

# Teamwork: Is It Always More Efficient?

**If it isn't thoughtfully applied, the team model may have unintended consequences.**

**H**ow can we be more efficient in primary care? How can we focus on doing things only physicians are trained to do and avoid doing clerical tasks and other things that less expensive employees can perform? Going even further, how can we make everyone in the office more productive, happy, and high-performing? The answer presented in this issue, "Team-Based Care: Saving Time and Improving Efficiency" by Drs. Kevin Hopkins and Christine Sinsky (page 23), is to train each of your staff to "work at the highest level of his or her qualifications" and to delegate. This article builds on a care model that *FPM* presented in 2008<sup>1</sup> and again in 2013.<sup>2</sup>

The idea is compelling. Drs. Hopkins, Sinsky and Peter Anderson (who authored the 2008 *FPM* article) all state that most outpatient visits can be divided into four distinct stages: 1) gathering data, 2) the physical exam, 3) medical decision-making, and 4) patient education/plan of care implementation. Rather than the physician being responsible for all four stages, they recommend that a clinical assistant (a registered nurse, licensed practical nurse, or highly skilled medical assistant) perform the more clerical stages, one and four, while the physician focuses primarily on stages two and three. The clinical assistant stays in the room with the patient during the entire visit, gathering the history and doing all the documentation. The physician joins them for stages two and three before moving on to the next exam room where a second clinical assistant has set the stage by performing stage one. This allows the physician to see more patients, thus covering the costs of additional clinical assistants.

This model seems to make sense. But I worry about the details. I worry about tough diagnoses, poor historians, and underlying psychosocial problems. The stages mentioned above describe how a novice clinician, like a medical student, approaches a visit. Experienced clinicians work differently. They begin hypothesizing diagnoses immediately after hearing the patient's chief complaint and then ask targeted questions to both rule out and rule in diagnostic possibilities. They then use a focused physical exam to help support or disprove their working diagnosis

and order tests if they are still unsure.<sup>3</sup> The history is typically the most important part of the process, requiring a deep understanding of medicine. True, the clinician could retake the patient's history in these tougher cases after hearing the clinical assistant's version, but is that more efficient?

What about counseling? Certainly clinical assistants can help, but the physician shouldn't drop that role entirely. Any competent health professional can provide instructions, but patients are more likely to comply with behavior change messages coming from a trusted physician.

What about intimacy? There is something special about the one-on-one interaction between family physician and patient. Patients tell us things that they often wouldn't share with anyone else. We develop special bonds. This is one of the prime attractions of primary care for those of us who chose it. Patients may be fine with a third party in the room, but how will we feel about it?

Additionally, should we design our practices so that the physician is the only one doing medical decision-making and physical exams? The model described here doesn't take advantage of using nurse practitioners (NPs) and physician assistants (PAs) for more routine acute and chronic care. In an office using NPs and PAs, it is common for a physician to see fewer patients, focusing on the sicker and more complicated ones. Some family physicians find that approach more satisfying, while admittedly others enjoy seeing everything, including colds.

Don't get me wrong, I believe strongly in teamwork. I don't think the model presented here is wrong or inappropriate. It just may not be for everyone. And I worry that if it isn't thoughtfully applied, it may not do what it aims to do – make physicians more efficient and happy without compromising diagnostic or therapeutic excellence. **FPM**



Kenneth G. Adler, MD, MMM, Medical Editor  
fpmedit@aafp.org

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