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Why Our Patients Deserve Our Time

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But with the advent of newly designed health systems in the Affordable Care Act, I would argue we have to fight for a system of care that works for our patients. Not every patient needs more face time from their primary care team, but many do.

The men in my primary care practice are usually sicker than average patients. Like most women physicians, I attract a much higher percentage of women than men into my practice; many of these women are fairly healthy. In contrast, the men who come to see me are often referred because they haven't done well with someone else.

A particular male patient of mine stands out as having taught me a lot about caring for patients. Earlier in my career I would spend about three months yearly attending on inpatient ward services, and Tudy B. was a patient who I first met during an inpatient stint. He was an older patient of Italian heritage and frankly would not have chosen a woman as his primary care physician under normal circumstances. Although I like to think that I develop positive rapport with most of the patients I see, I was surprised when he asked if I would care for him upon hospital discharge.

I soon learned one reason that Tudy likely had not thrived with his previous physician. Tudy needed to develop trust by spending time talking with his physician, and this process fit poorly into the 15- to 20-minute appointment slots that most of us are allocated for primary care visits. This was particularly true for a man with Tudy's formidable problem list, particularly longstanding and poorly controlled hypertension, heart failure, and associated sequelae. In my attempt to meet Tudy's needs without crippling the rest of my schedule, I took to seeing him during non-clinical time. This is the kind of thing that can decimate your academic time, but every once in a while you have to break your own rules.

I saw Tudy frequently, usually twice a month—partly to tinker with his diuretics and ACE inhibitors and partly to establish and maintain trust. Essentially, we developed a therapeutic relationship. Again, he surprised me—this time by how well he did. He stopped smoking, took his medications, and ate fewer salami sandwiches. His kidney function held its own for quite some time. In the course of these visits, I learned a lot about the history of Milwaukee and realized Tudy had many similarities to my own father. For example, both of them told me of the profound effects of seeing signs saying "NINA" in the storefronts when they were young men looking for jobs. In Tudy's world, "NINA" meant "No Italians Need Apply," while in my father's neighborhood, it was "No Irish Need Apply." Over time, I had gained Tudy's trust and understood his values fairly well.

From time to time, I meet with insurance company medical directors about the performance of our practices. In anticipation of one of these meetings, I was told that the insurer wished to discuss one of my faculty who was thought to be "churning" patients, which turned out to mean that he was seeing his patients with chronic illness more often than the norm. I braced myself to defend my faculty member, but the meeting went very well because in the interim the insurer had done more data analysis and learned that the outcomes of patients seen by this faculty member were substantially better than expected. It appeared that bringing certain patients in for more than the expected number of visits was somehow beneficial for glycol-Hb levels and blood pressure readings.

I cannot help but think that some of the better-than-anticipated outcomes for Tudy and for my faculty member who was initially thought to be "churning" had to do with building rapport—or connectedness—with patients. The relationship of frequency of visits (or visit time) and outcomes is fraught with selection bias and difficult to study. However, some data support a relationship between physician-patient connectedness and quality of primary care.[1]

Undoubtedly, we are all aware that health care costs in the United States are higher than in other affluent countries. But we may not all be aware of the extent to which health status and outcomes are worse in the United States than in other similar countries. Among 17 wealthy developed nations, the United States has the highest prevalence of obesity and diabetes and the second highest death rate from ischemic heart disease.[2] Life expectancy at age 50 is also lower relative to the 16 other developed countries. It might be argued that these facts reflect barriers to care for the under- and uninsured. However, the US health disadvantage is not limited to those of low socioeconomic status.

continued on page 2

PRESIDENT'S COLUMN

continued from page 1

It is found even among those who have health insurance, a college education, and higher incomes.

Some of the US health disadvantage may be due to societal policies, such as those related to firearms or to the way the layout of many of our suburban cities facilitates driving rather than walking. But one does not have to practice primary care very long to realize that the status quo with regard to expected length and frequency of visits is frustrating to both patients and providers. Studies of US patients vs. patients in other countries show that US patients are more likely to report episodes of low-quality, poorly coordinated care and miscommunication with their clinicians.[2] These are indictments of our "system" of primary care, and these apply to everyone—including those with access to services.

To me, these findings lead to a conclusion that many of our patients (especially those with chronic illness) need more of our time. Some tell me that I am naïve. We have a huge problem with the cost of medical care in this country, and the idea that primary care physicians should see fewer patients (i.e. be "less productive") will gain support from few. But with the advent of newly designed health systems in the Affordable Care Act, I would argue we have to fight for a system of care that works for our patients. Not every patient needs more face time from their primary care team, but many do. Of course, others may benefit from e-mails in the place of office visits. Somehow in the past, we let others set our expectations for how to structure primary care practice. We need to take this opportunity to advocate for a system that we can believe in.

References

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2. Woolf SH, Aron LY. The US health disadvantage relative to other high-income countries: findings from a National Research Council/Institute of Medicine report. JAMA 2013 (published online January 10, 2013).

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