From left, Dr. Basema Dibas, a pediatric kidney specialist, talks with kidney transplant patient Dakota Widdows during a May 19 follow-up visit at the ECU Pediatric Specialty Care practice in Greenville.

**ECU’s transplant program offers second chances**

DOUG BOYD, Special to the Daily News

GREENVILLE — Fifteen-year-old Dakota Widdows of Swansboro has a new kidney and a new outlook on life.

Thanks to a renewed transplant program at East Carolina University and Pitt County Memorial Hospital, he’s likely one of many young people in eastern North Carolina who will get a second chance thanks to a new organ.

Dakota was diagnosed with kidney disease five years ago after a doctor visit following the flu.

“He said his side was really hurting, so I said, ‘Come on, let’s go to the doctor,’” said his stepfather, Dennis Jackson. On a hunch, the physician performed a test, and the results showed Dakota had only 18-percent kidney function.

“Next thing you know, they called us and said his kidneys were shutting down and get him to the hospital,” said his mother, Jamie Jackson. It was the week before Christmas. “It was actually a miracle we even found out about it. His kidneys could have shut down, and he could have died,” she said.
The transplant took place in May, thanks to a kidney from his aunt and a pair of pediatric kidney specialists who recently joined the faculty of the Brody School of Medicine, Drs. Guillermo Hidalgo and Basema Dibas.

In North Carolina, more than 400 children, adolescents and young adults have end-stage renal disease, the most severe stage of chronic kidney disease, according to the National Institutes of Health. From 1988 to 2007, 365 pediatric kidney transplants were performed in North Carolina, according to the Organ Procurement and Transplantation Network.

A successful pediatric transplant program not only requires surgeons but also pediatric nephrologists to oversee the medical care before and after transplant, social workers and nurse specialists.

With the additional specialists, ECU officials anticipate performing six to 10 pediatric kidney transplants a year.

“There’s probably no population that benefits more from kidney transplants than pediatric patients,” said Dr. Robert Harland, chief of transplant surgery at ECU, who arrived in Greenville in 2010 from the University of Chicago Medical School. He operated on Dakota and said a healthy kidney usually improves a child’s growth, socialization and academic performance.

“So having a kidney transplant program, it gives them a second chance at life,” said Hidalgo, who came to ECU this year from the University of Illinois in Chicago.

Kidneys usually fail in children due to a congenital abnormality, as was the case with Dakota. They can also fail due to vesicoureteral reflux, or the abnormal flow of urine from the bladder back into the ureters due to a number of factors. That reflux can cause infections that can permanently damage kidneys.

Since a transplant involves taking medicine to suppress the immune system and ward off rejection, the Jacksons had to quickly remodel their home. Dakota had shared a bedroom with his two brothers, but would need his own once he had a new kidney. The Jacksons also had to take up carpet and replace it with laminate flooring to reduce dust.

To prevent rejection, he now takes 30 pills and other medication daily. Other than that, there’s little indication he was ever sick. He drinks plenty of water.

“I just noticed he sprang back real quick-like, and I couldn’t even tell he had surgery,” his stepfather said.
Dakota, a quiet 10th-grader at Swansboro High School, finished his schoolwork via the teleconferencing software Skype and maintained his A and B average. He’ll return to school in the fall.

“He’s the perfect patient for us,” said Dibas, the pediatric nephrologist. She joined ECU this year after completing a fellowship in pediatric nephrology at Children’s Hospital Mercy Hospital in Kansas City, Mo.

Pediatric kidney transplants have a long history at ECU. The first organ transplant done at the medical center was a 1981 kidney transplant on a 16-year-old Winterville resident. Between 1992 and 2009, ECU surgeons performed kidney transplants on 23 patients who were under age 16 and four under age 5, with the youngest being 2. The arrival of Hidalgo and Dibas along with transplant surgeons Harland and Dr. Jason Rolls have meant transplants can take off again.

“It is a program which I have wanted to expand but without pediatric nephrology could not do so,” said Dr. Carl Haisch, a transplant surgeon and professor at the Brody School of Medicine and former director of the transplant program. “Now that we have that part of the program, we should be able to expand, and I’m delighted.”

In 2010, the transplant program performed 72 kidney transplants and has performed more than 40 transplants so far this year.

Drs. Greg Murphey and Jonathan Taylor, local urologists, removed the kidney of Dakota’s aunt.

Doug Boyd is a writer for East Carolina University News Services in Greenville.

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Peat wildfire linked to heart failure risk
CHAPEL HILL, N.C., June 28 (UPI) -- A wildfire fueled by peat that burned for weeks in North Carolina resulted in increased respiratory and cardiovascular problems, researchers say.

A study by the Environmental Protection Agency, the University of North Carolina at Chapel Hill, The Brody School of Medicine at East Carolina University, Pitt County Memorial Hospital and the North Carolina Division of Public Health found an increase in the number of visits for treatment of symptoms of heart failure in counties exposed to the smoke.

The study, published in Environmental Health Perspectives, found a 37 percent increase in emergency room visits for people with symptoms of heart failure during a three-day period of dense smoke exposure and for the following five days.

The researchers used satellite imagery to identify counties affected by the wildfire -- which was sparked by lightning -- and compared the data to the numbers of emergency room visits for cardiac and respiratory problems.

The study did not examine health effects from other fires, such as controlled fires that are intentionally set, or other fires that burn vegetation other than peat, the researchers say.

The findings cannot be extrapolated to non-peat related fires because peat fires tend to burn slowly and close to the ground, so the smoke is not as easily moved upward and can burn for weeks or months, the study says.

School news

If you would like to have an event included in School news, send your news release to stories@newsoflylakenorman.com.

Davidson Day

New Lower School Head: Wes Wehunt has been named head of lower and middle school at Davidson Day. Wehunt comes to Davidson Day after four years as head of the lower school at Augusta Preparatory Day School in Georgia. Former Lower School Head Michael Cerkovnik now will serve as head of educational innovation.

Camps: Archaeology Camp for rising fourth- through seventh-graders with U.S. archaeology, mythology and world religions teacher Mat Saunders. Saunders is in Belize leading the archaeological dig of a Mayan temple. The camp is July 18-22 for students interested in world culture, ins and outs of archaeology and exploring dig boxes on the coast. Details: Email Emily Griswold at egriswold@davidsonday.org or visit www.davidsonday.org/summercamp.

Lake Norman High

ECU scholar: Kali Harrison of Davidson was selected for the EC Scholars Program at East Carolina University. The scholarship awarded 15 incoming freshmen four years of tuition and a stipend to study abroad, valued at $45,000. Candidates for the program must have a SAT score higher than 1300 and ranked in the top 5 percent of their high school class. EC Scholars must maintain a 3.5 GPA in the ECU Honors College, in addition to 24 hours of community service.

Hopewell High

Junior Leadership Lake Norman: Rising juniors will have the opportunity to take part in the Junior Leadership Lake Norman Program, which will expose students to leadership styles and personalities. Participants will take part in activities to illustrate positive leadership. Students will tour facilities, participate in seminars and have resources available in the Lake Norman area. The Lake Norman Chamber of Commerce is sponsoring the program.

Loomis Chaffe School

Local graduate: Laura Iglehart of Cornelius graduated with honors from The Loomis Chaffe School in Windsor, Conn. She will attend George Washington University.
DURHAM N.C. Central University has asked state and local prosecutors to help it recover hundreds of thousands of dollars in what state auditors are calling questionable payments from a secret bank account.

The former head of an education agency based at NCCU diverted more than $1 million into the undisclosed account over a six-year period, spent nearly $300,000 of it on herself and improperly paid $62,000 to a former NCCU provost, according to a state audit released Tuesday.

Nan Coleman, executive director of the Historically Minority Colleges and University Consortium, was fired in 2009 for poor performance, and Chancellor Charlie Nelms ordered an internal audit of the program.

NCCU turned over its findings to state auditors last year. They found that from 2004 to 2009 Coleman had spent $287,000 from the account on herself and improperly paid tens of thousands more to others associated with the program, including nearly $62,000 to former Provost Beverly Washington Jones, according to the audit report.

Neither Jones nor her attorney returned calls Tuesday. Rhonda Young, one of two attorneys representing Coleman, said she hadn't had time to read the audit and couldn't comment yet on its contents.

"We do have full confidence that our client has not done anything illegal or improper," she said. "There was maybe some sloppy bookkeeping, but we have full confidence in her integrity."

According to the audit, some of the money was spent via check card on "questionable" purchases such as repairs to cars apparently owned by Coleman and her husband, travel expenses for him, women's clothes and hair care products.

A freeze on the account

In a statement released Tuesday, Nelms, who began scrutinizing the consortium not long after he was hired in 2007, said the organization had been discontinued and that none of the leaders responsible are still employed.
by NCCU. The undisclosed checking account has been frozen, and new policies and procedures are in place.

"Personally and professionally, I am disappointed and dismayed regarding the alleged behavior of a few to the detriment of the university as a whole," Nelms said. "However, I am confident that North Carolina Central University will emerge from this situation stronger and even more committed to excellence."

The audit's recommendations include that NCCU seek repayment of the money and consider criminal or civil legal action to get it back.

A spokeswoman for NCCU said Tuesday afternoon that it had already contacted the state Attorney General's Office and the Durham district attorney to ask for help in recovering any money that was paid improperly.

Coleman had sole control over the undisclosed bank account and by opening it may have made herself responsible for repaying the full amount diverted into it, the audit says.

The consortium represented a dozen public and private institutions of higher education across the state that have traditionally had heavy minority enrollment. It got millions of dollars in state, federal and private grants to help minority children close the achievement gap with white children.

NCCU was a member of the consortium and served as its fiscal agent.

The money that went into the secret account came from a host of sources including local school systems, nonprofit community organizations, individuals and the university, according to the audit report.

Coleman wrote more than $60,000 in checks from the account payable to herself. Checks totaling $62,000 were paid to a company she owned, and nearly $47,000 was taken out in ATM withdrawals, according to the audit. Two of the ATM withdrawals, totaling $900, came after she was fired in August 2009.

**Where control resided**

Two administrative assistants told auditors that Coleman was the only person with access to the bank account's checks and ATM card.

Checks payable to a company owned by Jones total $37,700; checks payable to "cash" and endorsed by her totaled $13,000, and checks payable directly to her were $11,259.
When auditors repeatedly asked Jones about money she might have received from the account, she told them she had gotten reimbursement only for travel expenses to conferences, according to the audit report.

They showed her two checks totaling $3,750, and she said those were the travel expenses she had referred to. Auditors then showed her $8,009 in checks made out to her for "vendor services" and "evaluation services."

"This is interesting," she said, according to the audit. "Maybe I did receive funding."

After auditors showed her $13,000 more in checks made out to "cash" that bore what appeared to be her signature and asked why she would have received that money, she said she didn't have a response.

Also, the audit said, $23,500 in questionable payments was made from the account to two administrative assistants and a former consortium contractor.

The state audit found that the mailing address for the undisclosed bank account was initially a mail drop box in a Durham shopping center, about six miles from NCCU's campus. The address was later changed to another mail drop box in Raleigh, and then to Coleman's home in Raleigh.

The account was not discovered until the university's internal audit after Coleman was fired.

Early last year Chancellor Charlie Nelms said he had fired an unnamed auditor who wrote an initial draft of the internal audit, saying the auditor had done work that was so sloppy he didn't trust it. Then, after its investigation turned up the undisclosed bank account, NCCU suspended the internal investigation and turned its findings over to the state.

Nelms asked Jones to step down as provost in 2008 for unrelated reasons, and she took a six-month paid leave, receiving $104,000 as she prepared for her return to teaching. At the end of the leave, though, she retired. The move was considered proper under UNC system policy.

Coleman also once received an unusual payment at the end of a previous job. In 1999, the Durham school system didn't renew her contract as its director of vocational education just weeks after she was named by her peers across the state as the best in North Carolina. She petitioned a judge to force the school system to restore her contract, which she said had been improperly terminated.

The school system paid her $12,500 to end her effort to be reinstated.

jay.price@newsobserver.com or 919-829-4526
UNC Health looks at WakeMed offer

BY ALAN M. WOLF - STAFF WRITER

A committee set up by the UNC Health Care System to review Wake Med's $750 million, unsolicited bid to buy rival hospital Rex Healthcare is seeking public comments on the deal.

The committee, which met for the first time Tuesday in Chapel Hill, set up an online feedback form at http://unchealthcare.org/specialcommittee.

"This is just one piece of a larger puzzle, but we felt it was important to hear from community members and patients that we serve," UNC Health spokeswoman Jennifer James said. The committee also will weigh such factors in its review as financial data, legal issues and quality of care.

UNC officials have said they aren't interested in selling Rex, which the system bought in 2000. But they are reviewing Wake Med's offer as part of their "fiduciary responsibility."

The committee is expected to review Wake Med's offer for at least several weeks and give recommendations to the full UNC Health board. UNC Health's committee is led by D. Jordan Whichard. It includes UNC-Chapel Hill Chancellor Holden Thorp, Rex Chairman Dale Jenkins, N.C. Mutual CEO James Speed, Rev. Lisa Fischbeck and Dr. Andrew Greganti.

WakeMed officials contend that selling Rex would improve Wake County's health care market. Wake Med has set up a website to provide information and solicit comments: www.thewakemedxray.com/.
RALEIGH, N.C. – North Carolina community college leaders are balking at a proposal to save about $5 million a year by merging the administration and back-office work at the smallest campuses.

The General Assembly's program evaluation division reported today that merging 15 of the smallest colleges into bigger neighbors and forming a purchasing cooperative to get volume discounts would save nearly $30 million over six years.

No campuses would close. The schools with fewer than 3,000 full-time students would lose their separate presidents, payroll departments and other administrative functions to the larger community college in the merger.

Twenty of the state's 58 community colleges already run multiple campuses. Community College System President Scott Ralls says $5 million a year in savings is small compared with the disruptions the mergers would cause.
June 25, 2011

Even for Cashiers, College Pays Off

By DAVID LEONHARDT

ALMOST a century ago, the United States decided to make high school nearly universal. Around the same time, much of Europe decided that universal high school was a waste. Not everybody, European intellectuals argued, should go to high school.

It’s clear who made the right decision. The educated American masses helped create the American century, as the economists Claudia Goldin and Lawrence Katz have written. The new ranks of high school graduates made factories more efficient and new industries possible.

Today, we are having an updated version of the same debate. Television, newspapers and blogs are filled with the case against college for the masses: It saddles students with debt; it does not guarantee a good job; it isn’t necessary for many jobs. Not everybody, the skeptics say, should go to college.

The argument has the lure of counterintuition and does have grains of truth. Too many teenagers aren’t ready to do college-level work. Ultimately, though, the case against mass education is no better than it was a century ago.

The evidence is overwhelming that college is a better investment for most graduates than in the past. A new study even shows that a bachelor’s degree pays off for jobs that don’t require one: secretaries, plumbers and cashiers. And, beyond money, education seems to make people happier and healthier.

“Sending more young Americans to college is not a panacea,” says David Autor, an M.I.T. economist who studies the labor market. “Not sending them to college would be a disaster.”

The most unfortunate part of the case against college is that it encourages children, parents and schools to aim low. For those families on the fence — often deciding whether a student will be the first to attend — the skepticism becomes one more reason to stop at high school. Only about 33 percent of
young adults get a four-year degree today, while another 10 percent receive a two-year degree.

So it’s important to dissect the anti-college argument, piece by piece. It obviously starts with money. Tuition numbers can be eye-popping, and student debt has increased significantly. But there are two main reasons college costs aren’t usually a problem for those who graduate.

First, many colleges are not very expensive, once financial aid is taken into account. Average net tuition and fees at public four-year colleges this past year were only about $2,000 (though Congress may soon cut federal financial aid).

Second, the returns from a degree have soared. Three decades ago, full-time workers with a bachelor’s degree made 40 percent more than those with only a high-school diploma. Last year, the gap reached 83 percent. College graduates, though hardly immune from the downturn, are also far less likely to be unemployed than non-graduates.

Skeptics like to point out that the income gap isn’t rising as fast as it once was, especially for college graduates who don’t get an advanced degree. But the gap remains enormous — and bigger than ever. Skipping college because the pace of gains has slowed is akin to skipping your heart medications because the pace of medical improvement isn’t what it used to be.

The Hamilton Project, a research group in Washington, has just finished a comparison of college with other investments. It found that college tuition in recent decades has delivered an inflation-adjusted annual return of more than 15 percent. For stocks, the historical return is 7 percent. For real estate, it’s less than 1 percent.

Another study being released this weekend — by Anthony Carnevale and Stephen J. Rose of Georgetown — breaks down the college premium by occupations and shows that college has big benefits even in many fields where a degree is not crucial.

Construction workers, police officers, plumbers, retail salespeople and secretaries, among others, make significantly more with a degree than without one. Why? Education helps people do higher-skilled work, get jobs with better-paying companies or open their own businesses.

This follows the pattern of the early 20th century, when blue- and white-collar workers alike benefited from having a high-school diploma.
When confronted with such data, skeptics sometimes reply that colleges are mostly a way station for smart people. But that’s not right either. Various natural experiments — like teenagers’ proximity to a campus, which affects whether they enroll — have shown that people do acquire skills in college.

Even a much-quoted recent study casting doubt on college education, by an N.Y.U. sociologist and two other researchers, was not so simple. It found that only 55 percent of freshmen and sophomores made statistically significant progress on an academic test. But the margin of error was large enough that many more may have made progress. Either way, the general skills that colleges teach, like discipline and persistence, may be more important than academics anyway.

None of this means colleges are perfect. Many have abysmal graduation rates. Yet the answer is to improve colleges, not abandon them. Given how much the economy changes, why would a high-school diploma forever satisfy most citizens’ educational needs?

Or think about it this way: People tend to be clear-eyed about this debate in their own lives. For instance, when researchers asked low-income teenagers how much more college graduates made than non-graduates, the teenagers made excellent estimates. And in a national survey, 94 percent of parents said they expected their child to go to college.

Then there are the skeptics themselves, the professors, journalists and others who say college is overrated. They, of course, have degrees and often spend tens of thousands of dollars sending their children to expensive colleges.

I don’t doubt that the skeptics are well meaning. But, in the end, their case against college is an elitist one — for me and not for thee. And that’s rarely good advice.

David Leonhardt is a columnist for the business section of The New York Times.
**Same Job, Higher Salary**

The value of college is not only that it gives graduates entry to high-paying occupations. A four-year college degree also brings higher pay in many fields that do not require a degree, a new study has found.

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<th>GREATEST SALARY BUMP FOR THOSE WITH DEGREE</th>
<th>MEDIUM SALARY BUMP</th>
<th>LOWER SALARY BUMP</th>
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Salaries rounded to nearest $1,000, in 2009 dollars.

Source: Center on Education and the Work Force, Georgetown University
Family doctors are overwhelmed with patients, procedures and paperwork. Many are leaving the field, creating a scarcity of primary-care physicians. (Christopher Serra, For the Times / June 27, 2011)

What happened to the family doctor?
They're overwhelmed with patients and paperwork and they're leaving the field. Solutions could include patient-centered medical homes, healthcare coaches and fee changes.

By Cathryn Delude, Special to the Los Angeles Times
June 27, 2011

The days of the old-fashioned family doctor who knows us intimately and treats our kids — and our grandkids — are fading fast.

Instead, we're more likely to find ourselves searching for a doctor who will take our insurance, then waiting weeks for an appointment and hours in the waiting and exam rooms. Our doctor will rush in and rush through a series of pokes and prods and a checklist of questions, check off some codes on our record, then rush out again.

None of this makes us very happy — or, for that matter, the doctor either.

Primary-care doctors take care of the young, the old and the in-between; the sick, the well and the dying. Ideally, they're familiar with us and our family history, have a comprehensive overview of our various ailments and medicines and provide us continuity in the world of fragmented medical specialties. But their trade, they say, is getting trickier and more time-consuming, and that's fast making them an endangered species.

Patients, they say, want more from their doctor these days — more office hours, more email and phone contact, more follow-up, more coordination with specialists and
insurers, more discussion about options and more expertise on more topics (aided and abetted by that constant TV-ad refrain, "Ask your doctor if X is right for you").

And the healthcare system expects more of doctors too — more preventive services, more care for chronic diseases, more healthful lifestyle coaching, more screening for depression and risky behavior (guns? cigarettes? bike helmets?), more delicate discussions (prostate biopsy? end-of-life wishes?), more documentation and now electronic records too.

Numerous studies have found that when primary care works well, patients are healthier, with better management of chronic diseases and fewer emergency-room visits and hospitalizations. All that saves healthcare dollars too.

But many doctors say there is not enough time in a typical 15- to 20-minute office visit to cover all the tests, inquiries and procedures recommended by medical schools, the U.S. Preventive Services Task Force and other organizations — even when dealing with a healthy patient.

"It's almost overwhelming," says Dr. Christine Sinsky, a primary care physician at Medical Associates Clinic and Health Plans in Dubuque, Iowa. "I think many of the new expectations are laudable and yet can't be delivered by one person working all by themselves."

And so doctors must give some things short shrift. A conversation about prostate cancer screening that would ideally take 10 minutes gets maybe a minute, says Dr. Mark Friedberg, a researcher at the Boston office of the nonprofit Rand Corp. who practices two mornings a week at a Brigham and Women's Hospital clinic in the Massachusetts city. "Physicians don't have time to really do optimal primary care," he says.

The situation is worse, he adds, when you factor in the increasing number of patients with complex conditions such as asthma, diabetes, obesity or heart disease. They require more frequent visits, and the list of steps recommended for their care is steadily growing.

Rushed office visits are only a part of the problem: Growing too are activities outside the exam room. Every prescription refill request should trigger a review of a patient's medical records. Every lab test, imaging result and specialist report should be interpreted in light of the patient's overall treatment plan.

Doctors are now meant to keep registries of patients with chronic diseases and periodically reach out to them to make sure their conditions are managed.

"It's common to have two hours of documentation work to do at home after the kids are in bed," Sinsky says — and there's no formal way to bill for these tasks or receive productivity Brownie points for doing them.

Studies back up these doctors' gripes. It would take 10.6 hours a day for a physician to
follow all the treatment recommendations for patients with 10 common chronic diseases, including diabetes, heart disease, high blood pressure, depression, asthma and arthritis, according to a 2005 study in the Annals of Family Medicine. That doesn't leave much time for a 6-year-old's school physical or his mother's brush with the flu.

Activities outside the exam room consume about 20% of a primary-care doctor's workday, according to a physician survey reported in the Journal of General Internal Medicine in 2010. This tally includes telephone and email interactions that often substitute for office visits.

Many of us prefer these virtual visits: Our time is precious too. But they are a problem for doctors because most healthcare insurers, including Medicare, reimburse doctors only for face-to-face visits, a payment model called fee for service. And even many aspects of office visits are essentially free, because primary-care doctors must bill for their time using only five codes for Medicare and most commercial insurers.

"If you can't find a code that describes what you are doing, you don't get paid," said Dr. Roland Goertz, president of the American Academy of Family Physicians, which represents more than 100,000 doctors and medical students.

But for many primary-care doctors, the frustration is not so much about pay as about all the things that interfere with their ability to spend adequate time with their patients.

The number of U.S. medical school graduates opting for primary care dropped almost in half between 1999 and 2009, according to the latest statistics, though the trend has reversed a little in the last two years. They're flocking instead to specialties such as anesthesia and dermatology. Meanwhile, primary-care doctors are leaving their practices to become specialists or employees of hospitals, with set hours and salaries.

The trend comes at a point when they have a pivotal role to play in a nation suffering from more and more chronic diseases and higher healthcare expenses, experts say.

So what's to be done?

Four physician groups — the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Assn. — believe the answer lies with a different way of patient care, known as patient-centered medical homes. It's an idea that germinated in the late 1990s as a way to provide patients more access to primary care — with longer office visits and office hours, more convenient electronic scheduling, a team approach to managing patients' health and more email and telephone contact with physicians.

To date, more than 100 primary-care practices in the U.S. — a tiny fraction — have restructured themselves as patient-centered medical homes. Some are pilot programs funded by President Obama's Affordable Care Act.
For these "homes" to work, experts say, medical practices need to move away from paying doctors just for face-to-face visits to a system that pays them a set amount for each patient, including services outside the exam room, so that the doctor can focus on keeping patients healthy rather than checking off codes.

The medical homes also require well-functioning teams of doctors, physician assistants, nurses and other staff that share responsibility for patient care, says Sinsky, whose 115-physician group in Dubuque was an early adopter of the model. "That's hard for small or solo practices. It requires more infrastructure, and that doesn't happen for free," she says.

And there are other complexities. Ideally, the medical home model would give doctors more time with their patients — to make this happen, some advocates suggest that doctors should have fewer patients. But this could exacerbate the shortage of primary-care doctors, Sinsky says.

Another suggested alternative is scheduling fewer individual office visits with patients and more group visits — say, bringing together several obese patients to meet with a nutritionist — and offering more care remotely, such as having diabetes patients email their blood sugar or blood pressure results from at-home monitors rather than come to the office for them to be checked.

An even better solution, some say, could be to relieve physicians of more tasks that support staff could reasonably do — such as renewing prescriptions or ordering routine tests.

"You don't need a doctor to order a mammogram every two years for a woman 55 years old," says Dr. Thomas Bodenheimer, a professor of family and community medicine at UC San Francisco who practiced medicine for 32 years. A healthcare coach — who is a trained medical assistant — could do that just as easily, and could also handle a good chunk of the counseling about healthful living and disease management that is a key part of primary care.

Finally, perhaps it's time to allow doctors to focus on medicine and let the mass media and public service outreach handle topics such as seat belts, sun block, domestic violence and drugs, says Dr. Victoria McEvoy, medical director and chief of pediatrics at Mass General West Medical Group in Waltham, Mass. Obviously, adolescents should be discouraged from alcohol use, for example — but McEvoy notes that there's little evidence to suggest that advice from a physician actually convinces a risk-taking teen to lay off.

There are some nonmedical issues that just might stay in the doctor's office, though.

"I write letters to the electric company on behalf of my diabetic patients, pleading with them not to turn off the power. The cost to the system would be just too great if the insulin pump failed," Friedberg says. "No dermatologist will ever help you with your power bills."