Annals of Internal Medicine

Is Primary Care Practice Sustainable? From the Secretary's Desk

As a medical student in 1984, I thought being a primary care provider was the "right thing to do." The soaring costs of health care coupled with a rebound away from specialization led many to pursue primary care internal medicine. I did not. I chose infectious diseases, and for the past 25 years I have worked in a hospital-based academic practice. In an odd turn of events, I recently had some free time, and my husband, an internist, suddenly lost his secretary. Thus, I became the secretary for his solo internal medicine practice, one within a larger organization but an office staffed by two: the doctor and the secretary/office manager.

Monday, my first day on the job, I met Ida (by telephone). Ida was 85 and lived with and took care of Ester, her lifelong friend with whom she owned a home. Ester was 92 and, as I later learned, had advanced dementia. Ida started the conversation, "Who is this? This is Ida. What's wrong with the doctor? Friday I left a message for him to call me, and he didn't call back. I don't know what's wrong with him. He used to always call back. Are you the new girl? We have come to him for 20 years. He sent Ester for an x-ray but never called to tell us what it showed." It took me a solid 10 minutes to reassure Ida that we had the results and the doctor would call her that day.

My second day started with a relative emergency. A surgeon needing preoperative clearance for a patient had not received my husband's note clearing the patient for surgery and the electrocardiogram. Both had already been sent to the surgical center per the instructions that the patient had provided, but the surgeon wanted to review the notes the day before surgery (not an unreasonable request). Digging 2-inches deep into the pile of patient reports awaiting scanning, I recovered the clearance note and the electrocardiogram. Ida's was the second telephone call that day. "Hi, dear. I'm sorry to bother you. The doctor called last night and told us the results, but he wants Ester to do something and I can't remember what he said to do. Can you have him call me?"

On Monday morning of week two, the first call was from Ida. I could hear hesitation in her voice. "I think I better tell you about this. Yesterday, I was on my way home from church and this woman who was walking stopped me as I was driving. She said I had sideswiped three cars. I don't know what happened. I didn't know it at all. I didn't see anything. What should I do? I can't tell Ester about this. I don't know whom to tell. Will you ask the doctor to call me?"

"Call?" I thought to myself. Having taken away my own mother's car keys when she was 90, I knew the complexity of this issue. "Ida, you need to come in and see the doctor. We will get you in this morning." After a 50-minute visit and a neurologic examination, Ida perhaps began to understand that she would need help. She would next see the neurologist.

During my 4 weeks, I often thought of Ida and wondered when she would call again.

As secretary, I started each day at the fax machine retrieving radiology reports, consult notes, and laboratory results from providers outside of our health care organization (in contrast, in my organization, there is one electronic record). In this office, approximately 50% of which is composed of Medicare patients, a few patients enter by wheelchair; some have a cane or walker. A handful know their copay; several are hesitant to schedule a follow-up appointment because they do not know who will be able to take them to the doctor. However, every patient is the same on one count: They want the doctor to call and speak with them and review their test results.

My days raced by answering the telephone, receiving and sending faxes, scheduling and cancelling appointments, sorting bills, filtering duplicate clinical reports, and presenting forms to the doctor for review and signature. These forms came from endless sources: for example, pharmacies documenting that the patient received an influenza vaccination (which the physician must now transcribe into the medical record), the visiting nurses, the ostomy supply company, the shoe company for diabetics. I fielded calls for interim doses of medications when the mail-order prescription services failed to deliver on time and arranged blood tests at outside laboratories when using a laboratory separate from this office was more convenient for patients.

As I cleaned up the laboratory area, I discarded 81 doses of last season's high-dose influenza vaccine (cost, $29.34 per dose) and 4 vials of multidose vaccine (cost, $90.67 per vial) because patients had transitioned to using local pharmacies for influenza vaccination. When an application for assisted living needed completion, the patient insisted that she did not have the time to see the doctor but would drop off the paperwork en route to the senior center that afternoon. "I saw him last month. He has everything he needs to fill it out," she replied. "Really?" I thought to myself. "Assisted living applications ask about continence, ability to prepare food, hygiene, and activities of daily living. Doesn't completion of this four-page application merit a 20-minute office visit?" The patients are loyal to their internist, but they do not understand the financial implications of the office visit (and lack of one).

At the end of 4 weeks, 691 pages of documents from outside and inside the organization had been accumulated that needed to be scanned into the electronic health record. These 691 pages were for 162 individual patients, a per-patient average of 4.3 pages and a per-patient range of 1 to 33 pages. These materials included more than receipt of external consults, discharge summaries, and laboratory results; there were the records that the office sends to other physicians involved in the care of the patients; the prescriptions for outside laboratory draws; the patient self-reports of glucose monitoring; handwritten lists of medications; articles that patients brought in for discus-

 © 2015 American College of Physicians

Downloaded From: http://annals.org/ by Kevin Rosteing on 05/23/2016

sion with the doctor; as well as the visiting nurse, community living, and disability forms.

Many are trying to make health care safer. The electronic health record corrects the problem of illegible notes, but, without a universal health record, we have now committed our office staff to faxing and scanning, hoping that the legible note will be retrievable. Payers request responses about safety issues, such as why a diabetic is overdue for a hemoglobin A_{1C} measurement, yet, if the payers would first review their own data, they would learn that the patient has not seen the doctor and that is the reason for the missing measurement.

Medication reconciliation is an initiative that all agree reduces serious errors. The Centers for Medicare & Medicaid Services' new transitional care payments are an important step toward promoting medication reconciliation through primary care visits after hospitalization. Yet, postdischarge patients often cancel the follow-up internist visit because there are too many physicians to see and the specialist who followed them in the hospital becomes the priority. We seem to be living in a safety factory with multiple robots working 24/7, but each works independently, generating a part. What is being built and whether we are communicating with patients and changing patient behavior in a way that will improve health is unclear.

Many patients told me how much they appreciated the doctor, that he spent time with them, listened to them, and truly cared for them. As I think about Ida, an 85-year-old woman who had nowhere to turn when she sideswiped those cars, I know that primary care internal medicine remains "the right thing to do." But the model of solo practitioner and secretary is no longer sustainable; in fact, the practice described in this essay is merging with other internists into a larger office.

Documentation requirements created to make health care safer demand additional office staff, which then requires additional patient visits, a process that can chip away at the relationship between the patient and the internist and even at the relationship between the patient and the secretary. As we move into new models of primary care, seeking ways to nurture those relationships will be important. Models for primary care with payment rates adjusted upward to meet the growing burdens described and rates that will permit an appropriate reduction in the size of the patient panel with reimburse-
ment for telephone follow-up need to be supported expeditiously.

Marisa A. Montecalvo, MD
New York Medical College
Valhalla, New York

Requests for Single Reprints: Marisa A. Montecalvo, MD, Division of Infectious Diseases, Department of Medicine, New York Medical College, 40 Sunshine Cottage Road, Valhalla, NY 10595; e-mail, marisa_montecalvo@nymc.edu.

Ann Intern Med. 2015;163:394-395. doi:10.7326/M15-0339

Downloaded From: http://annals.org/ by Kevin Rosteing on 05/23/2016