

illness still is an open question. This needs to be made very clear so that the managed care providers and the other decision makers who are not physicians know exactly what the product of service is that you are providing to them. The academic agenda will follow from that. For the academic agenda, you also must decide what piece will move forward into the twenty-second century. Who are the scientists who are going to develop your discipline? They will have a role, but it will be a much more confined role than that defined by the marketplace. How many fellows are needed annually to really move the biomedical portion of the science forward? How many are needed to move the clinical research agenda forward? Those are tough questions. They need to be addressed in terms of how much of a referral base the discipline needs to survive. To what degree do you feel that the clinical syndromes around which you gather yourself need ongoing support? I have heard one allergist for every 60,000 population is a rough estimate.

Wasserman. Right now the population is about one per 65,000, and the HMOs use about one per 90,000.

Weiss. That is about 1% of the physician manpower. You have to ask whether 1% of the physician manpower dedicated to these diseases is enough.

Another question would be, "What percentage of your practice is being supported by allergy shots?" That is something you are going to confront head-on as cost-effective clinical effectiveness becomes paramount. Science is moving on and will likely provide better or alternative medicines. If "shots" drift away, your whole referral base is going to shift.

Austen. Dr. Weiss, do you want to say something about your quality assessments and outcomes?

Weiss. One of the things that I am working on is for the National Asthma Education Project, specifically, the task force on cost-effectiveness, quality, and financing of asthma care in this country. I struggled with the question of what the National Institutes of Health (NIH) and the biomedical industry need to do and know about cost-

effectiveness and financing. That has been the work of three wonderful subgroups. John Eisenberg, Head of the Department of Medicine at Georgetown, helped me look at the issue of cost-effectiveness. In financing I drew on Jen Falls, who works at Park Nicolett, and for quality on Mark Young, who does much of the quality improvement work at the Henry Ford system. One of the outputs is that the National Heart, Lung, and Blood Institute, in developing one of its new initiatives asked about the cost-effectiveness as part of a new clinical trial. However, I am not sure that the NIH in its biomedical agenda can afford to also address this additional agenda. In the pharmaceutical industry, if you have not addressed the issue of an agent's cost-effectiveness, you may be off the target for what you are planning to market. We are producing societal goods. The NIH does science for the year 2020 as opposed to science for the year 1997. New forces may say look to the year 1998 to be relevant for funding.

One of the things I noticed in talking to several medical directors of HMOs during the past 12 to 14 months is that the consumers, the patients, want "shots." There must be a mechanism for shots. At least for the short-term solution, that is something you will have to fold into your mix.

Bloch. Many people smiled when I said that we should go back home and learn how to own the HMO business, but if we don't do something now, we will never get in on the business because it is changing now. Also, we look on these outcome studies as if they were ways of holding on to patients with allergies. That is a mistake. The key will be how the results are interpreted. If it turns out that the reason we do better is because we teach the patients how to use an extender on their inhaler, it is up to us to teach the deliverer of health care to do that. It is not necessary for us to keep all the patients to teach them how to use the extender. I think that the allergist of the future whom we will wish to train will be a scholar, an educator, and a teacher of the generalist.

Integrating a primary care role with allergy and immunology training

Diane Schuller, MD, Robert Rakel, MD, and Albert Sheffer, MD

In the emerging field of managed care, primary care physicians play a critical role. For the sake of our patients, who must come first, and for quality care, we need to have input. There are two ways to approach this question. First, we can assume that

primary care physicians will provide the primary care for patients with allergy and asthma. We then need to determine how well qualified they are to take on this task and how much time they will have for managing and "educating" the patients. Other

relevant questions include the role of practice guidelines and the criteria for referral. Perhaps one of the greatest defects now is that the primary care physician often does not know when to ask for help. That is a discussion that the allergist/immunologist should lead.

A second approach is for allergists, who are also fully trained in either pediatrics or internal medicine, to become the primary care doctors for patients with chronic asthma and allergies. Over time this could well be cost-effective for children and young to middle-aged adults.

In 1985 there were 6.5 million visits to physician offices for ambulatory treatment of asthma. Sixty-five percent of care was given by physicians trained in internal medicine, pediatrics, or family medicine. About 25% of care came from allergists. Despite this, managed care perceives an oversupply of specialists and promotes primary care, largely for socioeconomic reasons. In addition, it is not uncommon for a health maintenance organization (HMO) to provide incentives for keeping the patient with the primary care gatekeeper. The dilemma posed by this system is that the primary care physician might not be able to obtain a consult even when it would be in the best interest of the patient.

Training programs for internal medicine, pediatrics, and family practice provide no uniform core curriculum or specific training in the care of allergic/immunologic disease. The Accreditation Council of Graduate Medical Education in their special requirements for residency training programs in internal medicine do not mention allergy/clinical immunology training nor do they outline a core curriculum. For pediatrics, residency training in emergency and acute illness includes status asthmaticus. Family practice requires some experience in allergy and immunology. However, the instruction may or may not be from a specialist in the field.

One approach to change will undoubtedly be education. The value of specialty care in terms of outcomes and quality of the patient's life needs to be promoted to the public, to medical school students through their curriculum, to primary care residents through training programs and fellowships, and to managed care organizations in terms of financial benefits to gatekeepers. In addition, certification by the American Board of Allergy and Immunology (and recertification) should be considered essential for credentialing as an allergist/immunologist, and the role of the allergist as the

primary care provider for patients with asthma and allergies needs to be fully addressed.

INTEGRATING A PRIMARY CARE ROLE WITH ALLERGY AND IMMUNOLOGY TRAINING: DISCUSSION

Schuller. We, the allergists, must be proactive in our approach to primary care. We must be our own advocates. We must educate the public. We must educate the primary care physicians about allergies and asthma. We must educate managed care administrators about the cost-effectiveness and quality of life data and the good outcomes that we do have with the limited studies currently available. We must educate our legislatures about the need for access to specialty care. We must develop an allergy and immunology core curriculum for medical students as well as for residency training programs. We must work with training program directors in family practice, pediatrics, and internal medicine to help develop a good core curriculum exposure to allergy and immunology. We also need to examine our role as possible primary care providers for our patients who have asthma. If we look at these multidirectional goals in trying to educate people and find a better spot for the allergist/immunologist in the new emerging role of health care, I think we will do well.

Austen. As we define what the discipline is now and in the future, we must also define what we are willing to give up. Otherwise we have no basis for shared education.

Rakel. Let me comment on some of the things that were said this morning. First, training in family practice requires some hours in the program in allergy and immunology. What some programs, such as ours, do is refer the resident to work with an allergist. In other programs the allergist visits in the family practice center and teaches with patients who are selected for consultation. Educational integration is very important. Another essential area of integration that we have not said enough about is joint research projects. Ours is an epidemiologically based population, and most of our research is oriented that way. That large primary care base is needed, especially because we must demonstrate not only quality but cost-effectiveness. I think it is essential that the family practice and the allergy and immunology communities work together to initiate some joint research.

What we have in common is that we are both ambulatory specialties devoted to the management of chronic diseases and involved in continuity of care. The more comprehensive patient care is, the more cost-effective it is. Therefore we must know when it is appropriate to have consultations. Currently, the primary care physician often does not know when to ask for help. That is one of the greatest things that we need allergists/immunologists to teach us. Managed care is telling us to get help only when we need it. This creates a moral dilemma. Do we serve the patients whom we are obli-

gated to serve, or do we serve our employer, the HMO, who says I will pay you more if you do less? We need to make sure that we do not provide inadequate care because of not obtaining a referral when we need it.

I have looked at the number of specialists in each discipline who are currently working in the United States per 100,000 people, and I compared that with the number of specialists working in a group of 16 HMOs. I found that there are more allergists per 100,000 people in the HMOs than there are in private practice per 100,000 people. The figure for HMOs is 1.3, and for private practice it is 1.1, which comes very close to the one allergist/immunologist per 60,000 individuals that was referred to earlier. So you are really not oversupplied.

Austen. Would you comment on how the subspecialty should interact with primary care? What should we expect primary care to be capable of doing?

Rakel. I think we should train primary care physicians to care for the patient with allergic rhinitis. I see a lot of patients with allergic rhinitis, and I probably refer 10% of them. I do not think I do a bad job for the other 90%. I feel the same about patients with mild and moderate asthma. The HMOs are going to insist that we manage most of those patients without referring them. The ideal way to teach, in the models that I have observed, is some kind of arrangement where the allergist comes in to the teaching practice, the family practice center, and teaches with cases that the residents and the faculty are seeing that are problems. When we refer such a patient to you in your office, even though you send us a good report, the learning is much less than if we are together consulting on that patient.

Sheffer. According to Dr. Weiss, we are really not talking about primary care, we are talking about principal care. So we have two groups of individuals who are clinicians, that is, specialists and primary care physicians. How can they establish or maintain their practice? In a sustained practice, if the physician is a principal care provider—whether he or she is a pediatrician, gynecologist, or internist—this can be cost-effective because we as physicians assume the initial responsibility for the care of these patients for all health-related needs. Patients know that they have a clinician they can depend on who will either manage their problem or refer them for crisis disease management. This is the way a practice is established and the way that it can be maintained. I do not think sending primary care physicians to an allergy office adequately instructs primary care physicians on allergy care. I think primary care physicians and general practitioners should be encouraged to participate in an academic clinical outpatient setting, where they can associate with trainees in allergy, have the same mentoring, and have clinical conferences to discuss their cases. Both the American College of Allergy, Asthma and Immunology and the American Academy of Allergy, Asthma and Immunology should develop some general programs just as we have for allied health professionals. I think that if we seriously educate primary care physi-

cians, they will refer more patients to us because they will understand the referral criteria.

Hilman. If this is really the ideal for quality education for family practice residents, then would it be worthwhile to us as training program directors to have a core curriculum and offer this along with certain rotations?

Rakel. Absolutely. In fact the best family programs will come to you and say these are the objectives that we hope you will teach our residents.

Weiss. I wanted to address the difference between perception and test hypothesis. Studies of the effectiveness of continuing medical education in changing the attitude and behavior of physicians in actual practice suggest that it is very ineffective. In fact, it is perhaps the lowest common denominator of ability to be changed. The social value of allowing for interaction on an interpersonal basis so that the primary care doctor meets the subspecialist is probably invaluable for the process of change. But in terms of actual information flow and changing practice patterns, it is pretty minimal. The most effective way is to find local opinion leaders in the community, and it is not necessarily the opinion leader who you think it is. You go to the primary care community and say, "Who is the doctor that you listen to on this topic?" They tell you, and that is the person with whom you interact to change physician behavior. However, it does not address the sociologic phenomenon of ensuring that you as a subspecialist and the primary care doctors actually have a social interaction that is constructive. That is independent of the knowledge transfer.

Lockey. The fundamental question I see from what was addressed here is can we on the boards, through internal medicine and pediatrics, allow family practitioners to become board certified in allergy and immunology? It seems to me that that is an ideal way to increase our pool of eligible and well-trained individuals.

Wasserman. Family practice has traditionally been very opposed to subspecialization. They have come to adolescent medicine, substance abuse, sports medicine, and geriatrics in a collaborative way with internal medicine through a certificate of added qualifications. It is conceivable that something like that could be done.

Another important issue is, "How much primary care will the allergist/immunologist do in the future?" In a staff model HMO like that of Dr. Schatz, they do very little because they are busy doing allergy care. In other situations, particularly where people have mixed practices, it may be a choice; in fact, their patients may require them to be, if not their primary care physician, then their principal care giver. This concept of principal care giver is well exemplified by the nephrologist who handles almost all the care for the patient with chronic renal failure on dialysis because the patient's care is so complex. What role does that model have for the allergist/immunologist? Are we going to take care of patients with severe asthma that way?

Sheffer. Why not? That is the energy needed in the specialty.

Wasserman. However, we may not be permitted to do that through some of the HMO plans with strong gatekeeping.

Ruddy. The rheumatologists have been doing this for a long time. It is not very difficult to argue that I can take care of a patient with rheumatoid arthritis better and more effectively than most generalists. However, it is not clear to me that managed care organizations are going to buy that lock, stock, and barrel, but we must be prepared to do it all.

Austen. In our center, some physicians are approved to do either rheumatology or primary care during a patient visit. Therefore the compromise that has been made with the reimbursement agencies is that the physicians will bill differently when the patient is being seen for primary care rather than for a rheumatologic visit. We are just beginning to experiment with this system.

Weiss. That is a transitional issue that may or may not become a permanent issue. Multiple questions must be asked: to what degree will you be providing principal care for certain conditions that are strongly related to your field? To what degree do you not want to? Where is that threshold? How can you articulate that package of principal care so that a managed care medical director understands it? Remember that the cardiologist is right behind you. And right behind the cardiologist is the gastroenterologist, and the neurosurgeon, and so on.

Austen. Is the concept of principal provider synonymous with disease-based care?

Weiss. Yes and no. Disease-based would be organ specific. A principal provider could do a little bit outside that; there's not that constraint of being truly organ oriented. However, there is some overlap on the way to primary care.

Venable. From a managed care perspective, it is going to be, let's make a deal. What have you done for me today? If I am the medical director and 90% of the time no patients with asthma have problems regardless of who takes care of them, then why should I go with you, the allergist, when you're three times the cost?

Wasserman. Because your turnover rate for patients of 1.5 years per plan could be diminished if you want that.

Rakel. I want to caution you about using the term "primary care" in joining the litany of specialties that now say they do primary care. "Principal care" might be a better concept. Primary care is where you take responsibility for managing the entire patient. So, if as a rheumatologist you are going to take that responsibility, that means you are doing Papanicolaou smears and mammograms. The most common problem seen in ambulatory care, which none of you are trained to do, is to recognize and treat depression. That is what primary care is, and you must be willing to do that if you are going to say, "I'm doing primary care."

Conjoint versus separate boards

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Historically, the subspecialty of allergy and immunology was contained within the specialties of medicine or pediatrics. In 1971, the present conjoint board arrangement began. The movement to form a conjoint board at that time came primarily from allergy practitioners who were forced to see both adult and pediatric patients in their practices. They proposed that separate subspecialty training in adult allergy and pediatric allergy did not adequately prepare subspecialists for practice. What followed in the next nearly quarter century was the establishment of the American Board of Allergy and Immunology (ABAI), a conjoint board of the American Board of Internal Medicine (ABIM) and the American Board of Pediatrics (ABP). The ABAI certified, by examina-

tion, candidates who have trained in training programs approved by the Accreditation Council for Graduate Medical Education (ACGME). These allergy and immunology training programs may be centered in departments of medicine or pediatrics or in combined arrangements. All candidates, whether they come from primary medicine or pediatric training programs, must receive clinical training in both adult and pediatric allergy and immunology.

With the recent changes in medicine brought about by health care reform, the question of maintaining the present conjoint board model has come into focus. Specifically, a debate has arisen among academic leaders in departments of medicine and pediatrics regarding whether the subspe-