"My practice is full and I can't take any new patients"

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All across the country, this refrain is heard with dismay by patients seeking a primary care physician. Although the concept is debated, there is consensus that it is good for patient care that every person be able to access a primary care provider to assist him or her with both routine and urgent care.

Physicians are independent practitioners, no less when demand for their services is high than when it is low. They are free to decide to work more or less, part-time or full-time, and even, perish the thought, to take holidays or retire. Against this backdrop are increasingly forceful demands for social accountability, "populational responsibility" and other demands that limit a physician's ability to manage his or her own time.

It is therefore not surprising to me that in the one area over which physicians have absolute control — the patient–physician relationship — they push back.

I say this because although I am among those who instruct their secretaries to advise inquiring patients that my practice is "closed," I am not quite sure how I know this. Digging a bit deeper, I think I am saying "I have as much work as I want, and I prefer to continue to care for patients I know than to take on new challenges with patients I don't." This is not quite the same thing as saying that my existing patients would be harmed (by waiting longer to see me) if I took on others. Even if on occasion an afternoon office is particularly lightly booked, my reflex is not to fill the slot with a new patient, but rather to take a coffee break!

I don't feel too guilty about all this. As a rural physician, I work long enough hours as it is. Nevertheless, I would welcome some tools to help me identify when and how to take on new patients, rather than doing so on a whim or as a result of a particularly effective lobby from a colleague, a patient or family member.

What I would like to see would look something like this:

- The responsibility for accepting new patients in a community becomes a "group" responsibility of the physicians of that community, and mechanisms need to be found to fairly distribute the load.
- There should be "1 number to call" for patients seeking a physician.
- The acceptance of a new patient should be remunerated in recognition of the challenge that a "new" patient presents, compared with a patient well-known for many years.
- Patients should have in their possession a standardized medical history, which would allow priority to be given to those with greater medical need.

Perhaps this already exists in various forms. If so, there would be benefit to making this known to the larger community. Certainly physicians have their limits, and only they can define them, but patients have a right to have their access to care determined on an objective rather than ad hoc basis. This achieved, the pressure could more effectively be applied where it belongs: on those responsible for physician supply — governments, colleges and medical schools.