

# Transatlanticism: Interview with the American College of Physicians’ Dr Steven Weinberger

**Dr Steven Weinberger** is executive vice-president and chief executive officer of the American College of Physicians (ACP). The RCP’s **Linsey Clark** talks to him about the major strengths of, and current challenges facing, the US healthcare system.

**In 2015, the ACP celebrated its centenary. The college, which has a membership of more than 143,000 and is the largest medical specialty organisation in the USA, is not formally affiliated with the RCP, but the organisations share many key values: a commitment to improving the quality of patient care, a passion for education and a determination to advocate for physicians.**

Although differences in organisation, funding, priorities, budgets and patient populations might make the US health system seem worlds apart from the NHS, physicians from San Francisco to Salford are experiencing many of the same challenges. But what lessons can we learn from our colleagues across the Atlantic? What innovations in care can be transferred from the USA to the UK, and vice versa? These questions and more were put to the ACP’s Dr Steven Weinberger, by Linsey Clark from the RCP’s International Office.

**A key component of the RCP’s Future Hospital model is the role of specialists working in the community. In the USA, there’s much more provision of traditionally ‘secondary’ care in a primary context – can the UK learn more from this?**

This goes both ways in the USA. There are primary care physicians who take care of more complex problems that would be considered secondary care in the outpatient setting, and there are, of course, also specialists or subspecialists who provide more than just subspecialty care when caring for their patients. For example, when I practised as a pulmonary physician, there were some

patients for whom I provided both primary and specialty care.

There’s more and more emphasis on primary care, recognising that patients often have comorbid illnesses that require care coordination and a more holistic approach. The basic idea is that an internal medicine specialist should be able to take more comprehensive care of a patient – not only the primary components of care but also

---

**‘Central to this trend is the whole system of reimbursement, which is going through a transition. There’s a push to have better reimbursement for primary care physicians, who have traditionally been underpaid when compared with specialists, particularly procedural specialists. There’s also a push towards reimbursement for quality rather than just volume.’**

---

often the more complicated or specialised ones. It’s better to be able to coordinate that care within the framework of one physician’s responsibilities as opposed to spreading the care out. The issue of fragmentation of care, and particularly the care of older patients, is a major issue in the USA – it’s something that we feel detracts from the quality and also increases the cost of care. If the patients have heart disease, lung disease and kidney disease, they’ll often be cared for by someone in each



of those specialties and then the problem becomes one of coordination of care, with information sometimes not being transferred from one physician to another.

**In the UK, there’s a push towards physicians being generalists to deal with the increasing numbers of patients with several comorbidities. Is something similar happening in the US?**

There’s definitely a push towards having generalists, such as general internists or family physicians, either to provide more comprehensive care or to coordinate care provided by specialty or subspecialty consultants. Central to this trend is the whole system of reimbursement, which is going through a transition. There’s a push to have better reimbursement for primary care physicians, who have traditionally been underpaid when compared with specialists, particularly procedural specialists.

There’s also a push towards reimbursement for quality rather than just volume. Traditionally we’ve had a ‘fee for service’ system, which means that the more you do, the more you get paid. Take the example of a surgeon who does an operation, doesn’t do a particularly good job, and the patient runs into complications and needs another operation as a result. The surgeon can bill for the second operation in addition to the first, despite the patient’s outcome being worse by the need for an additional operation. We’re trying to move towards a system where the surgeon in question would not get reimbursed twice and essentially be financially rewarded for a botched initial operation.

---

## How has Obamacare affected the work of hospital physicians in the US?

So far, Obamacare hasn't had a huge impact on hospital physicians. A significant impact on patients, yes, but I don't think it's had a huge impact yet on the work of hospital physicians. Obamacare is primarily about achieving greater coverage of the uninsured through mandating coverage while providing assistance for those with limited financial resources. There are two primary components. First, Obamacare has set up what are called 'insurance exchanges' for the uninsured to shop for and purchase health insurance. The government will provide subsidies for individuals who are not at the poverty level, but for whom buying insurance would be a really significant expense. This has covered quite a decent-sized chunk of people who would previously have been uninsured. Failure to purchase insurance by those who are financially eligible for the exchanges results in a penalty.

The other component of Obamacare has been the expansion of Medicaid, a programme of care for the poor. This is traditionally provided at the state level but has often been plagued by limited eligibility and benefits. Under Obamacare, the federal government has put in money to allow the states to expand Medicaid and expand eligibility, with the primary goal again being to increase coverage. Obamacare overall has been very successful in decreasing the number of uninsured patients. However, states have to accept Medicaid expansion, and failure of many conservative states to expand Medicaid remains an issue that has compromised Obamacare's ability to get even more coverage for the uninsured poor.

## What are the other major current challenges to the US health system?

Cost is a big one, as right now about 18% of our gross domestic product goes to healthcare – that's so far above any other country. Another problem that we're facing is around electronic medical records. There are many different electronic record systems, which don't talk to each other, unlike the banking system where I can put my debit card into any bank's ATM and it will recognise me. In contrast, if my usual care is provided by someone from a hospital in Pennsylvania but I then go to a hospital in New York, the New York hospital has no way of accessing my medical records.

And it's not just about this lack of interoperability. The main system used in academic medical centres is very complicated

and difficult to use. Data about a patient will be stored in many different fields, so that it's hard to get or follow the narrative on what's actually going on with a patient. This is actually a patient safety issue. There's currently research being done that looks at a simulated intensive-care-unit patient with problems developing, and how difficult it is for another physician to identify those developing problems just by looking at the electronic record.

## The UK is increasingly looking to physician associates to address challenges around staff shortages and cover. How do physician assistants (as they are known there) operate in the USA?

There are two types of non-physician personnel who are increasingly providing care – physician assistants and, perhaps even more prominent now, nurse practitioners. Physician assistants in the USA must work with

---

**'When we have physicians who come over from places like the UK, we see that there has been much more of an emphasis on core clinical skills, particularly physical examination skills. This deterioration in physical exam skills in the US has led to a much greater dependence on advanced, expensive imaging studies ...'**

---

a physician, and the regulations as to what a particular physician assistant can do are addressed at the state level rather than the federal level. By and large though, physician assistants are required to have everything signed off by, and supervised by, a physician.

This is a little different with nurse practitioners, who have been pushing for more and more autonomy. They do not, in many states, need to be supervised by a physician. There is resistance among many nurse practitioners to the idea of being supervised by a physician, and they feel that they should be able to practise independently. However, there has been significant push back from the physician community. Physician assistants, on the other hand, work with and are supervised by physicians, so there has been a lot less push back over their increasing use. This is all very much in a state of transition.

## What does the US healthcare system do well that the UK could learn from?

I can talk about some of the things I think we do well in the USA. I believe we have a very good educational and training system, and I think that in general the quality of care, particularly in the tertiary centres, is very good. Also, the kind of individuals who go into that sort of specialist care in an academic setting tends to be excellent.

We're also very successful in terms of medical research – generating basic evidence and data. The National Institutes of Health has a large budget, and what it's able to do both at its own facility outside Washington, DC and also in terms of funding of research generally is outstanding. This has generated a large number of individuals in academic medicine who are excellent researchers.

## By contrast, what does the UK do well that the USA could learn from?

Although there's a lot of work being done on reducing overuse and misuse of care, we still have too much unnecessary care, particularly overuse of imaging studies. Some of this overuse of care is driven by financial incentives because of our volume-based payment system. Another issue is overpricing of care. There are real concerns over a lack of transparency around pricing right now. For example, if you want to find out how much a CT scan costs at a particular hospital, it's almost impossible to get that information. Hospitals tend to guard their charges very closely and people will frequently get bills that seem outrageous.

There's also been a progressive deterioration in physical examination skills in the US. When we have physicians who come over from places like the UK, we see that there has been much more of an emphasis on core clinical skills, particularly physical examination skills. This deterioration in physical exam skills in the US has led to a much greater dependence on advanced, expensive imaging studies and lab tests when I think we all recognise that 80% of diagnoses come from history and physical examination. That said, there are major movements now to think about those things in the US healthcare system that need to be reformed. For example, we at the ACP are involved in a major effort to try to reduce the overuse and misuse of care that adds to cost but does not help patients. There's also more and more emphasis on working with patients as partners in their care, taking into account their values, goals and preferences as opposed to taking a paternalistic attitude. ■