

Readers' Forum

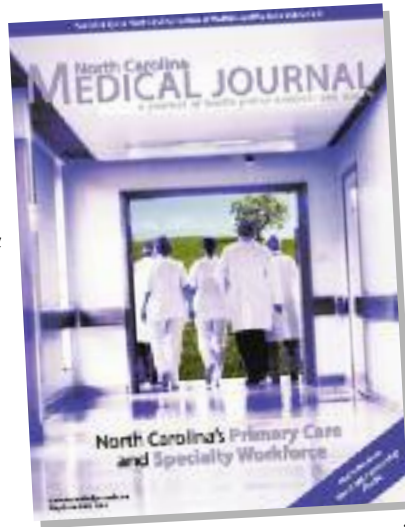
To the Editor:

The North Carolina Institute of Medicine should be commended for its timely recognition of the issues relating to medical manpower as addressed in the May/June 2007 issue of the *North Carolina Medical Journal*. The North Carolina Academy of Family Physicians published similar concerns over a decade ago in its publications *Who Will Take Care of Our People?* and *Who Will Care for Our Communities?* These were red flags to the NC General Assembly and the academic community from family physicians in this state who realized that the population was increasing while growing more aged and sickly, and that fewer medical students were choosing primary care and family medicine as a career. Sadly, there was no response, but this was the age of managed care, and we did see a small increase in family medicine match rates. Since that time the state's population has more than doubled and become on average older, and we find significant maldistributions of health care. Many of our state's citizens are underserved and face health care disparities. Unfortunately, both of our calls went unheeded. Perhaps your efforts will meet with more success in arousing public awareness of this urgent issue.

It is not surprising the NC Institute of Medicine found that even if we begin training more primary care and family physicians today, there will still be a deficit in the providers of first line care in the foreseeable future. Our answer: THERE ALREADY ARE too few primary care physicians to provide a medical home for all of the citizens of our state. Unless there is a change in the number of students choosing careers in primary care, the crisis threatens to be catastrophic.

There has been significant discussion about increasing class size at each of the four academic institutions as well as proposals for a fifth training site in Charlotte. None of the suggestions include an increase in the number of primary care providers in North Carolina. For many years the legislature has required that our universities report the specialty selection of the senior class of each school. However, this is an accounting of merely the intern year and does not consider matches in general internal medicine/pediatrics for a preliminary year where many go on to subspecialize. Strong consideration should be given to a change in legislation that requires accountability upon completion of residency. The American Association of Medical Colleges and the American Medical Association have recommended a graduation rate of 50% primary care and 50% specialty care physicians. This is not happening in our state and has contributed to the current shortage of primary care providers.

If past history is a predictor of the future, the plight of health care in this state will only worsen, and North Carolina



citizens will have to pay more for a system in which they receive care that is fragmented and reactive rather than preventative or comprehensive.

Why do countries such as Cuba and Great Britain rank higher in quality of care despite spending significantly less on health care than the United States? The answer is quite simple. It is the uncomplicated access to well-trained primary care physicians. The data in Barbara Starfield's research supports this premise. We have in this state demonstrated—through the work of Community Care of North Carolina—a system which achieves better access and improved quality of care while also achieving a cost savings. The basis of this system is that each patient is assigned a primary care medical home. The model utilizes care managers, pharmacists, nutritionists, and project specialists to assist in education of patients and improve standards of care. This is the model that has the potential to achieve the desired improvements in health outcomes sought by the NC Institute of Medicine. We do not need academic centers to create another model of inefficient, costly care.

I challenge our academic leaders to study the Community Care of North Carolina model, embrace the concepts of quality-based and accessible care, and provide physicians who can serve those needs in this state.

The North Carolina Academy of Family Physicians stands ready to aid in achieving this lofty goal.

Respectfully,
Michelle F. Jones, MD, FAFAP
President
North Carolina Academy of Family Physicians

To the Editor:

I would like to comment on some issues that were touched upon in the article by Dr Harvey Estes in the May/June issue of the *North Carolina Medical Journal*. I feel compelled to say that it was through Dr Estes' diligent efforts and pioneering work at Duke that the Physician Assistant Program came into being in North Carolina and subsequently became a vital link in health care delivery in our state and a model to the nation—with the Nurse Practitioner Program to follow.

I think the real core of dissatisfaction in the general public about the health care delivery system centers around concerns of expense, the limited availability (not the quality) of health

care, and the general perception of diminished interest in the individual patient by physicians. It is my perception that the public would readily accept the expense and logic for the creation of another state-owned medical school. I have always felt that there has been an abundance of qualified North Carolinians for medical training.

Since the advent of the Brody School of Medicine at East Carolina University, North Carolina has grown 2 million in population. It is interesting to recall that this school was violently opposed during its inception by the state's then 3 medical schools.

I also feel that economic and social changes are apparent in the culture of the medical profession. There is a willingness to accept more professional regimentation in order to escape the added hours and business aspects of practice and a seeming desire to escape close personal relationships with clientele.

This capitalistic approach is, to me, the excessive zeal for the accumulation of wealth which leads to unfettered capitalism, control through ownership, and favoritism to hospital employed or affiliated physicians. This situation serves as a deterrent to physicians with the same credentials and staff memberships to enter private or small group practices; ergo, establishing a private or small group practice starts out more risky, and its growth and survival is problematic.

Here in my hometown there is a strong feeling or recognition in private practices that if the hospital's ownership doesn't extend to your practice, you probably won't get equal opportunity to share in the patient pool. New physicians do not come to a community expecting to be discriminated against by the management of local hospitals. Equal opportunity should be applied to physicians regardless of affiliation.

Respectfully,
John R. Gamble Jr, MD
Lincolnton, NC

To the Editor:

The May/June 2007 issue of the *NC Medical Journal* defined the challenges faced by North Carolina in providing primary care, obstetric care, and psychiatric services to individuals across the state. As a clinical specialist in child and adolescent psychiatric and mental health nursing since 1990, and a recently licensed family psychiatric and mental health nurse practitioner (PMH-NP), I would like to respond from an individual practitioner perspective.

In my work with children and families, I became acutely aware of the impact of limitations in the availability of psychiatric practitioners. Primary care practitioners (PCPs) have been instrumental in filling the gap when medication was part of the treatment plan. However, with publicized warnings about possible side effects of some psychiatric medications and a growing demand for PCP services, some PCPs became less willing to manage psychiatric medications. In my experience, it was not unusual to see a child wait months to see a child psychiatrist, which often resulted in major implications for the child's academic and social functioning. These experiences motivated me to obtain post-masters

education as a family PMH-NP at the University of North Carolina at Chapel Hill School of Nursing.

I am fortunate to work for an organization that supported my ability to pursue the education and clinical placements necessary for training. FirstHealth of the Carolinas has also facilitated my ability to arrange collaborative practice agreements and supervision time with three highly skilled and experienced psychiatrists. This has been vital in my transition to this expanded role.

As resources for psychiatric and mental health services continue to be stressed, it is important that psychiatrists and community organizations be willing to provide the kind of facilitation that I have experienced. I also support Erin Fraher's recommendation to develop innovative models of interdisciplinary care that incorporate advanced practice psychiatric nurses into the psychiatric team. It is my hope that educational institutions, psychiatrists, and nursing leaders will continue to work toward developing models that serve to expand clinical resources to our citizens.

Sincerely,
Elizabeth Watson, MSN, PMH-NP
FirstHealth of the Carolinas
Outpatient Behavioral Services
Pinehurst, NC

To the Editor:

Your recent issue on physician supply indicated that there may be an emerging shortage of general surgeons. I have decided to pursue general surgery in my residency next year, and it may be useful for others to know why.

There are many reasons that I have decided to apply to general surgery residency programs this fall. During medical school, I discovered that I like the intensity of the interaction between patient and surgeon, the variety of health care issues faced while working in a clinic and an operating room, and the opportunity to master technical skills in addition to the diagnostic skills required of all physicians. Becoming any kind of surgeon could satisfy these interests, but I have chosen to practice general surgery. Although the old paradigm of general surgeons being similar to family doctors on the front lines of primary care is probably no longer true, except for in the most rural settings, the concept still appeals to me. I respect the communication and shared decision making skills that many primary care physicians possess, and I hope to emulate them in my own practice. I value practicing in a field of medicine that is accessible and comprehensible to patients. And, it is fulfilling to know that my career as a general surgeon might help fill an unmet need in the country's health care system.

Katharine L. McGinagle
Medical student
The University of North Carolina
at Chapel Hill