after many years. "They haven't talked badly about their doctor," he says. "They've been understanding."

The quality-of-care issue goes deeper than simple access, though. "We in primary care have really failed," says Thomas Bodenheimer, an internist and researcher with the Center for Excellence in Primary Care at the University of California-San Francisco. Most of the country's medical offices have yet to embrace best practices for managing chronic illnesses like diabetes, he notes, and very few have instituted such patient-friendly services as same-day appointments and weekend hours. He is one of a growing number of researchers trying to figure out how primary care might be fixed.

Some proposals focus on improving the supply of generalist physicians through debt

forgiveness for med students who go into primary care and more scholarships for those willing to practice in underserved areas. Others are seeking to change how insurers parcel out money, so that primary-care doctors can earn a satisfactory living doing what they do best. North Carolina's Medicaid program has experimented with shifting from the fee-for-service norm to a system that pays doctors an extra \$5.50 a month per patient to coordinate their care, for example; this fall, a similar project will be launched for Medicare patients.

And one of the more intriguing efforts aims to make the customer happy. When Amber Meiwes's husband shot a nail into his leg working construction in January 2007, she remembered that a doctor down the road had just opened a practice. Shortly after she sent her husband off, the phone rang. It was the doctor, Ric Corman, saying that Steven had to go to the hospital immediately for surgery, "and by the way don't let your husband tell you he doesn't need to go." Corman checked on him every day "and met him at the office on Sunday to give him antibiotics," says Amber, who quickly switched practices herself and takes their 1- and 3-year-old daughters to Corman. She can get a same-day appointment when the kids are sick and particularly likes that the office is open Tuesday and Thursdays until 8 p.m. and on Saturdays. "Everything's about good customer service," she says.

"I wanted to do it the old way and be a small-town doc," says Corman, whose two physician assistants deal with the sore throats and runny noses, while his office staff deals with insurance preauthorizations and such. He has time to take family histories, call specialists to synchronizicare, and really get to know his patients. "These people are not only my patients; they're my neighbors and my friends." His practice is being studied as part of a two-year experiment by the American Academy of Family Physicians testing out the "patient-centered medical home," a new approach to primary care. "This stuff really works," says Terry McGeeney, president and CEO of TransforMED, the AAFP project. In the past year, commercial insurers and large employers have become interested and are working with the National Committee on Quality Assurance, which accredits hospitals, to figure out how to compensate doctors so they're rewarded rather than penalized for spending time with patients.

Finding a doctor. For people who don't live near a Ric Corman, perseverance and old-fashioned word of mouth remain the best hope. Most people have to rely on friends' opinions to try to figure out who's good and who's not—and on luck to find a good doctor

who takes their insurance and accepts new patients. A few resources, none of them perfect, can be found here.

When friends and family ask to become patients at his practice, David Dale says he most likely will reply that he can't take on new patients. But Dale, who is in a group practice at the University of Washington (where he used to be dean of the medical school), allows that "you might get in because you're in our hospital or because people want to be nice." So, as a last resort, begging might help.

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