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Precarious future for primary care

KEITH BEDFORD/GLOBE STAFF

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r. Katie Jobbins, here with patient Stella Czelusniak, 97, at the Baystate High Street h Center in Springfield, relationships are the most important part of her practice.

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By Karen D. Brown | GLOBE CORRESPONDENT JUNE 23, 2015

SPRINGFIELD — Dr. Katie Jobbins rested her forehead in her hand, tapping her fingers rapidly as she waited for a crisis counselor on the other end of the phone to pick up. It was a busy spring day at the clinic on High Street, and one of Jobbins's regular patients needed help.

"I have a patient . . . who is actively suicidal and homicidal, who I'm going to send to the ER," she said urgently into the phone. As nurses buzzed around, Jobbins searched for the right admission forms.

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Jobbins was frustrated. For a year, she'd been treating this patient for depression and thought they had made progress. Still, she was relieved the patient knew to seek her help.

At 30, Jobbins is new to front-line medicine, and is still deciding whether to stick it out. She was among nine junior doctors at Baystate Medical Center training in primary care at a time when young doctors are more drawn to lucrative specialties than life as a family doctor. The Association of American Medical Colleges predicts a shortage of 45,000 primary care doctors by 2020.

The consequences hit everyone. As veteran doctors leave primary care faster than they can be replaced, waiting times for appointments stretch longer, and coordination of care becomes more haphazard.

"If you get people before medical school and even at the beginning of medical school, there's a huge interest in primary care," Baystate residency director Dr. Michael Rosenblum said. "And then we see that kind of peter off."

Rosenblum was delighted when the Affordable Care Act included money for new residency programs in primary care — including about 500 new residency slots each year nationally and training programs at community health centers. He considered it an opportunity to immerse young doctors in primary care, rather than just give them a taste of it while on multiple rotations.

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With that investment, Baystate Medical Center, affiliated with Tufts University School of Medicine, launched its primary care residency program in 2011.

> *'Our goal from the get-go has been to turn people on to primary care.'*
>
> R. Michael Rosenblum, Baystate Medical Center residency director

But most of the federal money for primary care training runs out later this year, even as the exodus from the field continues. Fewer than one-third of doctors in the United States today work in primary care, and that number is slipping, according to Dr. Fitzhugh Mullan, a George Washington University policy researcher.

That leaves educators redoubling their efforts to win over medical students before the system's incentives pull them another way.

"Our goal from the get-go has been to turn people on to primary care, and to turn the ship in the other direction," Rosenblum said. "Takes a long time to turn a ship, though."

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While most physician trainees spend the bulk of their time in hospital rooms and hallways, Katie Jobbins and her colleagues work long stretches at the urban clinic affiliated with Baystate.

During their three years at the clinic, they follow patients over time, monitoring their progress. There are diabetics who may improve their diets and lose weight. Women with abnormal mammograms who may undergo early treatment. Addicts who may enter recovery and improve.

But some people regress.

"This is the worst I've ever seen her," Jobbins told a colleague as she negotiated for an ambulance for the suicidal patient in spring 2014. "She won't even look me in the eye, and normally she does."

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[illegible]n a nurse came by to announce that another patient was waiting, Jobbins [illegible]d if someone else could take the appointment. Then she saw the patient's name. "She only wants to see me," Jobbins said.

Jobbins has wanted to be a doctor since she was an athletic, accident-prone teenager in Hampden. She had a close relationship with her own pediatrician — a kind man, she recalled, who wore a toy koala bear on his stethoscope.

“I broke all of my fingers once when I was in middle school running onto the tennis court with a racket in one hand and a bottle of water in the other,” Jobbins said. “He just looked at me and kind of shook his head and laughed and said, ‘OK, what did you do now?’ ”

While her closest friends studied the humanities and went into public relations, Jobbins stuck with math and science and applied to med school. After graduation, she started to train as a surgeon. She liked the idea of infiltrating a male-dominated field, and appreciated the straightforward approach: “You had a problem, you fixed it, you take it out.”

But after two years of gallbladder removals and blood vessel surgeries, she noticed something about herself. While the other surgeons tried to spend as much time as possible in the operating room, she wanted to be with patients.

So she transferred to Baystate’s primary care residency — with trepidation.

“You have to know enough about so many different diseases. Was I going to be able to keep up with this?” Jobbins said. “Was it going to burn me out?”

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Primary care doctors work long hours but make a lot less money than most specialists. A 2015 survey by Medscape, an information service for physicians, pegged the average salary for family doctors at roughly $195,000. Specialists make twice that — or even more.

“I’m trying to remind myself I didn’t go into this for the money,” said Dr. Sara Tischer, who became Baystate’s first primary care resident in 2011. “The challenge we always talked about in medical school is, how are you going to be able to pay those loans back and still have a comfortable lifestyle, and feel like all the work that you put in is not going to result in your being poverty stricken later in life?”

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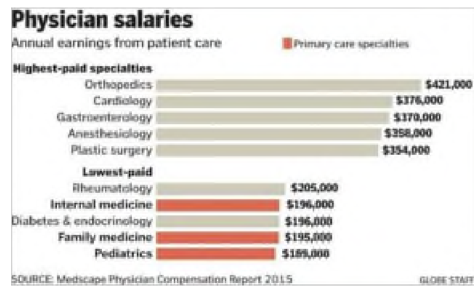

Policy specialists blame the salary discrepancy, in part, on a health care system that historically has rewarded procedures over conversations.

The bias against primary care starts, some analysts argue, in medical schools. As primary care providers face pressure to see more patients faster — while taking on more mental health and social work issues — leading medical schools have been criticized for a "hidden curriculum" against primary care. The smartest people, the message goes, don't stay in primary care.

"There are these type A, competitive people that have been at the top of their class like since kindergarten, so you get into residency, and you want to do the next competitive thing," said Dr. Gina Luciano, codirector of Baystate's primary care residency. "And you have these mentors telling you, you could do cardiology, you could do critical care — what's looked at in our culture as the most prestigious things to go into in medicine."

Of course, specialists are critical, too — and many of those fields are also shrinking. But without enough primary care doctors, analysts warn, who will act as gatekeepers to the medical complex? Watch for signs of decline? Push for healthy habits?

At Baystate, residents are encouraged to spend time not just at the low-income clinic but at more affluent private practices. They are assigned mentors who advocate for a career in primary care. And they learn how to manage the harder parts of the job — the hectic pace, the insurance paperwork.

Tischer entered medical school in her late 20s, after an early career in marine biology, because she was tired of sitting alone in a lab. As she was finishing her last year of residency, it wasn't hard to see her love of patient relationships, of playing medical detective.

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[illegible] evening, during a volunteer shift at a free clinic, she was gently checking a [illegible]r-old's itchy rash and trying to put him and his worried mother at ease.

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"Can you believe all of us are here for a rash?" she said playfully.

When a man came in later with a chronic cough, she was personable and empathetic — "That sounds like how I've been feeling!" — before prescribing ibuprofen and rest.

Tischer said she briefly tried to talk herself into other fields — psychiatry or neurology, maybe — but kept coming back to primary care. Last fall, as Baystate's first primary care graduate, she joined a private practice in eastern Connecticut, where patients were calling to get on her list before she even started.

Many of Tischer's contemporaries made different choices.

Dr. Donielle Sliwa, another primary care resident at Baystate, was at her computer one morning, staring at a roster of her patients, most of them no-shows. "If everyone comes it can be very busy, a little bit overwhelming, a little bit stressful," she said, "but then sometimes you have days where half your [schedule] doesn't show up."

A couple of months earlier, Sliwa made a tough decision. She had just come back from a trip to the Himalayas, where she volunteered at a rural clinic conducting makeshift cervical cancer screenings using a vinegar-like acid. It was during that experience that she decided to switch from primary care to hematology/oncology, a field she found "combines spirituality, religion, science, and long-term partnerships."

She knew she'd be disappointing a lot of people, including her primary care colleagues, who tease her, she said, for being a "traitor." But to Sliwa's relief, the directors of the primary care program were supportive.

"In my mind she's still doing primary care, but with a more oncologic twist to it," said Luciano, her adviser. Plus, the more specialists who start out with primary care training, Luciano said, the more they will respect what generalists do.

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Luciano admits she has been disappointed that, even as residency slots have …me highly sought after nationwide, Baystate has not always been able to fill all its primary care openings.

Advocates continue to look to national leaders and the federal government for help, especially in leveling the financial incentives between primary care and specialties. The Affordable Care Act included money to boost Medicaid and Medicare rates for primary care visits, though that funding is also set to expire this year.

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On a crisp morning last fall, at the beginning of her third year in residency, Jobbins came in late and checked her schedule. Her first patient didn’t show up. That gave her time to e-mail a woman who wanted a doctor’s note to get a bigger state-subsidized apartment. Jobbins thought about it, decided there was no medical reason for the request, and said no.

Her next patient was one of her favorites: a 59-year old woman named Rosa, who came in for a postoperative follow-up.

“How are you feeling, Rosa?” she asked through a Spanish interpreter. “Still having chest pains?”

They talked about Rosa’s medication, her nutrition, her mood. “Your blood tests look great,” Jobbins told her.

As Jobbins got up to hand her a prescription, Rosa insisted on giving her a hug. Jobbins blushed. “She really helped me the last year,” Rosa said, through her interpreter. “She’s like a counselor.” And then, to Jobbins, she said, “I got used to you.” Jobbins smiles again. “I know. I got used to you, too.”

What Rosa didn’t know was that Jobbins had just made a career-altering decision. She would be leaving primary care to become a cardiologist.

It wasn’t for the usual reasons — salary and prestige. Instead, Jobbins worried outpatient care might get monotonous, and she thought she would miss intensive hospital work. “I really do love doing primary care, but I wanted something a bit more than that,” she said.

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[illegible] started the application process for a cardiology fellowship. She interviewed with a few cardiology programs and started to gather letters of recommendation.

But as the year progressed, Jobbins took on more advanced responsibilities and found she loved teaching the younger primary care residents. Her relationships with patients, like Rosa, deepened, and by spring 2015, she reconsidered her career once more. Her "aha" moment came after a conversation with one of her mentors. If relationships are important, he told her, then primary care is the place to stay. If she wanted to spice up her practice, he assured her, she could develop specialties within primary care, such as nutrition or heart-disease prevention.

What finally tipped the balance was personal. Jobbins's sister moved back to Western Massachusetts and couldn't find a primary care doctor.

"She didn't even know where to start," Jobbins recalled. "They're so filled to the brim with appointments. And I wanted to be able to go back to the community I'm from and make sure they have the resources they need."

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