Are PCPs Nearing Extinction? An Interview with Dr. Richard Parker

by Debbie LaValley, BSN, RN, and Jock Hoffman

Ms. LaValley is a Senior Loss Prevention Specialist for CRICO/RMF and Issue Editor of Forum. Jock Hoffman is Editor of Forum.

The erosion of the enjoyable aspects of practicing general medicine in an office practice is well chronicled. Vacancies are becoming harder to fill and keeping established providers from seeking alternatives is difficult. Selling primary care as a career choice is a tough challenge in light of the stresses and strains imposed on those who choose that path.

But, then again, complaining about your job is as American as apple pie. What *Forum* wanted to examine was how this evolution in health care delivery is affecting patient safety. To explore that, we spoke with Dr. Richard Parker, an internist at Healthcare Associates, Beth Israel Deaconess Medical Center (Boston) and Medical Director for the Beth Israel Deaconess Physician Organization. Dr. Parker occasionally serves as an expert witness in medical malpractice trials.

Forum: *Dr. Parker, how do the challenges that internists face these days impact patient safety?*

Richard Parker: Doctors are asked to see patients even faster than we used to just a few years ago: it is now 30-40 minutes rather than an hour for a new visit, and just 20 minutes instead of 30 minutes for a follow-up visit. That substantially increases the risk of the doctor missing something important that could lead to an adverse outcome. A doctor needs to be thinking clearly, needs to be at least a little bit relaxed, needs to be paying attention to the patient. He or she has to be in a reasonable frame of mind to do the work.

How can a physician prepare to be in that frame of mind when he or she comes into the office in the morning?

We need to pay more attention to the whole issue of morale. I believe that doctors who feel good about their work, who are generally well rested, who feel supported by their practice on a daily basis, who feel supported by their leadership, and who have a reasonable schedule, are more likely to connect better with their patients and have fewer adverse events. The converse of that is doctors who feel stressed, harried, pushed around, and uncared for. Quite likely, the work product that comes out of those people is not going to be as good.

Let me give you an example: imagine a complicated patient calls on a Friday afternoon. The satisfied physician is more likely to say, "Yes, I will add Mrs. Jones onto my schedule. She has a fever and a rash and I know her well and I need to see her."

The doctor who is unhappy, or perhaps even depressed, may be more likely to say, "You know what? That's not my job. She can go to the ER, or someone else will have to take care of it." Those little decisions, on the margins, can really have an enormous effect on the outcome for a patient.

Is primary care really losing its appeal among physicians, or is that just an urban legend?

The marketplace is speaking. We have seen a growing difficulty in hiring and retaining high quality internists because many of them perceive the job as overworked, underpaid, and not worth the stress. I dearly hope that the market and the system will adjust so that this very important job, which includes coordination of care for ill individuals—as well as being on the frontline of diagnosing diseases and caring for chronic diseases—is appropriately valued once again.

How do we do that?

Like anything else, before you can have a treatment you need the diagnosis, and the diagnosis to this problem resides partly in the Medicare fee schedule which codifies how internists and procedural specialists are paid. Specialists have been very successful in lobbying in Washington for rates of reimbursement higher than those for nonprocedural doctors. That has to be corrected in order to right the balance between procedural and nonprocedural physicians.

What can patients do to get better care?

Act like a lobbyist. Patients who advocate for themselves in an organized fashion probably get better care. An organized patient prepares ahead of time. Even though doctors may cringe when they see "the list," at least they can ask the patient which are the most important items for today's visit and then, if there is not enough time, invite the patient to return another day to cover the remaining concerns.

Why would a physician cringe?

Because a physician seeing a patient who comes in with a list of 12 problems will often not be able to satisfy that patient during that visit; there is not enough time. Doctors can, however, communicate very effectively in short periods of time, so the brief visit can be used efficiently. But that often means talking less, listening more actively, and paying close attention to expectations.

What gets in the way of the doctor doing a full assessment?

One issue is the patient who comes in with an agenda ("the list")—perhaps with multiple physical and emotional problems on her mind—and we never get around to the cancer screening issues. That is where a systems approach can help remind the doctor that this patient still has not had a mammogram, Pap smear, or colon cancer screening. Regardless of the patient's episodic agenda, the physician is obligated to have a system to keep track of health maintenance needs.

A different sort of challenge is presented by the patient who comes in with a constellation of symptoms that seems confusing and cannot be solved in one visit. In this situation, the physician needs to ensure follow-up to go over the problem again and review all data already gathered. If the patient is referred to a specialist, two-way communication assures that the specialist knows the question being asked and that the internist hears the specialist's opinion. If the problem remains unresolved, the internist is responsible to oversee the ongoing care and keep the door open to further investigation.

Can technology help?

Yes, but not all EMRs (electronic medical records) are created equal. Some systems can be very helpful and some can be downright irritating. And, some can be both! When a system ends up nattering in the faces of doctors so frequently with reminders about this, that, and everything, then the doctor begins to tune out most, if not all, of it. When the system that is supposed to be the solution does not take human factors into account, it becomes neutralized.

On the other hand, a good information system, set up correctly, can really help doctors not miss things. But of course, good information systems are very expensive to set up and incur significant time costs (missed work) for doctors in the transition from paper to EMR. It is a complex and expensive undertaking, which explains why it is not as prevalent as it should be.

Is there a way to make that EMR "noise" useful for reminding the practicing internist to do the colonoscopies, mammograms, et cetera?

Systems or no systems, noise or no noise, physicians are responsible for the care of their patients. I am responsible to make sure that my patients over the age of 50 get screened for colon cancer. Certainly, I welcome any help the EMR or the staff can give me. The tough question is, what works best?

The leadership within an organization must set the priorities. Real leadership means including the physicians on the front line in the discussion. For example, we might ask of our primary care providers "Focus on screening for colon, breast, and cervical cancer, and we will put the systems and staff in place to help you accomplish those goals." The leadership within an organization decides what the priorities are and then engages the doctors and staff in accomplishing the goals.

Is the doctor responsible for contacting no-show patients and helping to reschedule the test?

The doctor's responsibility is proportional to the gravity of the diagnosis for which the test was ordered. If I think a patient has active tuberculosis, and I send him for a chest X-ray, and he doesn't go for it, then I had better take every step imaginable to get that patient back in here to get that chest X-ray.

On the other hand, if I send a teenager with a possible toe fracture upstairs for an X-ray, and she decides not to get it, I don't think anyone thinks I need to chase her down.

Who's responsible for closing the loop on abnormal results and referrals?

It depends.

Say, for example, a physician detects a worrisome breast lump and advises the woman to obtain a mammogram and see a surgeon. The high intensity of that situation obliges the physician to make sure she goes for that test, even to the extent of (if necessary) repeated letters and phone calls (which should be documented). On the other hand, say the physician advises a patient to get labs done for cholesterol and the patient declines. The physician has much more discretion about whether to chase down that patient.

In my practice, I send letters to every patient who has a test and I find that it provides a safety net. If I miss a test result and the patient doesn't get a letter, they call me up and ask why. I realize that many of my colleagues may feel they don't have the time to do that but, whatever system they do use, they are responsible for tests that they order.

What is the internist's role when test results come back with an unanticipated abnormal finding, such as a pulmonary nodule on a chest X-ray?

The doctor who orders the test is responsible for reading the entire report and acting on any significant abnormalities. This represents a major burden for internists as he or she reads so many reports each day. Part of the problem here is information overload. We are ordering more tests than ever before.

Is that unreasonable?

Yes. Patients request too many tests and doctors order too many tests. Often, doctors feel pressured to order the tests because they are afraid of missing something (and then being sued). But, excessive testing leads to false positives that then lead to yet more expensive testing, often with procedures that have morbidity associated with them. In the end, it is not of benefit for the patient and it drives up health care costs.

When patients see more than one physician, whose job is it to coordinate their care?

When doctors are working within the same system—more specifically, when they are using a shared electronic medical record—the coordination of care is fairly easy. Doctors and nurse practitioners can forward their notes to each other and share them along with labs, X-rays, reports, et cetera in a medical record that everyone has access to.

Continued on page 12

Continued from previous page

with post-discharge medication reconciliation, ideally during the patient's first post-discharge visit with his or her PCP. This requires a review of what medications the patient was taking prior to admission, the discharge medication regimen, and the patient's clinical status, and then creating a new post-discharge medication list to be communicated with the patient and all providers. Partners is working on a post-discharge reconciliation screen within its LMR, but paper processes are also feasible.[17] Going forward, medication information, including lists from outpatient electronic health records and hospitals, as well as pharmacy and claims information, will need to be available in a standard electronic format that can be communicated across all sites of care so that an accurate medication list can be obtained wherever care is delivered. ■

References

1. Billings JA, Stoeckle JD. *The clinical encounter: a guide to the medical interview and case presentation.* Chicago: Year Book Medical Publishers, Inc.; 1989.
2. Murff HJ, Byrne D, Syngal S. Cancer risk assessment: quality and impact of the family history interview. *Am J Prev Med* 2004;27:239–45.
3. www.partners.org
4. Volk LA, Staroselsky M, Newmark LP, et al. Do physicians take action on high risk family history information provided by patients outside of a clinic visit? Paper presented at: MedInfo, 2007; Brisbane, Australia.
5. For example, the CRICO/RMF Breast Care Management Algorithm and the CRICO/RMF Colorectal Cancer Screening Algorithm both feature a risk assessment checklist that includes family history in guiding providers to the appropriate level of testing.
6. Wald JS, Middleton B, Bloom A, et al. A patient-controlled journal for an electronic medical record: issues and challenges. *Medinfo* 2004;11:1166–70.
7. Kripalani S, Henderson LE, Chiu EY, Robertson R, Kolm P, Jacobson TA. Predictors of medication self-management skill in a low-literacy population. *J Gen Intern Med* 2006;21:852–56.
8. Alibhai SM, Han RK, Naglie G. Medication education of acutely hospitalized older patients. *J Gen Intern Med* 1999;14:610–16.
9. Beers MH, Dang J, Hasegawa J, Tamai IY. Influence of hospitalization on drug therapy in the elderly. *J Am Geriatr Soc* 1989;37:679–83.
10. Kripalani S, Phillips CO, Basaviah P, Williams MV, Saint SK, Baker DW. Deficits in information transfer from inpatient to outpatient physician at hospital discharge: a systematic review. *J Gen Intern Med* 2004;19 (S1):135.
11. Calkins DR, Davis RB, Reiley P, et al. Patient-physician communication at hospital discharge and patients' understanding of the postdischarge treatment plan. *Arch Intern Med* 1997;157:1026-30.
12. Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med* 2005;165:1842–47.
13. Schnipper JL, Kirwin JL, Cotugno MC, et al. Role of pharmacist counseling in preventing adverse drug events after hospitalization. *Arch Intern Med* 2006;166:565-71.
14. American Association of Retired Persons. Mi registro de medicacion. http://assets.aarp.org/www.aarp.org_/articles/health/docs/PersonalMedRecordSP.pdf. Accessed October 20, 2006.
15. American Association of Retired Persons. My Personal Medication Record. http://assets.aarp.org/www.aarp.org_/articles/learntech/wellbeing/medication-record.pdf. Accessed October 20, 2006.
16. See 2007 National Patient Safety Goals 8, 8A, and 8B: www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/07_hap_cah_npsgs
17. Several examples are available in *What Works: Effective Practices in Office-based Care* at www.rmf.harvard.edu/patient-safety-strategies/office-practices.

Continued from page 9

Where I see problems occurring most is when patients obtain care at different systems. They come to see one doctor at Hospital A and go two blocks down the street to Hospital B and see another doctor who does not have access to Hospital A's information system. Communication cannot be as good under these circumstances. I have seen a number of lawsuits filed because patients went to multiple medical centers and no one person knew all of what was going on... and things were missed.

Whose responsibility should it be for coordinating such situations?

It is always easy to say that it should be the internist, but I think that if the internist has encouraged the patient to stay within the institution—so that continuity of care can be achieved—and the patient still chooses to go out of the system, then it is harder for the internist to be held completely responsible. Doctors do need to communicate across institutions, but we need to better educate patients who choose to go across institutions that there may be problems with the coordination and the continuity of their care. Of course, the ultimate solution is having all doctors and hospitals on one information system like Great Britain, Denmark, and the Veterans' Administration have achieved.

Are office staffs being asked to do too much, or not enough?

Better allocating of staff roles can improve care and decrease adverse events. For example, our practice cares for approximately 40,000 patients. Rather than relying on the memories and abilities of individual physicians, it may make more sense to have nurses look at patient registries and medical records to find out who might be missing a screening test.

Are hospitalists helping primary care providers?

It depends. Hospitalists are well trained, have the advantage of being on site most of the day, and provide a high level of care—those are all pluses. On the negative side, hospitalists, by definition, are unfamiliar with most of the patients who get admitted. They may not know some of the subtle historical issues that could be important about any given patient. I do know that our hospitalists work hard to communicate with the referring doctors during the hospitalization and at the time of discharge. That's another place where electronic medical records and systems can really facilitate the communication of accurate medication lists that are vital.

Why do people choose general internal medicine as a career?

People who are dedicated to caring for patients over a long period of time and enjoy building relationships with patients—and even their families—are best suited for internal medicine. I saw a patient in the hospital today with pneumonia complicated by myocardial infarction, someone whom I have cared for for 20 years. When he saw me, he broke in to a big smile. ■

Click here for the complete issue.