Concluding Thoughts—Looking Forward

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Physicians are currently practicing in an environment few anticipated when they chose a career in medicine. The increased proportion of Americans enrolled in managed care plans has created discomfort among many physicians and the public, resulting in a crescendo of voices proclaiming a crisis in medicine.

Primary care physicians, in particular, confront a mosaic of opportunities and frustrations. The ascendance of managed care has emphasized the central importance of primary care, and some structures have developed to support the rhetoric. However, a number of primary care physicians report dissatisfaction with the changes in medical practice, and they blame those changes on managed care, rightly or not. For example, in one survey primary care physicians reported that gatekeeping is a better strategy for controlling costs than for promoting quality,¹ and many patients have resented the restrictions on access to specialty care—no matter how well motivated.² The Center for Studying Health System Change recently reported that 16% of Americans are concerned that their doctors might not refer them to a specialist when needed, and up to 31% of primary care physicians report difficulty obtaining referrals to high-quality specialists when medically necessary.³

The vision that primary care physicians would be the new conductors of the medical symphony has never been realized; rather, the music has often become cacophonous and more difficult to play. Meaningful strategies for adapting to, anticipating, and managing these multiple and concurrent changes, however, have not yet become an important part of public discourse in the Society of General Internal Medicine (SGIM).

In 1996 a group of SGIM members established the Task Force on Managed Care to develop strategies for addressing the impact of health system changes on our work as clinicians, educators, and researchers. Like most interest groups within SGIM, the Task Force includes individuals who represent a broad spectrum of diverse perspectives regarding the changing health care environment—from those who believe we are close to having the tools to combine primary care with a focus on population health, to those who believe the organization should actively resist all change. An important stimulus for the precursor “The Evolving Role of Physicians in Managed Care Organizations” was the conclusion by the Task Force that, in contrast to the intensity of informal discussion at

annual meetings, there was little guidance for physicians entrusted with the education and socialization of future physicians. The charge for leaders in the primary care disciplines is to rise to the challenges presented by a changing health care system in terms of clinical practice, education of future physicians, and patient and health care system advocacy. Our expectation was to begin a process of engaging SGIM members in a common dialogue to develop practical strategies for education and clinical practice, to identify opportunities for leadership within their institutions and evolving health systems, and to articulate a vision of patient-centered care within a rapidly changing landscape.

A specific focus of this course was the impact of recent health system changes on the interface between primary and specialty care. For SGIM members, tensions between generalists and specialists are often amplified beyond their baseline. Within traditional fee-for-service practice (the “good old days”), decisions to refer patients to specialists were a highly individual matter and limited only by logistical issues and—more often than we might choose to admit—the patient’s insurance coverage. Specialty consultation was viewed as an opportunity for learning and encouraged by the proximity of multiple specialists at academic medical centers. The gatekeeper (or conductor) role forces us to consider more explicitly which patients are most likely to benefit, and to confront the alarming lack of available evidence to inform apparently simple clinical decisions.⁴ Strategies to restrict direct access to specialists also require that we learn to manage patient expectations and our own clinical uncertainty, develop patient-centered systems for coordinating with our specialist colleagues, and prepare students and residents for new practice environments.

To begin to chart this new territory, the Task Force, with input from the Society of Teachers of Family Medicine (STFM), specialists, and leaders in managed care organizations, developed a 1-day symposium that focused on the many dimensions influencing interactions between primary care physicians and specialists. The first half of the symposium consisted of formally prepared presentations. Gold’s paper on the myths and realities of financial incentives provided an overview of what is known—and what is not—about the impact of changing reimbursement practices. In particular, she emphasized the importance of assessing financial incentives within a context that includes all strategies for influencing physician behavior, including administrative interventions and quality measurement efforts.⁵

Pearson turned to long-established codes of ethics to articulate some guiding principles for interactions between generalists and specialists that articulate responsibilities of the referring physician, the consulting physician, and

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health plans. These principles are not intended to be all-inclusive, but to provide a basis for teaching students and residents and designing innovations to enhance patient care.⁶

A vision of how organizations can enhance physician's efforts and help move primary care practice from a series of individual interactions to an expanded focus on population health was presented by Suchman. This future-oriented view does not always resemble today's practice settings, but does remind us of what may be achievable in the future.⁷

Goold and Lipkin's paper reviews the essential aspects of physician-patient relationships and describes incentives, opportunities, and strategies for sustaining trusting relationships in a changing health care environment.⁸

The second part of the symposium required the active involvement of all participants to share experiences and challenges as well as to synthesize the first phase conclusions for a much larger audience. The remaining papers⁹⁻¹³ offer a summary of current endeavors and struggles among SGIM members to address educational and clinical challenges while also attempting to understand and influence the multiple systems in which they work.

Future Directions and Challenges

The success of this symposium will fade quickly if it is not viewed as a necessary but insufficient step in engaging SGIM members, colleagues in family medicine and specialty organizations, managed care organizations, and academic medical centers in rethinking our responsibilities as clinician-educators. In the cycle of quality improvement (plan-do-check-act), we are still in the planning phase. This supplement will be distributed to all members of SGIM and STFM, as well as to selected leaders of health plans and can help move us to the "do" phase, and even to "act" on opportunities for improvement.

Most if not all clinician-educators in primary care are struggling to translate and adapt successful teaching methods to a transformed environment. Relevant domains of knowledge have been identified,¹⁴ but regional variations in penetration and predominant models of managed care create new challenges to identifying collective strategies for improvement. A clear agenda for professional organizations will be to identify the common themes, recognizing inevitable local nuances, in order to develop, evaluate, and disseminate new educational strategies and tactics grounded in contemporary practice. This will involve dealing not only with the difficult issue of what to teach, but also with the questions of who should teach and in what settings. A renewed focus on evidence-based medicine is an essential component, but it must be expanded to include evidence about organizational and financial as well as clinical interventions. For example, the current interest in hospitalists merits the same attention as any new biomedical advance.

Leaders in the primary care disciplines have made tremendous progress in creating new interdisciplinary models for undergraduate education. Within SGIM a new interest group focused on referrals to specialists has recently been established, and more research has been presented and published. We must now involve our specialist colleagues and leaders of academic centers and health plans in changing traditional educational approaches.

Collectively, we have the intellectual capital and leadership capability to begin the process of reshaping educational and practice strategies for a new environment—informed by the same rigorous methods we use to evaluate new clinical innovations. The Task Force aims to build on this symposium to translate these discussions into action and constructive curricular content and teaching methods. We welcome your responses to this supplement and future involvement with the Task Force.

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