When the Best Hospitals Are the Worst

If you had $13 billion to train doctors, how would you spend it?

Dr. Helen B. Taussig, co-developer of the "blue baby operation," at Johns Hopkins Hospital in 1968. The hospital's pediatric cardiac center is now named in her honor. (William A. Smith / AP)

Assume we successfully get health insurance for 32 million more Americans. Not a single person "falls through the cracks." Every aspect of Obamacare launches and integrates perfectly. The exchange websites are beautiful and intuitive; every state with gaps conjures an elegant fix. There's a quantifiable change in barometric pressure as the nation collectively sighs.

What does it mean to be able to afford care if no one is there to provide it?

The moment would be fleeting. Panic resumes when the newly insured try to get appointments to see doctors. Overbooked, miles away, or otherwise inaccessible; what does it mean to be able to afford care if no one is there to provide it? Within the decade, the U.S. physician shortage will be around 91,500, with about half of them in primary care. Already today, 60 million Americans live in federally designated primary care shortage areas.

That's the picture painted by demographer and senior research fellow with the New America Foundation Phillip Longman in the current issue of *Washington Monthly*, where he takes a thoughtful at look at how federal dollars spent training physicians are distributed.

Residency training programs, which are the on-the-job work done after graduating from medical school but before doctors fly solo, are paid for by federal taxes. It costs the government around $100,000 per year to train one doctor. (The resident gets about $50,000 in salary, and the hospital gets the other half.) The 759 institutions in the U.S. with residencies get a total of around $13 billion federal dollars every year.

But many hospitals aren't using that money to do what the taxpayers most need. 158 of them produce zero graduates that go into primary care. The worst offenders, in terms of the number of primary-care physicians produced, are the hospitals we hold in highest regard. Those perennially among the "top hospitals" in nebulous magazine rankings: Mass General, New York Presbyterian, Cleveland Clinic, Brigham and Women's, Stanford, Washington University in Saint Louis, etc.

Training at these places comes with prestige, credibility, esteem. It's valued among patients searching the Internet to find a new doctor, and has cachet within the physician job market. Yet data from the Graham Center at George Washington University puts all of those among the 10 worst institutions in terms of producing the doctors that the U.S. most needs.

Longman describes the scene at Johns Hopkins:

> ... Its teaching hospital in Baltimore towers over a low-income neighborhood designated by the federal government to be suffering from a shortage of primary care doctors. Yet between 2006 and 2008, of the 1,148 residents who graduated from Hopkins's residency programs, only 8.97 percent went into primary care. Only two graduates went on to practice in a federally qualified public health clinic, and not one participated the National Health Service Corps, a program designed to encourage doctors to practice in underserved areas. In 2009, Hopkins residency programs costs the taxpayers $80.7 million.

The problem is not new; even in the 1960s there was talk of overspecialization as a burgeoning problem. Longman traces the roots back earlier, when after World War II General Omar Bradley started using the Veterans Administration hospitals to train new doctors, and got federal money for doing so. Then in 1965, the passage of Medicare guaranteed subsidies to private institutions, as well, for medical training.

Longman also profiles the now-prototypical overworked, underpaid primary care physician:

> Linda Thomas-Hemak grew up in a small town outside of Scranton. Inspired by the example of her family's physician (an old-fashioned doctor named Thomas Fadden Clauss who still made house calls in the snow), she made her way through medical school and then on to Harvard's combined medicine and pediatrics residency program at Massachusetts General Hospital. She was on her way to becoming chief resident at Mass General, she says, when she was drawn back to her roots, returning to Scranton in 2000 to join her aging mentor in his local practice.
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> She soon discovered, however, that being a modern-day primary care doctor, especially in a medically underserved area like Scranton, left her with little time to breathe. In short order she found herself responsible for 2,600 patients. "I felt I could never get a cold or take a sick day," she says. "I felt so far away from Harvard." She felt frustrated, too, that so many of Scranton's aspiring young doctors would become

discouraged by the lessons they took from seeing how she and her colleagues were struggling. "At the end of the day you take bright, idealistic, and Pollyannaish students and expose them to that, what do you think will happen?"

Thomas-Hemak's experience led to the founding of The Wright Center which, like some VA primary care clinics, is becoming a model of integrated team-player primary care training. ("The mission of the Wright Center is to provide excellent graduate medical education in an innovative and collaborative spirit in order to deliver high-quality, evidence-based and patient-centered care to the communities we serve.")

Addressing the shortage in said communities comes down to realigning incentives. Even for the noblest of selfless primary care physicians, it means getting days off, getting enough time with patients to establish fulfilling relationships, and making enough money to pay off student loans easily. It means some degree of prestige and respect without training at a *big-name* institution -- perhaps *because* they didn't. It means being held in the same regard as the physicians who get their names in textbooks for pioneering niche cutting-edge surgeries at ivied institutions. Feeling like their patients can get follow-up care in a network of other community care providers, so they aren't just treading water refilling prescriptions, alone against the tide.

Longman's fix: "Congress needs to demand that [residency]-sponsoring institutions increase their production of primary care doctors and of other health care professionals of the kinds we need, or risk losing their subsidies."

That is, for example, to tell Hopkins that they're welcome to continue to train as many high-earning sub-sub-specialists as they choose -- to be, say, the best place in the world to be treated if you have an ultra-rare ear tumor that affects one in 700 billion people. Or to do pioneering work in neonatal cardiac transplants. We need institutions like that. But are they the best places to invest our finite amount of training money? If Hopkins can't produce more of the doctors that the nation most urgently needs, then more of their $80.7 million annual subsidy would be directed to places that can and do.

Longman concludes:

Within today's rising Millennial generation, there is a wellspring of idealistic young people trying to be part of the solution to America's health care crisis by becoming team players in primary care and community-based medicine. This is true despite compounding student loans and often the prospect of forfeiting enormous potential future earning streams by not going into lucrative specialties. But the greatest obstacle of all is an incumbent system of graduate medical education that with too few

exceptions crushes their idealism and teaches a hidden curriculum of counterproductive values and attitudes.

It may be idealistic in itself to presume that Millennial idealism translates into motivation or ability to solve any crisis, much less health care. But I know there are at least some Millennials who want to do things other than improv classes and selling artisinal knots on Etsy and never owning a house. Systemic change might at least give them an opportunity to channel idealism into health reform.

Of course every medical student should be able to practice the kind of medicine that most interests them, and world-class academic hospitals must continue to train world-class academic specialists. Right now, though, the U.S. either invests more than the current $13 billion every year to train doctors (which would be kind of a drop in the $3 trillion health-care spending bucket), or redistributes it to the places that are creating more primary care physicians per dollar.

Primary care physicians save money across the system, stemming problems before they require expensive specialist interventions. Training them should be the newest metric of institutional prestige. When we don't invest enough in them, everyone feels the costs. And a nation of overbooked, unavailable primary care doctors could mean that for all our worries, as the Association of the American Medical Colleges has said, Obamacare would essentially provide "insurance in name only."