Why Our Patients Deserve Our Time
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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 referred because they haven’t 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.

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. 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.
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. 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
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).