Examining American Family Medicine in the New World Order

A Study of 5 Practices

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BACKGROUND. In the last decade managed care has become the major form of health care delivery in the United States. Though some persons believe that managed care is the salvation of family practice, critics claim that it threatens many of the core concepts of primary care. We systematically examined 5 US family practices, to provide a microanalysis of the current situation, particularly from the viewpoint of the care providers.

METHODS. During 1997 and 1998, case studies were conducted at 5 sites using long interviews, focus groups, and extensive participant-observation of provider-patient and provider-staff interactions. Participants included 54 health care providers, 18 administrators, 45 nurses or nursing assistants, and 30 ancillary staff at the sites.

RESULTS. We found dominant themes of rapid change, disruption, increased demands, interference in clinical decision making, and adaptation. Health care providers have the perception of being in the midst of a revolution with disruptions of key relationships and local knowledge. The clinicians in the study feel a loss of certainty, control, and autonomy.

CONCLUSIONS. There appears to be a rampant ideologic competition occurring between business and beneficence for the moral sensibilities of family medicine providers. This is potentially hazardous to feelings of trust in the provider-patient relationship. The focus of much of the warring has been on managed care, though many of today's problems either predated its development or were peripheral to it. More empirical and observational studies are needed to document the fundamental changes taking place in today's health care environment.

KEY WORDS. Managed care; family practice; primary care; qualitative research, trust. *(J Fam Pract 1999; 48:620-627)*

Managed care continues to grow rapidly in the United States, both in terms of absolute numbers and its effect on the health care system. Though managed care originated here in the early 1900s as pre-paid group practices, real growth did not accelerate until the passage of the federal Health Maintenance Organization (HMO) Act in 1973. Total enrollment in HMOs rose 58% between 1993 and 1996, and by 1997, half the population and nearly three quarters of insured working Americans were in some type of managed care plan.[1-2]

Though proponents see managed care as the savior of family practice, critics claim that it threatens many of the discipline's core concepts. There is particular concern for the preservation of the physician-patient relationship.[3-5] Elements of managed care's very structure and organization are claimed to be the source of conflicts and ethical dilemmas for providers,[6-8] constraining or otherwise negatively affecting the provider-patient relationship.[9] What was traditionally (and perhaps mythically) considered a dyadic relationship between the clinician and the health care consumer has been potentially jeopardized by a new triangular interaction: the patient–provider–managed care/health insurance bureaucracy.

To date, such allegations are primarily opinion; there is an absence of sound empirical or observational data to support or refute these charges. This is a particularly serious void given the growing importance of the subject, the rapid changes in the field, and the current ideologic nature of the free-market health care debate. The objective of our research was to provide a systematic microanalysis of the state of American family practice, giving particular attention to the effects on health care providers.

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METHODS

Sites and Subjects

Case studies were conducted at 5 family practice groups in Massachusetts and Pennsylvania, the states ranked second and eighth, respectively, in terms of HMO market penetration with 42% and 21% of their residents enrolled.[1] To increase generalizability, efforts

TABLE 1

Practice Site Characteristics

	Setting	Patient Diversity	Provider Full-Time Equivalents	Male/Female Provider Ratio	Insurance Plans Accepted	Total Billings, % Managed Care	Covered Lives
1P	Urban group practice and training site	Multiple ethnic and economic	1 MD 0.5 NPT 3 Resident	2/1 0/1 6/6	13 contracts Almost all others accepted	49	1500 Cap 0 FFS
2M	Urban and suburban community health center	Diverse ethnic and economic	8.75 MD 5 NPT 1 PA	5/5 0/5 1/0	12 contracts. Bill 250 and almost all others accepted	58	1500 Cap 2300 FFS 1400 Medicaid
3S	Suburban group practice	White poor, working and middle class	7 MD 2 NPT 1 PA	4/3 0/2 0/1	27 contracts Almost all others accepted	45	5000
4W	Urban group practice	White middle and upper middle class	1.5 MD 1 NPT	1/1 0/1	16 contracts. Almost all others accepted	50	2000 Cap 1800 FFS
5F	Small urban and rural group practice and training site	Diverse ethnic and economic	2 MD 6 Resident	1/2 3/3	45 contracts. All others accepted	63	963 Cap 1787 FFS

NPT denotes nurse practitioner; PA, physician assistant; Cap, capitated patients; FFS = fee-for-service patients; Covered Lives, patients for whom the practice carried contractual responsibility to a managed care or insurance company for some type of case management or global medical care.

were made to provide a balanced mix of urban, suburban, and rural practices serving diverse patient populations (Table 1). Site preference was given to practices affiliated with independent practice associations (IPAs), since these are the dominant form of HMO in the United States.[1] Each practice contracted with several managed care companies (range = 12 - 50), either directly or through their IPAs. Such contracts accounted for approximately 50% (range = 45% - 63%) of total billings.

The number of physicians at the sites varied from 1.5 to 9 full-time equivalents (FTEs). All physicians were board-certified family physicians, except one general internist-pediatrician, and 2 family practice residents. Mid-level providers or their trainees (nurse practitioners and physician assistants) were present at all sites. All practices were owned at the onset of the research by vertically integrated, not-for-profit health care organizations, except one, which was an independent not-for-profit community health center. Care providers were salaried, though individual contracts contained varying incentive plans.

Data Collection*

We conducted pilot studies in 1996 and 1997 to gain familiarity with the issues, focus research efforts, refine the data collection tools, and test the feasibility of the study.

Data collection at the 5 practices was conducted between June 1997 and March 1998. Each case study used multiple qualitative methods including participant-observation,[10-11] focus groups,[12-14] long interviews,[15-16] and the analysis of key texts.[17] These techniques were chosen because of their ability to identify key issues, record actual behavior in its context, elucidate lived experience, generate unexpected insights, and bring to light the shared meanings, cultural categories, and mental world of informants.

The chief investigator, serving in a capacity of family physician-anthropologist, observed and participated in more than 900 patient encounters, and attended staff meetings, hospital rounds, utilization reviews, and in-service training. Participant observation at each site varied from 1 to 4 months and direct contact ranged from a minimum of 90 hours to a maximum of 350 hours. Individual long interviews were conducted at the sites with all health care providers (physicians, nurse practitioners, and physician assistants, [n=54]), administrators (n=18), nurses or nursing assistants (n=45), and ancillary staff (n=30). In addition to being interviewed individually, 24 physicians participated in focus groups using a prearranged moderator's guide consisting of general questions supplemented by probes. Analyzed key texts included training and administrative manuals, brochures, financial and mission statements, policy guidelines, and historical documents from each site.

Informed consent was established through departmental memos or verbal discussions with physicians, administrators, and staff, as well as before every interview and

*For a more detailed account of our data collection methods, please visit the *Journal's* Web site at www.jfampract.com.

focus group. Field notes of the participant-observer were recorded each day, while process notes were kept of interviews and focus groups. All focus groups and interviews, except those with ancillary staff, were also audiotaped for later transcription and analysis.

Data Analysis

Immersion-crystallization was used to analyze the data. This involves concentrated textual review of the data, with concerned reflection and intuitive insights, until reportable interpretations become apparent.[18-19] Cycles of data collection followed by data analysis and refinement of study tools were repeated until interpretations were formulated and verified. Triangulation[14,15,18-20] of data sources and searches for alternative interpretations and negative cases were also stressed as part of the analysis.

To assist with the verification of the accuracy of the interpretations, the investigator returned to each practice site to present findings and receive feedback. Most interpretations were confirmed during the ensuing discussions, and when inconsistencies arose, further review of the data and consideration of alternative interpretations was undertaken.

RESULTS

The care providers at the sites generally reported the sense of "doing better, but feeling worse" during interviews, focus groups, and informal discussions: the salaries and status of family practitioners have improved dramatically in the last 5 years, but so has the sense of discontent. Primary care's central role in managed care has led to an increased demand for the discipline, and recruiting primary caregivers is a high priority among hospital organizations. Family practice physicians for the first time have taken seats on health care institutional boards and have entered the upper echelons of administration. As one family medicine department chief noted, "Twenty years ago I felt like we were outside throwing stones at the institution; now we're driving the bus." Although they perceive that primary care has "come of age," many speak of being less happy in their profession than in the past and complain of varying levels of demoralization. There were physicians at 4 of the 5 groups who had recently left the group to replace practicing family medicine with less demanding forms of primary care, alternative medicine, nursing home administration, or early retirement. Those that remain have many concerns and fears, most notably regarding rapid change, disruptions of relationships, increased demands, and interference in clinical decision making. To clarify which data sources support or refute these interpretations, notations are provided throughout the text: I = interviews; F = focus groups; P = participant-observations; E = patient encounters; and D = textual or historical documents.

Change and Disruption

In the words of the medical director of a family practice group in Massachusetts, "Revolutionary change happened here. Got on the slippery slope, starting thinking of medicine as a business, physicians started sounding like CEOs, all decisions started being in terms of dollars. You go down that path long enough, take small steps, and even though you know it's wrong, you've taken so many little steps already, you go and do it...You've been talking the talk long enough, it doesn't seem strange." (I)

Even though the managed care organizations in the sites' practice areas largely support the primary care provider concept, the practitioners speak of the current situation as an unmaintainable "transitory period of craziness" that they may be unable to survive (I, F, P). Providers in the sample share the sense of being in the midst of a "revolution" where it is difficult, if not impossible, to keep abreast of changes. As compared with previous periods of transition, change and disruption are now perceived as constant and unrelenting (I, F, P). Though many of these assertions are difficult to verify given the paucity of the historical record and the subjectivity of experience, clearly multiple key strategic health care alliances and structural arrangements have been altered (I, F, P, D). For example, 3 of the 5 medical centers associated with the practice sites either merged or were purchased during the 9-month study period; 2 of these linked with their former competitors. The hospitals with which the other 2 sites were affiliated underwent downsizing. In addition, 2 of the practices were recently sold to their affiliated hospitals, ending long periods of independent entrepreneurship (I, F, P, D).

With these sales and mergers have come disruptions in the manner of doing business, in referral patterns, and in strategic alliances (I, F, P, E, D). Ramifications have ranged from the redefinition of the "target community," the "enemy," and the "common good," to reconsideration of the worth of redundant facilities and personnel, and the value of educating students and residents (I, F, P, D). At a practice sold to a for-profit hospital group, the changes have been more fundamental: reordering of priorities to increase earnings, movement from local community and religious leadership to distant corporate management, and layoffs of affiliated staff and physicians (I, F, P, D). After years of allowing practices in their network to run at a deficit, the new owners brought with them a new business ethos. As one administrator described: "These guys are serious — if you don't make a profit you're out." (I)

As networks, alliances, managed care organizations, health plans, hospitals, and medical groups arise, merge, and disappear, providers are experiencing discontinuities in many of their key professional relationships (I, F, P, E, D). For example, as pressures to trim expenses accelerate in the more competitive health care environment, some nurses have been replaced with lower-salaried nursing assistants. Physician-hospital relation-

ships have been disrupted as the affiliated community hospitals are closed or converted to nonacute patient wards, as happened in 4 of the 5 study sites. Even the relationships with HMOs and managed care companies have been fractured as these corporations merge and change names and personnel (I, F, P, D).

Physician-Patient Relationships

One of the most fundamental changes noted is the disruption of long-term relationships between patients and care providers (I, F, P, D, E). At the study sites, the choice of health care plan or benefits is largely vested with employers or government agencies, rather than with consumers. As both providers and patients noted, insurance choices can shift either when the patient changes jobs or when employers (or patients) choose "cheaper" plans during yearly bidding (I, E, P). These shifts often necessitate finding a primary care provider who is enrolled in the new plan. Providers felt that this situation results in the splintering of the continuity of care and the impression of "endless" numbers of new patients (I, F, P). It is rare to open up a patient chart in these practices without coming across duplicated records from at least one previous practitioner (E, P). Though some exceptional patients choose to stick with their providers under any circumstances, both parties seem to be aware that those bonds may be severed at any time (I, F, P, E). Some providers even report a change in their attitudes toward "investing" in patients, since they do not see the same kind of continuity and mutual commitment as existed previously (I). Nonetheless, despite such pronouncements, it should be noted that in nearly all observed care provider-patient encounters, the care providers appeared sincerely engaged in the care of their patients (P, E).

Clinicians at the sites report increased patient demands, "pushiness," and suspicion (I, F). In physician-patient discussions over such issues as referrals and imaging tests, they report new concerns among patients who fear that their physicians are "holding out on them" to increase profits or to "save the money for themselves or the insurance company" (I, F). Patient concerns are perceived to be shifting from receiving "unnecessary" health care to receiving "too little" care.

Physican-Physician Relationships

Among the family practice physicians interviewed, there is a strong sense that, as one physician stated, "Managed care has made relationships more adversarial...not just between doctors and patients, but also between doctors and other doctors." There are confrontations over money and monetary concerns — negotiating subcapitations, dividing the capitation pie, and limiting utilization — or over the responsibility for getting authorizations (I, F, P).

Physician Roles

The role of the family physician at the practice sites appears to be undergoing transformation from the traditional one of gatekeeper (I, F, P, D, E; Table 2). Under fee-for-service arrangements, though the physician may have had a financial interest in encouraging the use of health services, providers incurred no financial risk from their medical decisions (I, D). Today, as billing for fee-for-service dwindles, primary care physicians have increasingly become subcontractors to managed care organizations (I, F, P, D). In addition, they are assuming new roles as stakeholders or co-insurers in certain capitated plans whereby a varying degree of their income is "at risk" (I, F, P, D).

In an environment in which the provider's choice of tests, referrals, and treatments may directly influence their group's and their own fiscal health, there is a definite temptation to limit services or to use different strategies for capitated as opposed to fee-for-service patients (I, P). The influence of insurance status on clinical decision making is an inflammatory topic (I, F ,P). As one physician noted, "Morally and legally we are in a bad place if we start treating differently." The interviewed providers vehemently deny such practices and little of this type of behavior was observed (I, F, P, E). The normalized value, whether stated or implicit, is "the right care at the right place at the right time," irrespective of other factors (I, P). Nonetheless, a few minor inequities were noted (I, P). For example, several physicians admitted to protesting more if patients in their group's risk pool appeared at the emergency department for what they considered unjustified indications, compared with when the cost was shouldered by the patient or a third party (I). Some physicians were more hesitant to order expensive tests for their capitated patients (ie, spiral computerized axial tomography scans for renal lithiasis or endoscopy for suspected peptic ulcer dis-

TABLE 2

New Permutations of the Physician's Role as Gatekeeper

Case Managers.	A monitoring role that maintains the perspective on the whole patient and the "keys" to the medical enterprise.
Toll-Takers.	A bureaucratic role that patients may view in a derogatory manner: "Being the place patients have to go to when they want to go somewhere else."
Deep Pockets.	A complex stakeholder role characterized by financial risk and the assumption of control over allocation of health care resources, in addition to the provision of care.
Allied Advisers.	A collaborative role that links together patient and provider. Physicians in this role may both provide knowledgeable advice about health care problems and the health care system and work with patients to override insurance coverage.

Note: These roles are not mutually exclusive.

ease) than they were for their "free-spending indemnity patients, past and present" (I, P). Elaborate mechanisms of utilization review were also in place for patients in total risk contracts; no such mechanisms were present for other patient panels (I, P, D, E).

Increased Production Pressures and Monitoring

Care providers, particularly the more veteran ones, perceive increased pressures to see more patients in less time, while documenting more details of their care (I, F, P, E). Though it is debated whether actual numbers of visits per hour have increased in the observed practices since 5 or 10 years ago, physicians clearly feel that there are marked increases in the amount of administrative and insurance paperwork associated with patient care and in the number of administrative-type visits (I, F, P, E).

In addition, there has been a steady growth in the degree of productivity monitoring (I, F, P, D). Internally, such reports are routinely used as a basis of either actual or projected incentive plans. Externally, "provider profiles" are compiled by insurance groups. Physicians disparage these for having the potential for getting them "deselected" from particular plans (I).

Information Overload

As medical groups and alliances contract with more managed care organizations, practitioners are flooded with staggering amounts of information about each plan's administrative rules, payment methods, referral networks, drug formularies, and incentive programs (I, F, P, D, E). The situation is further complicated by managed care organizations that create individualized plans for large employers or provider groups, each with its own particular idiosyncrasies (I, P, D, E). Care providers lose track of details as the names, alliances, plans, and rules rapidly change (I, F, P, E). Administrative books from managed care organizations are so numerous they are often ignored, left unopened, or immediately discarded (I, P).

Interference in Clinical Decisions

Care providers in this study were nearly universally concerned about perceived interference in clinical decision making by managed care organizations, insurers, and even their own IPAs (I, F, P). There was a strong sense of a transfer of decision-making power, particularly regarding drugs, laboratory and imaging testing, inpatient stays, and referrals. For example, nearly every managed care organization publishes a medication formulary that lists "preferred" drugs (D), sometimes even specifying preferred pharmacies. Practitioners who choose different drugs from the same class often have to justify their choice, or undertake time-consuming procedures to override the system (I, F, P, D, E).

There was the sentiment among the providers and staff at the study sites of having to jump through "endless managed care hoops" with multiple demands on time and labor (I, F, P, E). This was compounded by the lack of coordination between managed care organizations, each having its own rules and requirements (D). Tremendous energy was being expended in "managing to manage"— from training staff, keeping up with changes, negotiating contracts, providing utilization review and quality assurance, passing audits, and coordinating care of one's own and others' patients (I, F, P, D, E). Practitioners felt forced to communicate with vast numbers of bureaucracies: from hospitals, to insurance and managed care companies, to licensing bodies, and local, state, and federal agencies. Particularly for the more veteran physicians, these demands were often seen as "whittling away" time and energy from more productive activities, such as discussions of difficult patients, journal clubs, continuing medical education, or free time (I, F, P).

Adaptations

The medical practices observed in the study appear to have adapted to cope with the demands and pressures of the new health care environment in their area (I, F, P). Some of these changes are difficult to track or corroborate, given the absence of historical documentation. For example, one of the most significant claims made by some of the providers and administrators is that the managed care environment has led to the adoption of cost-effective and evidence-based medical practice (I, F). This movement, though perhaps accelerated by the managed care organizations, likely predated their arrival. Other adaptations have clearer paper trails. For instance, there is ample evidence that to compete in the medical marketplace, physicians and practices at the sites have entered into larger alliances and networks, whether of the IPA or limited liability corporation type (I, F, P, D). These bargain with the insurance companies to avoid discounts on primary care services and provide a steady flow of patients. Physicians at one of the sites even claimed that their decision to sell their practice to a larger network was based on their fear of being unable to compete without such a connection (I).

To cope with the increased business and marketing demands, there has been a specialization of roles within groups, both through the formation of administrative teams and through the hiring or training of insurance specialists who manage the multiple plans, benefits, and referral networks (I, F, P, D, E). The administrative teams at the study sites have tended to include a senior physician (always male and middle-aged), a nurse-manager, and an administrator who is not a care provider. Finally, to avoid the potential loss of a large number of patients if they change insurance plans, groups have begun to accept nearly all plans available in their areas (I, F, P, D, E).

Positive Aspects of Managed Care

The positive effects of the new health care environment on primary care were apparent both from observations

and interviews. Many of the tenets of managed care — such as the need to coordinate care through the primary care provider — have been advocated by family physicians for years and now appear to be reinforced by the new systems (I, F, P, D, E). As one family physician put it, "We're now doing the things we always wanted to do...like having patients come to us before going to specialists."

Many of the physicians also recognize that they personally receive direct and indirect financial benefits with managed care (I, F, P). As practice administrators and physician managers at most of the sites admitted, capitation is a better financial deal than fee-for-service had ever been; capitation provides a predictable monthly income and cash up front (I, D). Most practice groups are following the national trend[21] and realizing greater profits from capitated patients than from those covered by indemnity or discounted fee-for-service. In addition, some providers voiced their satisfaction at being paid for global care under capitation, not just for clinic or hospital visits (I).

Providers defended managed care's benefits to patients by pointing out that a growing number of them were getting more types of care with less out-of-pocket expenses (I, F, P, D, E). For example, patients who could not previously afford to pay for preventive check-ups, tests, and immunizations were now covered by their managed care organizations for such services and were receiving them freely (P, E, D). Care providers also noted that in some cases managed care was leading to tighter coordination and case management, and increased disincentives for performing unnecessary procedures (I, F, P, D, E).

DISCUSSION

Competing Ideologies and Moral Values

As observed at the 5 sites, US family practice centers have become ideologic battlegrounds between primary care as a business and as a "calling" (Table 3). Those who espouse the notion of family medicine as a beneficent calling perceive its goal in terms of humanistic care for individuals, families and communities, the performance of good acts, and the relief of suffering.[22-23] Though physicians have always had to earn a living, they were nonetheless expected to have their patients' well-being as their primary concern.[3] In the managed care era, a new set of convictions, models, and terms has been adopted by many providers who view health care as a managed commodity where economic self-interest is linked to the interests of populations, managed care organizations, and the economy as a whole.

In the current health care environment, there is an ongoing struggle among the managed care organizations' attempts to turn care providers into their agents,[24-25] the patients' best interests, and the care providers' professional and personal self-interest. In an age of ambiguous and shifting alliances (provider with insurer; insurer with patient; patient with provider), clinicians are frequently forced to answer, "Whose side are you on?" (Table 4).

The Local Reflects the Global

The rapid restructuring of primary care and its affiliated institutions, though seen here as a local or regional phenomenon, reflects the predominance of the global political economy of competition, commoditization, and free marketeering. The effects of these forces extend beyond the reorganization of health care services to include the possible transformation of family practice's basic culture, moral values and experience. In what has been referred to as the "most dangerous transformation,"[26] doctoring as a moral enterprise may be becoming doctoring as an economic enterprise. This transformation is being accomplished by medical directors and administrators who passionately believe in the value of their endeavors. Though the sincerity of such beliefs is not in question, the physicians may fail to recognize the revolutionary shift in the moral values that created those beliefs. As market values become increasingly impor-

TABLE 3

Competing Ideologies in US Family Practices

Ideology	Medicine as a Business	Medicine as a Calling
Values	Market economics	Relationship
Conceptualization of Health Care	Managed commodity	Human right; service
Physician Terminology	Providers	Doctors, practitioners, healers
Health Care Users' Terminology	Covered lives, consumers	Patients, people
Alliances	Provider-insurer	Provider-patient
Provider-Patient Relationship Care Model	Economic exchange, cost-effective, and quality assurance	"Sacred" partnership
Purpose of the Relationship	Satisfying consumers and payers	Patient-centered
Success Measurement	Low medical loss ratios, utilization and quality review	Responding to suffering; caring
Level of Focus	Populations, common resources	Healing
		Individuals

TABLE 4

Competing Roles for US Family Practice Physicians

Fiduciary Agent	Steward of Common Resources	Financial Stake- or Shareholder
Serve only the patient Prohibit, regulate, and avoid anything that influences the relationship with the patient	Responsible for populations Consider access, equity, allocation	Financial self-interest (free-market forces) Consider medical loss ratio — costs of care provided versus premiums received
Limits • Patient's wants may not be medical needs • Need to ration physician time and medical resources • Physician's self-interest	*Limits* • Need to consider individual circumstances and exceptions since medical encounters are with individuals, not groups	*Limits* • Need to consider appearance to health care purchasers, consumers, and regulators • Professional ethics

Parts of this table are adapted, with permission, from a presentation by Bernard Lo, MD, and Director of the Program in Medical Ethics, University of California, San Francisco, at the Professionalism and Ethics in Managed Care Conference, November 8, 1997, Cambridge, Massachusetts.

tant, corresponding changes are manifested in the experience, language, sensibility, and emotions of patients and care providers.

Effects on Trust in the Provider-Patient Relationship

Patients' trust in medical care and in their clinicians may be particularly vulnerable to changes engendered by the new health care environment.[7,8,27,28] Trust refers to the expectations that health care providers will assume responsibility without inappropriately deferring to others (control), will perform in a technically proficient manner (competence), and will make their patients' welfare the highest priority (agency).[27] As Gray notes, "The rise of managed care often is seen as undermining the fiduciary ethic and lessening the trustworthiness of care."[8] Trust is critical in maintaining the stability of the provider-patient relationship and provides the glue that holds the whole health care system together. When trust is absent, conflicts and friction increase throughout the system, generating significant social costs to check physician performance and guard against possible adverse outcomes.[29] For example, malpractice litigation, "doctor-shopping," and poorer patient compliance are more likely to stem from provider-patient relationships marked by distrust, suspicion, and poor communication.[30-32]

The changes engendered by managed care may well lead patients to doubt the motives of their health care providers and the quality and cost of what they provide.[33] Although it is too early to assess the long-term impact of many of the changes, there is already evidence that this may be happening.[34-36]

Limitations

The limitations of this study are numerous, primarily because of the qualitative nature of the research and the limited number of study sites. Generalizability is further compromised by the clear regional variations. Nonetheless, this research and others like it may help shift the debate regarding choices in the structure of health care delivery from that of free-market competition between commercial products to one concerned with the impact on patients and providers. As Eisenberg[37] has recently noted, "The personal equation remains at the center of medicine; the patient-doctor relationship is the linchpin of medical care."

CONCLUSIONS

This study presents a rather discouraging snapshot of the American family practice. Much of the blame for the current situation is placed on managed care organizations, but the genesis of many of the problematic processes was unrelated to managed care. In addition, some of the negativity may be transitory, since the studied regional managed care markets are still in an immature state and there is some evidence that physician satisfaction increases with market maturation.[38] Multiple solutions have been formulated for preserving the physician-patient relationship or forging a new model.[3,24,39,40] Given the importance of the issues and the paucity of data, more empirical and observational studies are critical. Further studies can not only document the fundamental changes taking place: they can also provide the building blocks for future solutions.

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