Reclaiming Primary Care's "Secret Sauce"

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Imagine how much more effective primary care physicians could be if we weren't burdened with non-physician tasks.

As I lay on the stretcher in the pre-op area before my shoulder replacement, I fretted about what could go wrong. I had selected an excellent surgeon and hospital, but one very specific concern popped into my mind: the doctor operating on the wrong shoulder. Just then my surgeon came in. With hardly a word, he took out a black marker and made a big "X" on my right shoulder.

"Perfect," I thought to myself. "He addressed my one worry."

Throughout my surgery and recovery, the only tasks he did were ones no one else on the health care team could or should do.

In his office, he had a scribe enter data in the EHR and staff who performed all other paperwork. In my entire 12-month course of care, I think he spent no more than five minutes on data entry. At the hospital, he had registration receptionists, followed by pre-op staff, operating room scrub nurses, post-op staff, floor nurses and aides, and occupational and physical therapists. They all supported the surgeon during my one-day stay in the hospital so that he was able to work at the top of his license.

If only primary care physicians were able to do that.

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A POWERFUL PRINCIPLE

Working at the top of one's license is an operations management principle I learned 30 years ago in business school. Eliyahu Goldratt's classic book *The Goal*[1] describes it well: If you are manufacturing a product (in my case, a new shoulder), you want all your resources to support the most valuable piece of equipment (i.e., the surgeon) to make sure no bottlenecks or constraints prevent that piece of equipment from functioning as efficiently as possible. This basic manufacturing principle has now become widely adopted in medicine, with good results in places like operating rooms and emergency departments. But clearly it's not been fully operationalized in all medical settings.

I contrasted my surgeon's situation to my experience as a primary care physician, formerly in private practice and more recently as an employee in a hospital-based system. In both settings, I was lucky to have a receptionist and a medical assistant. No nurse, no scribe, no other ancillary staff.

Why the difference? First, a surgeon's work is much more highly valued than a primary care physician's work — despite studies showing primary care's high return on investment.[2,3] Second, our foremost purpose as primary care physicians has been recast from being relationship-based comprehensivists to being documentarians.

THE SECRET SAUCE

Many years ago, I had the honor of having dinner with the great primary care physician-researcher Barbara Starfield, MD, MPH. She said the "secret sauce" of primary care was providing comprehensive care within a therapeutic, trusting relationship.[4] But that's difficult to do these days. Due to the amount of money that depends on proper documentation of quality metrics, severity of illness calculations, and the like, health care organizations and even independent primary care practices have repurposed the workload of primary care physicians from providing that secret sauce to "documentation medicine." Primary care doctors are left to perform myriad menial tasks anchored by mind-numbing data entry that now consumes more than half our workday.[5] This takes away our most important tool: face time with the patient — the family physician's equivalent of the surgeon's scalpel.

Primary care could work wonderfully if, like the surgeon, we had other staff to offload tasks and allow us to do what we were trained to do: relationship-based medicine. If my documentation time was the same as an orthopedist's, I would have far more appointment availability for my patients. Instead, because schedules are full, our patients are offloaded to nurse advice lines, urgent care, or covering physicians who don't know them.

What would my office environment look like if my work were prioritized, valued, and supported comparably to an orthopedic surgeon's? There would be a health coach to help improve my patients' lifestyles, a mental health specialist to help them with stress, anxiety, and depression, a pharmacist consultant to assist them with

complex medication schedules, and a social worker to help those falling through the cracks of our health care system. Referral and prior authorization specialists and scribes would take care of documentation tasks. Not all of the support staff would need to be dedicated to me, but they would be accessible.

When I entered family medicine, our key asset was Starfield's secret sauce: the trusting relationship with the patient that came from providing comprehensive, continuing care. Now that care is increasingly fragmented. As recently as 20 years ago, I saw patients in the hospital, at nursing facilities, and in their homes, as well as in my office. Now hospitalized patients are taken care of by hospitalists. After discharge, they are cared for by transitionalists. Larger integrated health systems often prefer that patients with acute illnesses, such as respiratory infections, be seen in urgent care. If our patients have a problem with a certain organ system, instead of being referred back to their primary care physician, they are now often referred directly to specialists.

> Changing the valuation of primary care physician work will lead to greater financial support.

Meanwhile, we miss key touchstones in the doctor-patient relationship. Those visits for colds, minor injuries, and post-hospital care that are now seen in urgent care were previously opportunities for the physician to catch up on how things are going for patients at home: "What is happening with your family? Are you remembering to take your medicine and monitor your blood pressure? Are you still working on the lifestyle modifications that we discussed previously?"

Atul Gawande wrote about the importance of this sort of longitudinal doctor-patient relationship in his 2017 *New Yorker* article, "The Heroism of Incremental Care."[6] His point was that what makes primary care effective is not "home runs" (one-off, intensive procedures) but lots of "singles" (small but steady health improvements due to medication adjustments, lifestyle changes, early detection of illness, etc.) strung together over time. To do this, you need lots of "at-bats" (i.e., interactions with the patient), but the compression of services primary care physicians perform combined with the excess time spent in documentation are taking them away.

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REVERSING THE TREND

How can we reverse this trend? First, more people must perceive the need for change. Many patients have grown up with physicians glued to EHRs, and for many young physicians excessive documentation has become normalized. We need to break this malaise with a new level of activism for systemic change.

Second, we need a new accounting of primary care that values long-term, comprehensive, therapeutic, and trusting doctor-patient relationships at a similar level as a shoulder replacement. I'm not referring to "value-based care," where we're burdened with quality measures and data reporting. But for those who are sticklers for metrics, we could consider the percentage of times patients see their primary care physician as part of the value equation. Changing the valuation of primary care physician work will lead to greater financial support for robust primary care teams.

Third, we need to eliminate unnecessary documentation (the recent E/M changes are a good start) and stop constantly funneling clerical tasks to primary care, so we can get back to the business of caring as opposed to charting.

With so many primary care physicians burning out or retiring early, the stakes are high.

I have gotten a physician satisfaction survey once a year for the past 25 years. One of the recurring questions is, "Would you go into your current specialty if you had it to do over?" In the past, this was always a no-brainer for me — the answer was yes.

As I filled out my most recent survey, though, I began to think that being a surgeon might have been a better choice. Then I thought, "Sure, surgeons have great support teams and can practice at the top of their licenses, but I have long-term relationships with my patients."

But what if we no longer have that? What is left? I fear that far too many of us are now confronting that question. FPM

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