Putting Aside Preconceptions — Time for Dialogue among Primary Care Clinicians

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In this issue of the *Journal*, Donelan and colleagues[1] report that primary care physicians and nurse practitioners often work side by side but inhabit different universes, at least perceptually. Daniel Kahneman, the psychologist and Nobel laureate who helped found the emerging field of behavioral economics, would find this unsurprising. He contends that all humans are influenced by powerful unconscious mental filters that shape how they perceive the world around them.[2] Given the heated debate over the roles of physicians and nurse practitioners in providing primary care in the United States,[3] those filters are probably working overtime when these professionals reflect on their practice experiences and the literature on their respective performance.

The differing views of physicians and nurse practitioners about their work can have troubling consequences. Also in this issue of the *Journal*, Iglehart[4] recounts how a promising dialogue between primary care physicians and nurse practitioners reached consensus on interprofessional collaboration, only to have the proposal spurned by professional organizations. Neither physicians nor nurses can afford the impression that narrow professional interests are guiding their responses to a pressing national problem.

That problem is the predicted shortage of primary care clinicians as the U.S. population ages and as millions gain insurance in 2014. Debate persists over whether we currently face a shortage in the primary care workforce, but the data are worrisome. The United States has fewer primary care doctors per capita than any other industrialized country: 30 per 100,000 population, as compared with 80 in the United Kingdom, 159 in France, and 157 in Germany.[5] A Commonwealth Fund survey showed that 16% of U.S. adults report having to wait 6 or more days to see a primary care physician when needing care.[6]

A shortage of primary care clinicians would constitute a major obstacle to improving the performance of our troubled health care system. Good primary care is essential to the quality, efficiency, and equity of health care services generally, and deficiencies in primary care help explain why the performance of the U.S. health system lags so dramatically behind that of other developed nations.[7]

One option in addressing the threatened primary care shortage is to rely on nurse practitioners to provide a wide range of primary care services. Now numbering approximately 180,000, nurse practitioners have become an important part of the U.S. health care workforce.[1] The existing literature shows that nurse practitioners provide care similar to that of physicians with respect to health outcomes, resource utilization, and cost, and the same studies show that nurse practitioners get higher grades than physicians with respect to communication with patients seeking urgent care.[8]

These studies, however, leave important questions unanswered. Physicians and nurse practitioners receive very different training, and it would be surprising if their competencies were identical. Whether these different competencies affect their comparative ability to manage complicated diagnostic problems or treat patients with multiple, interacting chronic illnesses remains to be determined. Patients' preferences regarding who provides their primary care also need to be taken into account.[8]

Trends in the organization of care and health-information technology create additional uncertainties. New models of primary care practice, such as patient-centered medical homes, increasingly rely on teams of physicians and nurse practitioners. Some observers suggest that such teams could increase the efficiency of care to the extent that the feared shortage will melt away.[9]

If the optimal composition of our primary care workforce remains uncertain, the principles that should guide primary care policy are clearer. First, objectively interpreted data on the competencies of professionals should guide policy, not rigid, often antiquated state laws. Second, policy should be dynamic and flexible in response to changing knowledge about the roles and abilities of health care professionals, as well as changes in the organization and financing of health care. Third, patients' preferences with respect to who provides their care should play a much more prominent role in the debate than such data

have in the past. Fourth, the United States must give higher priority to the development of a high-performing primary care infrastructure if it hopes to attract and retain a competent, satisfied workforce. Finally, unless physicians and nurse practitioners collaborate to improve primary care, neither will be happy with the outcome. We urgently need a facilitated, open dialogue about the roles of physicians and nurse practitioners that includes representatives of the public.

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