UNDER MY SKIN

Who Will Take Care of the Patients?

BY ALAN ROCKOFF, M.D.

My last student confirmed it: Derm is indeed white hot. Only the very brightest dare apply, she told me, and even they face long odds. One of her top classmates who failed to match in dermatology has taken a year off to do the research he needs to buff his resume.

An earlier column that told of my experience hiring a physician assistant (PA) drew some strenuous responses ("Associates," September 2002, p. 10). A few of these accused dermatologists like me who engage so-called physician extenders—PAs and nurse-practitioners (NPs)—of irresponsible venality.

When my PA gave unexpected notice last year, I considered taking on a graduating dermatology resident. Directors at nearby training programs agreed to post my opportunity but said they weren't sure how many in their graduating cohort actually planned to enter practice. I got no bites.

Shortly after that I spoke with a consultant, who shared some statistics that I quote without being able to guarantee. He said the number of trainees sitting for the dermatology boards each year roughly approximates the number of practitioners who retire, but residents intending to practice are in fact much fewer. The rest, he said, "are interested in laser and Mohs."

Later in the year I had a chance to confirm these comments, if only anecdotally. Interviewing two men about to finish their training, I learned that several of their fellow residents were indeed heading for careers other than practice: cosmetic or Mohs fellowships, or leaves of absence for family reasons.

Attracting such applicants is indeed cause for optimism that a new generation of this caliber may make discoveries that will benefit patients and society at large. A small doubt, however, nags.

Caring for patients with everyday conditions offers many rewards and demands special skills, but high-octane intellect and entrepreneurial moxie are perhaps not among them.

If I am a super-bright young dermatologist with research credentials and interest, how will I view the quotidian task of managing acne, warts, and eczema?

Several trends therefore seem to point to this problem: If trainees see dermatology as an avenue to do exciting research, learn sophisticated technical skills, or advance lucrative cosmetic careers, then who will take care of the patients?

This is not a rhetorical question. In other countries dermatologists function as secondary or even tertiary consultants. Primary care of skin disease is the province of other practitioners. In principle, there is no reason internists, family physicians, and pediatricians shouldn't manage basic skin problems in the United States as well, but those of us who field referrals from these groups are continually amazed—and appalled—at what a poor job they often do.

The near absence of dermatology teaching in medical school explains a lot of this, of course; the standard curriculum imparts not just limited skin knowledge but an implicitly dismissive attitude toward caring for the banal complaints of ordinary people.

There should thus be no surprise at the burgeoning of "physician extenders" (a barbarous term that conjures up "Hamburger Helper"). Dermatology PAs have for some time had a vigorous organization, the Society of Dermatology Physician Assistants. Dermatology NPs are likewise getting their act together. Near Boston the prestigious Lahey Clinic Medical Center has a new training program for dermatology NPs.

What distinguishes such practitioners is that they actually want to do clinical work. They view caring for patients with everyday problems not as a distraction from their main career, but as its fulfillment. In light of evolving trends in dermatology training and practice, perhaps our profession ought to support and guide the proliferation of dermatology NPs and PAs rather than decrying or ignoring it.

If research provides new treatments, who will administer them? When patients need help, who will take care of them? ■

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"I know we all have group insurance, but this is ridiculous."

PRO & CON

Will health savings accounts leave people vulnerable to bankruptcy?

YES

When we studied more than 900 people who had filed for personal bankruptcy, more than half of them cited medical causes (Health Aff. [Millwood] Feb. 2, 2005; [Web exclusive]). This was true even though three-quarters of the debtors had health insurance at the onset of their illness. Of those, the majority had private coverage, although a third of those with private coverage lost it during the course of their illness. Those who were on public programs such as Medicare and Medicaid were much less likely to experience gaps in health coverage.

Not surprisingly, a lapse in health insurance coverage during the 2 years before filing was a strong predictor of a medical cause of bankruptcy. Nearly 40% of the debtors who had a "major medical bankruptcy" had experienced a lapse in coverage, compared with 27% of debtors who did not have a medical cause. Of those who didn't have coverage, 56% said that premiums were unaffordable, 7% couldn't get coverage because of a preexisting condition, and most others cited employment issues.

A health savings account, which involves patients paying for their care up to a certain dollar amount, after which a catastrophic coverage policy kicks in, probably would not have helped most of these people. That's because debtors' out-of-pocket medical costs were often below levels that are commonly labeled "catastrophic." In the year before their bankruptcy, out-of-pocket health care costs—not counting insurance premiums—averaged $3,686.

Of course, any coverage that's employer based—as many of these health insurance policies were—often fails to protect families, because illness may lead to job loss and the consequent loss of coverage.

Only broad reforms can address these problems. As it is in Canada and most of western Europe, health insurance should be divorced from employment to avoid coverage disruptions at time of illness. The low rate of medical bankruptcy in Canada suggests that better medical and social insurance could greatly ameliorate this problem in the United States. ■

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NO

Undoubtedly some families do indeed have a problem when they get sick or injured and they lose their jobs and their health insurance as well. But the study discussed at left provides absolutely no information about those families. Their real plight is lost in an effort to exaggerate and overstate the case. All credibility is lost in the hyperbole.

Solutions to these problems are not hard to find, however. Putting everyone on Medicare clearly is not the solution, since the study's conclusion shows that Medicare is no protection against bankruptcy.

But enabling people to own their own insurance plan would help. That would allow people to keep their coverage even when they become too ill to work and lose their job.

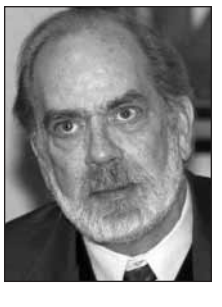
The best remedy might be widespread adoption of Health Savings Accounts (HSAs). People who are able to save money in an HSA while they are healthy have a nest egg to fall back on when they become ill and incur extraordinary medical expenses, or when they lose their job and have to pay their own premiums.

Critics argue that HSAs will "fragment the insurance pool" by taking out all the healthy people. But there is no "insurance pool" in the United States. There are tens of thousands of insurance pools, none of which subsidizes the others. Each individual pool pays only the costs of its own enrollees. HSAs do not change that.

President Bush's proposal to create refundable tax credits to help lower-income people afford health insurance coverage would provide further assistance. Those people who can no longer work and enjoy the benefit of an employer subsidy would be able to get help from the federal government instead.

So we can be grateful that Dr. Woolhandler and her colleagues have published this study.

Though it is grossly exaggerated, it does call attention to a need for which consumer-driven health care is the much better solution. ■



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