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When the Doctor Is Not Needed

There is already a shortage of doctors in many parts of the United States. The expansion of health care coverage to millions of uninsured Americans under the Affordable Care Act will make that shortage even worse. Expanding medical schools and residency programs could help in the long run.

But a sensible solution to this crisis — particularly to address the short supply of primary care doctors — is to rely much more on nurse practitioners, physician assistants, pharmacists, community members and even the patients themselves to do many of the routine tasks traditionally reserved for doctors.

There is plenty of evidence that well-trained health workers can provide routine service that is every bit as good or even better than what patients would receive from a doctor. And because they are paid less than the doctors, they can save the patient and the health care system money.

Here are some initiatives that use non-doctors to provide medical care, with very promising results:

PHARMACISTS A report by the chief pharmacist of the United States Public Health Service a year ago argued persuasively that pharmacists are “remarkably underutilized” given their education, training and closeness to the community. The chief exceptions are pharmacists who work in federal agencies like the Department of Veterans Affairs, the Department of Defense and the Indian Health Service, where they deliver a lot of health care with minimal supervision. After an initial diagnosis is made by a doctor, federal pharmacists manage the care of patients when medications are the primary treatment, as is very often the case.

They can start, stop or adjust medications, order and interpret laboratory tests, and coordinate follow-up care. But various state and federal laws make it hard for pharmacists in private practice to perform such services without a doctor’s supervision, even though patients often like dealing with a pharmacist, especially for routine matters.

NURSE PRACTITIONERS In 2012, 18 states and the District of Columbia allowed nurse practitioners, who typically have master’s degrees and more advanced training than

registered nurses, to diagnose illnesses and treat patients, and to prescribe medications without a doctor's involvement.

Substantial evidence shows that nurse practitioners are as capable of providing primary care as doctors and are generally more sensitive to what a patient wants and needs.

In a report in October 2010, the Institute of Medicine, a unit of the National Academy of Sciences, called for the removal of legal barriers that hinder nurse practitioners from providing medical care for which they have been trained. It also urged that more nurses be given higher levels of training, and that better data be collected on the number of nurse practitioners and other advance practice nurses in the country and the roles they are performing. Tens of thousands will probably be needed, if not more.

Mary Mundinger, dean emeritus of Columbia University School of Nursing, believes highly trained nurses are actually better at primary care than doctors are, and they have experience working in the community, in nursing homes, patients' homes and schools, and are better at disease prevention and helping patients follow medical regimens.

RETAIL CLINICS Hundreds of clinics, mostly staffed by nurse practitioners, have been opened in drugstores and big retail stores around the country, putting basic care within easy reach of tens of millions of people. The CVS drugstore chain has opened 640 retail clinics, and Walgreens has more than 350. The clinics treat common conditions like ear infections, administer vaccines and perform simple laboratory tests.

A study by the RAND Corporation of CVS retail clinics in Minnesota found that in many cases they delivered better and much cheaper care than doctor's offices, urgent care centers and emergency rooms.

TRUSTED COMMUNITY AIDES One novel approach trains local community members who have experience caring for others to deliver routine services for patients at home. Two pediatric Medicaid centers in Houston and Harrisonburg, Va., have tested this concept to see if it can reduce the cost of home care and avoid unnecessary admissions to a clinic or hospital.

The aides are trained to consult with patients over the phone by asking questions devised by experts. A supervising nurse makes the final decisions on the care a patient requires. The community aide may visit the patient, provide care in the home and send photos or videos back to the supervising nurse by cellphone.

The aides are typically paid about \$25,000 a year, according to an article in Health Affairs by the pilot study's leaders. The study concluded that the program would have averted 62 percent of the visits to a Houston clinic and 74 percent of the emergency room visits in Harrisonburg.

The aides cost \$17 per call or visit, compared with Medicaid payment rates of \$200 for a clinic visit in Houston and \$175 for an emergency room in Harrisonburg.

SELF-CARE AT HOME A program run by the Vanderbilt University Medical Center and its affiliates lets patients with hypertension, diabetes and congestive heart failure decide whether they want a care coordinator to visit them at home or prefer to measure their own blood pressure, pulse or glucose levels and enter the results online, where the data can be immediately reviewed by their primary care doctor. The patient could consult by phone or e-mail with a nurse about his insulin dosage, but there would be no need for a costly visit to a doctor.

Taking this idea a step further, a hospital in Sweden, prodded by a kidney dialysis patient who thought he could do his own hemodialysis better than the nursing staff, allowed him to do so and then teach other patients, according to the Institute for Healthcare Improvement, a nonprofit organization in Cambridge, Mass. Now most dialysis at that hospital is administered by the patients themselves. Costs have been cut in half, and complications and infections have been greatly reduced.

HEALTH REFORM LAW The Affordable Care Act contains many provisions that should help relieve the shortage of primary care providers, both doctors and other health care professionals.

It provides money to increase the number of medical residents, nurse practitioners and physician assistants trained in primary care, yielding more than 1,700 new primary care providers by 2015. It offers big bonuses for up to five hospitals to train advanced practice nurses and has demonstration projects to promote primary care coordination of complex illnesses, incorporating pharmacists and social workers in some cases. And it offers financial incentives for doctors to practice primary care — like family medicine, internal medicine and pediatrics — as opposed to specialties.

These are all moves in the right direction, but they will need to be followed by even bigger steps and protected from budget cuts in efforts to reduce the deficit.

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