Late Again

Category: Stories
written by Paul Gross | September 18, 2009

Paul Gross

One thing I love deeply about being a family doctor is that I get to take care of people—body and soul. A patient comes into my exam room with a litany of physical symptoms ("My shoulder…my knee…my stomach…so tired…this nausea…") and then, in response to a questioning look, suddenly bursts into tears.

It's all mine to deal with. The shoulder. The stomach. The tears. I get to gather the pieces and see if we can't put this broken person back together again.

What a privilege.

And yet the joy of primary care is also its curse. With each patient, I have to keep track of everything—the trivial and life-threatening, the physical and mental, the acute, the chronic and the preventive. And try as I might, I simply don't have enough time.

On paper, my office schedule looks simple: I see one patient every fifteen minutes beginning at 8:30 a.m. If I stick to my timetable, I can wrap up my twelfth patient by 11:30, finish up any leftover paperwork and enjoy an hour's lunch before starting again at 1:00.

Ha.

The reality is that I'm never done by 11:30. In fact, my colleagues and I are often still seeing our morning patients at 1:00, when our afternoon session is supposed to begin.

Lunch hour? Wouldn't it be nice.

And I have it easy. One hears of offices scheduling patients every ten minutes—*every ten minutes!*—and doctors "seeing" fifty patients a day.

Doctors talk of running on a hamster wheel. Patients complain that their doctors seem distracted, don't take the time to listen, and run late—as I routinely do.

Am I a bad doctor—disorganized and inefficient?

Or maybe I'm doomed to fall short as I bump up against powerful economic forces—the "do-more-with-less" pressures that make medical administrators everywhere create schedules like mine, designed to bring in enough money to keep health centers afloat but which end up hustling me and my patients along at an impossible pace.

As a nation, we are now trying to fix our foundering healthcare system.

Before we set new rules in place, shouldn't we first ask this basic question: how much time is actually required to see a patient?

Looking for an answer, I decide to record the events and actions of a recent office visit.

Today I'm seeing Minerva Santos, an extremely nice 49-year-old woman with diabetes and hypertension. Mrs. Santos is a great patient—she takes her medicines, shows up for appointments and is agreeable and uncomplaining. Compared with many other patients who are frail, in chronic pain, depressed, argumentative or uninsured, she's easy to care for.

So how long should a visit with Mrs. Santos take? Let's see.

At 8:30 this morning she walks in, placid and neatly attired, with short reddish-brown hair.

After a smile and a handshake, I tell Mrs. Santos that I'd like to review her labs and check her blood pressure. "Is there anything *you'd* like to talk about?" I ask.

"I've got a cough that's really bothering me," she says.

"Tell me about that." I add *cough* to my internal agenda. She describes a recent upper respiratory infection that flared briefly into a fever and now has her sniffling and hacking.

"Why don't I take a look in a minute?" I say.

"And I need all my prescriptions renewed," she adds. *Prescriptions*, I echo to myself.

We peer together at the computer screen. Mrs. Santos's measure of long-term diabetes control—her HbA1c—is elevated at 8.4. "We'd like to see it below 7," I tell her, "to reduce the risk of complications from your diabetes." Meanwhile, I'm wondering why her control isn't perfect.

Mrs. Santos checks her blood sugars at home; she tells me that her evening sugars are above 200 (normal is 100). Asked how she takes her diabetes medications, she says, "After eating, just like my last doctor told me to." This is odd, as they're supposed to be taken before or with meals.

We move to the examining table. I double-check her blood pressure: it's 160/100. Our goal is 130/80. Her throat, neck and lungs are unremarkable. "Looks like a bad cold," I say. "Would you like some cough medicine?"

"Fine," she says.

She fumbles in her bag and removes seven pill bottles, a modest number for someone with her ailments. I line them up, unscrew the tops and point to the diabetes pills. Could she take them *with* dinner rather than afterwards? And how would she feel about increasing one medication's dose?

“Okay,” she says.

I share my concern about her blood pressure. “It looks like you really do need a fourth blood pressure medication. How about if I give you a new one? You’ll take it once a day—with your other blood pressure pills.”

“All right,” she says.

I spend several minutes printing out all of Mrs. Santos’ prescriptions—four for hypertension, three for diabetes, one aspirin and one for cough. Acutely aware that I’ve added one new pill, changed the strength of another, and altered the timing of two others—a recipe for confusion—I spend a few minutes going over all this with her.

Scanning her chart, I also notice that she needs a tetanus shot, so I order one.

Mrs. Santos leaves the exam room with a request to make an appointment for one month from now. Feeling a pang of remorse that I neglected to inquire about her family, I look at the time: 9:03. This “simple” visit has taken thirty-three minutes. And it will take more time to complete my note.

So what did I do wrong?

Well, maybe nothing—and I did accomplish quite a few things. I

* evaluated and treated Mrs. Santos’ cough
* explained her lab results to her
* counseled her about the importance of diabetes and blood pressure control
* evaluated her blood sugar monitoring and clarified her pill regimen
* adjusted the dosage of her diabetes medications
* checked her blood pressure and prescribed a new medication
* ordered a tetanus shot and
* arranged for a follow-up visit

In addition, I also

* elicited her concerns
* assessed her understanding of our plan and
* deepened our connection

In some ways, I did a great job. But now my stomach’s churning because I’m twenty minutes behind schedule. A crabby seventy-eight-year-old woman with congestive heart failure, diabetes and chronic pain is next. Can I hope to see her in fifteen minutes?

I don’t think so.

Why not schedule longer visits? My health center could do that, but we’d lose money and have to fire staff and turn patients away. As it is, we already struggle to meet the needs of our vibrant, diverse Bronx community.

When I look at the big picture, I realize that I’m racing the clock partly

because there aren't enough primary care providers around. Medical students, who graduate on average more than $150,000 in debt, gravitate toward specialties that pay them more—or stress them less. In other words, they become just about any other kind of doctor.

This past year fewer than one in ten students graduating from U.S. medical schools chose residencies designed to train them in primary care. This is topsy-turvy, especially when you consider that countries with robust systems of primary care reward their citizens with better health outcomes—at lower cost—than ours does.

As our experts, policymakers and legislators take aim at our healthcare system, my plea is this: Make primary care a priority. Train more clinicians to do this critical work. Give every patient easy access to high-caliber primary care. And please…

Give me the time I need to see Mrs. Santos.

About the author:

Paul Gross is editor-in-chief of *Pulse—voices from the heart of medicine*.

Story editor:

Diane Guernsey