When I started a private solo family practice in 1980, I struggled to get paid from insurance companies, Medicare, and Medicaid. Who could understand and follow all those regulations! As I cared for a population I became increasingly familiar with, I could viscerally feel how much money I was saving the payers by being a pragmatic family physician. “They should be sending me bonus checks!” was a common reflection after a day of using lots of common sense in the office. I knew these patients well, and their common problems rarely required much testing, especially advanced imaging such as CT scans or MRIs that I knew the specialists routinely ordered.

Young et al, at the Residency Research Network of Texas (RRNeT) have captured the cost-effectiveness of family physicians through a qualitative study of 38 physicians. First-year medical students were trained to conduct in-depth interviews of family physicians in one Texas location. The 38 physicians included nine in community practice, 24 faculty, and five residents. In the responses given by these physicians, their inherent pragmatism came out, and their behavior was driven by a deep knowledge of the patient.

Starfield measured this phenomenon epidemiologically but could only postulate about how family physicians and primary care in general were cost-effective. She and her colleagues proposed six mechanisms for the beneficial impact of primary care: (1) greater access to needed services, (2) better quality of care, (3) a greater focus on prevention, (4) early management of health problems, (5) the cumulative effect of the main primary care delivery characteristics, and (6) the role of primary care in reducing unnecessary and potentially harmful specialist care. The qualitative study by Young et al gave life to these mechanisms, especially a better understanding of primary care delivery characteristics.

My observation is that the culture of family medicine is to be therapeutic pragmatists more than compulsive diagnosticians. This was borne out in a study I conducted during my residency training. As we take our histories, besides thinking what is wrong with the patient, we are quick to think how we can help them. We tend not to value as much thinking about what tests should we order. Also, if we believe we can help the patient, no need for a referral. The physicians interviewed in this study brought these out and were sensitive to the financial strain that high cost care had on the patients. They were inclined to educate the patients to care for themselves and not undergo unnecessary evaluations.

As I precept residents in the academic setting, I worry about whether this cost-effective pragmatism will carry over to the next generation. Residents are inclined to order more tests and make referrals partly in response to their own insecurity about their clinical judgment. That is why all patients seen by residents should be actively precepted to model the clinical judgment of experienced physicians, supported by evidence-based clinical guidelines when possible.

While only five residents were part of this study, and the numbers of physicians interviewed was small and in one location, this data

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calls for more research and analysis. How do family physicians develop these characteristics? Are we self-selected by choosing family medicine, or does mentoring develop these skills? As controlling health care costs while improving the quality of care is an imperative today, much more work should be done to study how family physicians are cost-effective. Certainly we can be better, and we cannot rest on our cultural inclinations and consider that optimal care.

All patients deserve a high level of expertise in their care, and increasingly that will come with decision support from digital sources. As computers like IBM’s Watson suggest what we and our patients should do, our common sense judgment and knowledge of the patient will take on a whole new context. Big data is coming, including routine genomic profiles of our patients integrated at the point of care. Family physicians will be needed more than ever to provide wisdom and perspective in clinical decision making. We are the doctors of Star Trek, and we may be in roles like that soon, not in space, but right on earth as the information age continues to unfold.

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