EDITORIAL

Making Choices About the Scope of Family Practice

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At Keystone III, a dialogue about family practice after 30 years of development in the United States, a futuristic view of the potential failure of family practice suggested that family physicians could fail because they abdicated their functional domain to other providers.[1(p316),2] In this issue of the *JABFP*, Rodney and Hahn focus on the functional domain of family practice by assessing the financial implications of deleting selected procedures and hospital services from the scope of family practice in an urban setting.[3] Given the turmoil that frontline practice is in at the moment, these findings are timely, and they fit into a succession of domain-defining research that should inform debate concerning the redesign of family practice.

Rodney and Hahn describe 1 year's experience in a teaching practice with about 30,000 visits per year, a financial case mix that was 84% Medicaid-Medicare, and net collections of 45.2%. They show that, after deducting direct and opportunity costs, both hospital care and procedural services were financially rewarding even with low collection rates. These findings are based on prudent rather than extreme assumptions. The authors coped explicitly with capitation issues, conducted tests of both internal and external validity, and reached across outpatient and inpatient settings. Even though the data are drawn from one practice, are subject to unknown variations associated with valuation and accounting practices, and doubtless excluded some costs, the strengths of their findings are sufficient for this study to be taken seriously. In short, this study shows that even with a poor case mix and low collection rates, a positive effect on the bottom line can be attained by including in family practice selected procedures and hospital services that many patients need.

Evaluating and debating what procedures should be taught and done are not new to the landscape of family practice. Studies cited in the Rodney and Hahn article and others found that training programs were providing training in more procedures than were done routinely by practicing family physicians.[4] With the addition of this careful analysis of economic implications to the literature, a prudent conclusion is family physicians can learn procedures and hospital skills that are relevant to the needs of their patients, they can provide excellent service, and they can be financially rewarded for doing so. To a large extent, those procedures and hospital work to be included in the domain of family practice are choices to be made by family physicians.

There are aspects of this report that reveal why some family physicians might choose to abdicate procedures and hospital care to others. Two thirds of the hospital activity in this study occurred before 8:30 AM and after 5:00 PM. The hundreds of hours spent doing procedures and hospital work displaced alternative uses of professional and personal time. Making these services available and maintaining the skills necessary to do them well is hard work and requires a commitment of personal and financial resources. Furthermore, family physicians are trained to provide many nonprocedural, outpatient services that are also needed and important and that compete for their time and effort. Finally, there is evidence family physicians do make choices about their domain that exclude procedures and hospital work.

According to survey data collected by the American Academy of Family Physicians (AAFP), only 6.7% of Florida family physicians provided obstetric services in 2000 (lowest in the country). This situation exists even though Larimore and Sapolsky reported that Florida family physicians who provided obstetric care found it both financially and psychologically rewarding.[5] Nationally, only

Submitted 28 January 2002.

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22.4% of family physicians reported doing routine obstetrics. According to a 1999 AAFP survey, 77% of members who did not have routine obstetric privileges did not want them; only 6% found liability coverage too high, and only 0.7% had been denied privileges.[6]

In 2000, less than 2% of family physicians reported having involuntarily given up hospital privileges, but 12.4% of practicing family physicians reported having no desire for these privileges.[7] Of those with hospital privileges, 84.5% in all regions of the country reported that they were satisfied with the scope of their privileges. Twenty-one percent had no desire to provide intensive care unit care (51.4% did), 27.6% had no desire to see patients in the emergency department (57.8% did), 50.5% had no desire to do flexible sigmoidoscopy (29% did), 70.2% had no desire to do colonoscopy (3.3% did), 70.1% had no desire to do esophagogastroduodenoscopy (3.4% did), and 58.9% chose not to do colposcopy (17.5% did). Many family physicians are apparently choosing to provide care that is more comprehensive than basic primary care. This variation reflects, in part, the versatility and adaptability that distinguishes family physicians and permits them to be responsive to the needs and expectations of their communities. It is possible, perhaps probable, that in some instances, this variation confirms abdication of a commitment to provide the most comprehensive care possible.

Payment mechanisms are known to play an important, sometimes distorting role, in which procedures are offered and where, as well as the economic valuation placed on health system components. Rodney and Hahn rightly recognize that creating product lines in medical practice and choosing to limit practice to office visits without procedures or hospital activity are choices that transfer expense and revenue. Transfers that move more revenue than expenses threaten the financial viability of family practice. Given the relatively lucrative nature of procedures, various clinicians and organizations might be quick to claim specific services and the technology used to provide them.

Transferring procedures, such as colonoscopy, sonography, and colposcopy, out of family practice and into the hospital outpatient clinic and to other disciplines is likely to fragment care, reduce net revenue in the practice setting, and increase the need for other types of health care providers, thereby contributing to a specialist shortage. Hospitals and other entities eager to provide financially rewarding services might be pleased to relieve family physicians of the burdens of hospital and procedural care. By providing these services, they thereby redirect family physicians and other primary care providers into activities that have relatively higher overhead and lower revenue. Abdication of components of care that have been or could be part of the domain of family practice affects the role and position of family practice in the health care system. The possible reduction in the family physician's contribution and value to medical care might result in demoralization associated with being loss leaders.

It is essential that decisions about the domain of family practice be grounded in assessments that move beyond provider perspectives and focus on how choices about the domain of family practice affect patients. Patients want and need many things from their family physicians, including the procedures Rodney and Hahn studied. As Figure 1 shows, at the end of the 20th century, a large portion of the US population still lived in primary care health professions shortage areas. In many instances patients need their local primary care clinicians to provide the fullest scope of practice they can. Sustaining an economically viable, sufficiently robust family practice is almost certainly in the nation's interest.

The effect of family physicians withdrawing from providing any or all services is illustrated in Figure 2. If family physicians had withdrawn from the physician workforce at the end of the last century, the number of US counties designated as health profession shortage areas would have grown from 864 to 2,048. Some 50 million people outside metropolitan areas would have increased difficulty in accessing care. Currently, family physicians are well positioned to be providers of hospital and procedural services, as well as other critical services, for this population. A uniform exclusion of a service from family practice, even if family physicians retained their role and distribution, would have a major effect on those living in counties that depend on family physicians.

There are other reasons to think carefully about the domain of family practice. Family physicians comprise one half of the rural underserved workforce and one half of the community health center workforce. There is no other workforce presently configured to provide adequate procedural care to

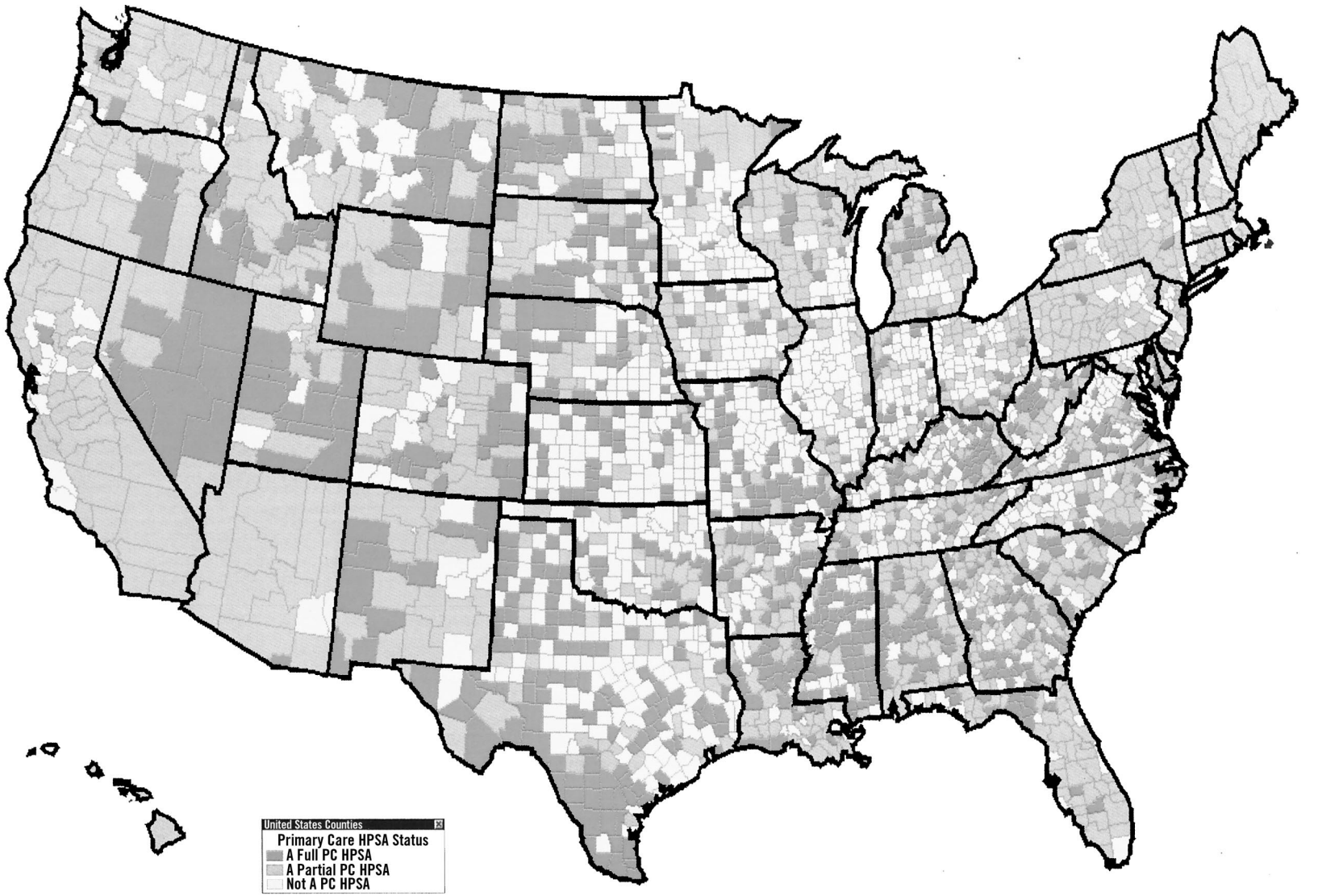

Figure 1. 1999 distribution of counties with full or partial primary care health personnel shortage designation: with family physicians. Source: The Robert Graham Center: Policy Studies in Family Practice and Primary Care.

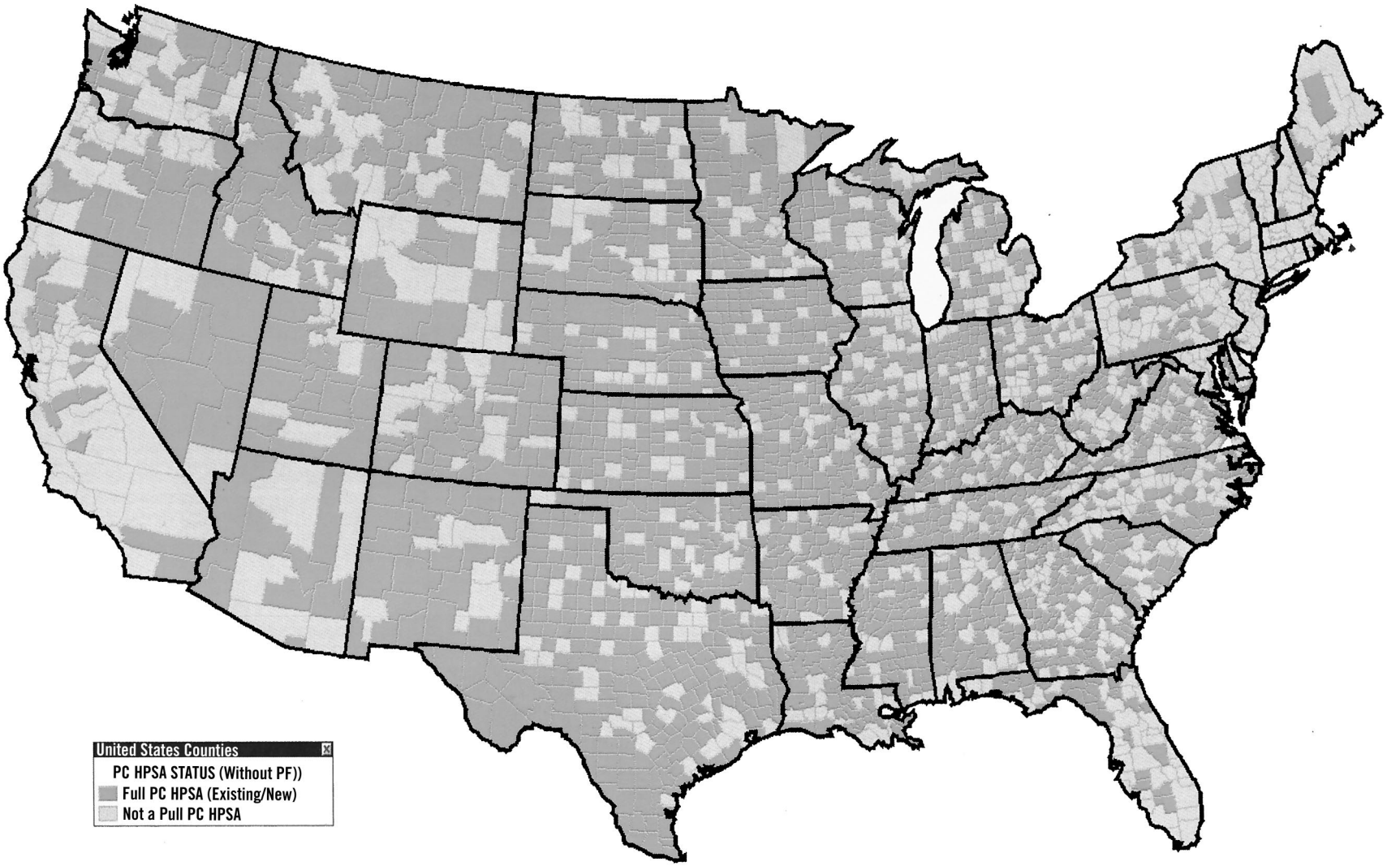

Figure 2. 1999 distribution of counties with full or partial primary care health personnel shortage designation: without family physicians. Source: The Robert Graham Center: Policy Studies in Family Practice and Primary Care.

these populations. Specialists cannot be expected to meet current recommendations concerning disease prevention, such as colorectal cancer screening, for the entire population without help from primary care providers.[8,9]

So what should be and what will be the domain of family practice? As the most general of the generalists and the oldest root of all medical practice, family practice would be expected to face a complex set of challenges and questions associated with major shifts in medical knowledge, organization, and financing. Many elements of these challenges now faced by family practice were captured in the proceedings of Keystone III. After the Keystone dialogue, the major national family practice organizations decided it was timely to develop explicit plans for the future of family medicine. The AAFP is administering a project beginning in 2002 to do just that. This effort might be able to provide guidance about redesigning family practice so that it is sufficiently robust to meet in an excellent and sustainable manner the needs of those who seek health care in the information age. It remains to be seen whether family practice becomes a minimal triage function, an optional medical boutique among many, or a critical determinate of improved health status.

The effort of maintaining the appropriate domain of family practice, defining and supporting its boundaries, and pushing its frontiers as new technologies evolve must not be rooted in protectionism and the pursuit of financial reward. Family practice is about the ability to care best for patients by establishing competencies and a comprehensiveness that allow family physicians to be healers, advocates, negotiators, and consolers. As Phillips and Haynes said so well at Keystone: "If we allow limited specialists to carve out diagnoses and procedures, business people to design industrial-strength health systems, or lawyers to regulate relationships between physicians and patients, what will be left of what we have shared with our patients for so long . . . ? Who will be left to care about the hard work of caring?"[1(p74)] The choice is ours.

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