Family Physicians of Old Town Fairfax
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President Barack Obama
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500
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Dear President Obama,

I am a 48 year old board certified family physician, with added qualifications in geriatric medicine who has been in private practice in Fairfax, Virginia for over twenty years. I am the father of four children ranging in age from nine to 15. I am writing to express my concern for the future health of my family, my patients, and for the citizens of this great country. Instead of just complaining, I would like to offer some practical suggestions to improve our health care system. I am very apprehensive about the socialization direction our medical system appears to be heading and the negative impact it will have. Although our current health system is far from perfect and needs adjustment, I have trepidation about the rapid pace in which our government is moving to permanently change our health care system and not necessarily for the better. On the first day of medical school, we were taught "Primum non nocere"--First Do No Harm. We learned that the treatment may be worse than the disease.

Tort reform, standardizations of computerized records, and streamlining of the insurance process need to be addressed. We family physicians are being smothered with paper work requiring pre-authorizations for referrals, medication, tests and procedures. These pre-authorizations take up an enormous amount of staff time, are very costly and detract from patient care. The bureaucracy needs to be tamed. To have a lasting positive long term impact on our country's health while controlling costs (regardless of the system chosen), we must increase the supply of **quality** primary care physicians.

A qualified, board certified primary care physician will evaluate and treat multiple conditions in one office visit. It is common for me to evaluate a patient for hypertension, hypercholestermia, diabetes, insomnia, fatigue and back pain in a single office visit. The specialist is trained to evaluate and treat one ailment at a time at a much higher pay scale. Our current health care system has economically encouraged physicians to sub-specialize resulting in a growing shortage of well qualified practicing primary care physicians. In general specialist physicians work fewer hours, have less overhead, and are more generously paid. This has resulted in our health care

system having more specialists and fewer generalists. We have an upside down pyramid resulting in much higher medical costs for all. Ideally, primary care doctors should be handling primary care problems, not specialists.

A well trained family physician can handle 85 to 90 percent of the problems in his office in a cost effective manner. He is a specialist in common diseases and will only refer out to specialist for problems that require specialty care. I tease my sub-specialist colleagues about the old story about the seven blind men and the elephant. Each of the blind men has a different description of an elephant based on what part of the body they are feeling. The blind man feeling the trunk likens the elephant to a snake while the man feeling ears reports the elephant is like a fan, the one feeling the elephant's feet compares the elephant to a tree trunk etc… A well trained family physician takes the bird's eye view of a patient. He is the one with the eyes and sees the big picture. The specialist has tunnel vision and is trained to focus on only one specific area. Furthermore, family physicians offer preventative health care which may result in cost savings and improve the quality of life for patients.

There is no glory in prevention so it is tough to prove that because of an intervention a person did not get sick. Many of our victories in overcoming disease through prevention take years to realize. Many of the medications we use to prevent disease have side effects. When a patient gets a side effect to a medication, it is easy to place blame and condemn that medication. But when the medication is effective, such as in lowering cholesterol or blood pressure, it is difficult to prove that in an individual patient it prevented a fatal heart attack or stroke. Taking the time to discourage a teenager from smoking, or counseling a patient predisposed to diabetes about his/her diet may not be glamorous, but it will pay dividends in better health with overall lower costs in the future. Some of my patients are like the Titanic heading for the iceberg of diabetes. If I can alter their course even a little bit, they may avoid disaster. There is no glory (and no direct monetary payment) in prevention. As a family doctor, I take a holistic view and treat the entire patient, not just an organ system. I offer preventative care because it is good medicine.

A patient who presents to my family practice office complaining of headache pain will have a workup done in a logical, stepwise, cost effective manner. The vast majority of my patients responds to initial treatment and do not require a specialty consultation. If the patient does not respond to primary care treatment, then I will gladly refer him for a specialty opinion with a neurologist. When I hear gallops I look for horses and usually find them. If I don't see any horses then I will refer to a sub-specialist who is trained to look for the far less common zebras.

The problem with a sub-specialist (such as a neurologist) being the first physician to evaluate a common problem is the buck stops with him. When I as a primary care physician refer to a specialist, that specialist assumes that the patient has already had a basic work up and requires more intensive evaluation. Most neurologists will initially order a battery of tests including a radiographic scan of the head, (head CT or MRI of the brain), an electroencephalogram (EEG), a lumbar puncture, and lab work as an initial evaluation for a patient with headache. This is expensive and appropriate only if the patient has already been worked up adequately by his family doctor. The neurologist (without a referral from a primary care doctor) is evaluating a primary care problem from a specialist perspective. This is very expensive and does not result in

a better outcome. The neurologist is worth his salt only if his skills are effectively used by the patient has already been adequately evaluated by a well trained primary care physician.

In my opinion, there are not nearly enough competent board certified family physicians, pediatricians, and internist to meet the demand necessary to run our medical system in a cost effective and efficient manner. A poorly trained, over worked, exhausted primary care doctor (or nurse practitioner) often times acts as a traffic cop triaging any medical problem to a specialist for further care. This just aggravates the costs. We have too many specialist evaluating primary care problems.

It literally takes years to train a competent cost effective family physician or internist. Their value to our medical system is vastly underestimated and underappreciated. A competent well trained family physician can save literally millions of dollars per year while a poorly trained general practitioner or nurse practitioner can waste millions. The family doctor is the low man on the economic ladder of medical doctors. This lack of respect and relative lack of income discourages many of the best and brightest United States medical graduates from even entering a primary care specialty. One of the barriers to attracting medical students into family practice is their high student loan debt relative to the income potential of a family doctor. With education debt skyrocketing, many medical school graduates cannot afford to enter into a primary care specialty such as family practice, pediatrics, or general internal medicine. They can make up their huge investment in time, money and sweat much more quickly by entering into a subspecialty. For example, the training time for a dermatologist, or an anesthesiologist, is the same as for a family physician, internist or pediatrician, but their income potential is much higher. Some medical students have indicated they would consider family practice but they cannot afford to go into it because of their student loans. I have heard many physicians express the sentiment that a medical school graduate would be foolish to enter a primary care specialty from a business perspective.

In recent years, the number of American medical school graduates opting to go into primary care has continued to decline. In fact, the percentage of Family Practice Residency programs filled by American medical school graduates is less than 50 percent. This means that over one half of the United States residency positions are filled by foreign medical school graduates. These graduates of foreign medical schools may be very bright and motivated, but in general from my experience, they are not as prepared to excel in primary care medicine. There are many cultural and language barriers for them to overcome. Communication is one of the great keys in delivering quality cost--effective medicine. This is personally distressing to me as I have had a difficult time hiring well trained and dedicated family practice graduates motivated to make a career of practicing family medicine. There is a growing need in Fairfax as well as the rest of the country to attract skilled physicians into primary care medicine.

I am the owner of my practice and I employ three other board certified physicians--two full-time and one part-time. As a family physician and a geriatric specialist, it pains me to turn away elderly patients needing care as my practice can no longer accept new Medicare patients. We are at capacity and I have not found a suitable physician to hire. Our emergency rooms across the

nation are overwhelmed with patients--many who do not have a primary care physician. This results in increased costs, lower quality of care due to lack of continuity, and prolonged waiting times which could be life threatening to a patient with a true emergency.

In addition, the prestige of practicing in a primary care specialty has eroded with the inaccurate perception that physician adjuvant such as nurse practitioners or physician assistants can do an equivalent job delivering medical care at a much cheaper cost. This results in a downward spiral whereby American medical students shun the primary care specialties and that void is filled by foreign medical school graduates and nurse practitioners. In general foreign medical school graduates are not as rigorously trained in their medical schools. Nurse practitioners have only 18 months of instruction after nursing school to obtain their nurse practitioner diploma. Often, they may not know what they do not know. It is hard to consider a diagnosis if you have never heard of it. Their educational training and qualifications are much less intense than that required of a medical doctor. The legal profession does not have paralegals litigating capital murder cases for good reason. There are many people who claim to play golf but few who can do it well enough to earn their living as a professional. Interesting, I do not see nurses doing appendectomies, cholecystectomies, joint replacement, colonoscopies, nor brain surgery, but they are allowed in some states to practice medicine and prescribe drugs without a medical degree or supervision from a qualified physician. In a misguided effort to control costs, are nurses going to be performing surgery? When your or a loved one's health is on the line, you want the most competent professional to treat you. The end result of using less qualified health providers is a lower quality of health care at a higher cost.

There is a place for nurse practitioners and physician assistants in our medical system. They do best when they are practicing in a narrow based specialty or specialized field such as doing prenatal care or neonatal intensive care medicine. They do not have the depth of training to acquire the broad based knowledge necessary to practice primary care medicine in a cost effective, efficient manner. They tend to refer primary care problems to specialists raising medical costs for all. Medical sub specialist such as cardiologists will lose their skills in practicing primary care after a few short years away from it. If you don't use it, you lose it.

One possible solution which may cost more in the short run, but will be far cheaper in the long haul is to offer a loan forgiveness program for American medical school graduates opting into a primary care specialty. I would recommend that the graduate would have to have graduated from an accredited
American medical school, complete an accredited three to four year residency in a primary care specialty (family practice, general internal medicine, pediatrics), and practice full-time in that specialty for a minimal number of years. (I would suggest seven to 10 years after residency). In return and after meeting the above requirements, their student loans would be forgiven at up to $200,000 or they could opt for a tax free payment of $100,000. This would be available only to current medical students enrolled in accredited United States medical schools and future graduates. There should be no grandfather clause.

Another possible solution would be to encourage a higher reimbursement for primary care

services, preventative health care and mental health care. I understand that the issues surrounding health care are nationwide, very complex and will take years to adequately solve. My goal is to improve the quality of primary care physicians by encouraging our best American medical school graduates to opt for a primary care medical career. This would ultimately lower costs and improve health care for everyone.

I have been in practice long enough to be financially secure. I was fortunate to obtain my education at state supported public schools so my debt load was very low relative to today ‘s graduates. Despite the challenges, I am glad that I chose to become a family physician. However, I feel like the Indiana Jones character outrunning the fireball exploding just behind me. I am fast enough and far enough away to escape disaster, but younger physicians who chose family practice, general internal medicine, or pediatrics as a career are at high risk to be engulfed in the flames. Something needs to be done soon to begin fixing the broken system or it may never be repaired satisfactorily.

In summary, to improve our health system, we need to train more quality primary care doctors. There need to be economic incentives in place in the form of tuition assistance or loan forgiveness to recent medical school graduates who enter and complete a primary care residency. The compensation for a primary care must be increased to attract qualified people into the field. To ignore the shortage of primary care doctors and to try to replace them with less qualified providers is short sighted, and will further increase overall costs while being a detriment to our country’s health.

Obviously, you are very busy, but I invite you or your representative to spend a day in my office to get the feel of a well established, computerized family practice.

Thank you for your time and consideration.

Sincerely,

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