PRESIDENT'S COLUMN

Let's Not Waste a Crisis

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Almost every year, the head of the hospital system connected with my medical school articulates the current crisis. He is effective in its description—often some combination of impending payment cuts, payor mix shifts, and/or new competition from a boutique hospital (heart, orthopedics, cancer, etc.), which soon will be siphoning off the few cases on which the hospital makes its annual operating margin. And he is especially effective in using the crisis to produce results that improve the efficiency of the hospital system (e.g. lesser increases in compensation, lower cost procedure trays, and greater productivity expectations per unit of support). The crisis of the year is not wasted, which is one of the reasons this hospital system has a positive operating margin while several hospitals in the area have closed or merged. I continue to marvel during each budget season at the effectiveness of this leadership strategy.

I have learned some important lessons from observing this strategy. One is about communication. When advocating for change (whether locally or nationally), it is critical to communicate in relatively simple and unambiguous terms a compelling need for change (the crisis). We in SGIM comprise a Society full of thoughtful and critical thinkers, and I think we are sometimes guilty of wanting to explain all the nuances in such a way that our audiences may hear those nuances more than the key message. While it is a good thing that we understand the incredible complexity of our field, for communication outside our Society we need to be clear and stay on message.

SGIM members are well aware that general internal medicine (GIM) is facing a crisis. Shortages of generalist physicians (ambulatory and inpatient) already exist, in GIM as well as other fields. The venerable *New York Times* journal of medicine says that 60 million patients are without primary care doctors,[1] and anyone who has tried to hire GIM hospital medicine specialists can attest to the shortage of inpatient-oriented internists. This shortage is likely to worsen as the changes included in the Health Care Reform legislation are phased in, thus raising the demand for primary and secondary care—areas that are the bailiwick of GIM.

Numerous articles, most concentrating on primary care, have been written to explain the lack of sufficient physicians entering generalist fields. While many explanations have been put forth, in my view they reduce to two basic problems. The first is compensation, and the second is the professional environment associated with generalist careers.

The compensation of generalist specialists per unit of clinical work is too far inferior to the compensation for other specialists to attract generalists in the numbers needed. Much of relative physician compensation is set by the Relative Value Scale Update Committee, also called the RUC, a committee consisting mainly of representatives of professional societies. This committee is dominated by non-generalist fields, with only five of 29 RUC members from primary care.[1] Given the high financial stakes and the fact that the makeup of the RUC favors historical inequities in relative compensation, expecting the compensation situation to self-correct is pure wishful thinking. I am not clear whether physicians overall are paid too much, as some have concluded. As the economist Uwe Reinhardt has pointed out,[2] US college graduates bright enough to enter medical school would be able to secure other high-paying jobs if careers in medicine became less attractive, and if the compensation of all physicians were to decline by 20%, total national health spending would be reduced by only 2%. What I am sure of is that the inequity in incomes between generalist specialists and most other specialists has led many top-notch early-career physicians to choose more lucrative careers.

I suspect that some general internists who concentrate on inpatient medicine are thinking that my comments related to compensation do not relate to them. While hospitalist compensation often exceeds compensation for ambulatory medicine, this is due to a combination of increasing demand for the still relatively new field and substantial hospital cross-subsidies (estimated at more than $130,000 per physician annually), not due to adequate payment for clinical services.[3] When the supply of hospitalist physicians catches up with demand, the hospital executives are likely to take notice and reconsider their subsidies. It is not a healthy situation for either inpatient- or ambulatory-oriented generalists to be so dependent upon cross-subsidies to support clinical compensation.

In addition, the professional environment available to generalists does

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not support the values and vision that typically lead physicians to take up generalist careers—that is, an emphasis on treating the whole person and attending to the biopsychosocial aspects of patient care. Instead, most generalist environments emphasize productivity based mostly on number of encounters and based minimally on the quality of the care provided. Initiatives such as the patient-centered medical home (PCMH) model are structured to shift the focus to quality care outcomes and may improve physician satisfaction.[4] However, the fact is that most generalists still work in environments that strongly tie compensation to volume. Quality (or value) of the care provided accounts for a very small percentage of the compensation for most generalist physicians, even those working in PCMH environments.

Traditionally SGIM as an organization has focused primarily on education and research issues related to GIM, and we will continue to do so. We have traditionally partnered with other like-minded organizations to accomplish changes in health policy relating to clinical issues and reimbursement, and we will continue to do this as well. However, at its last retreat, the SGIM Council felt that the organization needs to increase its focus toward articulating the crisis that exists for our field more generally, not solely limited to the education and research aspects. Within the internal medicine umbrella of organizations, we have an obligation to be strong advocates for our field, as we are the group that focuses solely on general internal medicine. One sign of the Society's move in this direction is the National Commission on Physician Payment Reform, which was spearheaded by Harry Selker during his presidential year. The Commission will examine how physician payment reform can enhance value for the health care system while enhancing patient and physician satisfaction and autonomy. The Commission, chaired by former SGIM president Steven Schroeder, has been described previously by Dr. Selker in the *Forum* and is proceeding with its work. The Society has also secured funds from the Agency for Healthcare Research and Quality to partner with the Society of Teachers of Family Medicine and the Ambulatory Pediatric Association to host a second national invited conference to develop a research agenda to further inform the adoption of the PCMH model of care delivery.

In addition to these initiatives, I have asked our SGIM committees each to consider what more we can do to communicate the challenges faced by our field and to develop and articulate potential solutions. There is a wide national consensus that our health care delivery system is in crisis and requires re-design, even though there is disagreement about the solutions. We need to articulate the crisis as it pertains to GIM and work among ourselves and with others to develop solutions. This is a real crisis, and we need to be sure we do not waste it!

References

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