Prioritizing Patients With the Greatest Care Needs: Time for Family Physicians to Lead

Amanda Niklasson, MD; Victor M. Montori, MD, MSc; and Minna Johansson, MD, PhD

According to one estimate, family physicians would need to work 27 hours every day to follow the clinical practice guidelines that apply to their patients, and more than one-half of those hours would be spent on prevention in asymptomatic individuals.[1] We face a tsunami of recommendations but can follow only a small fraction of them.[2] Prioritization (eg, patients with severe symptoms over those with mild or no symptoms, interventions with greater benefits over those with small or uncertain benefits, prevention for high-risk populations over low-risk populations) is difficult and haphazard in primary care.[3]

Performance measures, tied to guidelines that are impossible to follow, exacerbate the prioritization problem. Examples of such measures include the proportion of people screened for alcohol consumption or physical inactivity, or the proportion of patients with diabetes achieving target A1C, blood pressure, or low-density lipoprotein cholesterol levels. Although these measures should theoretically improve quality of care and help prioritize the most impactful interventions, they may have a different effect.[4]

Consider a 74-year-old patient with prediabetes, hyperlipidemia, and knee pain who is grief-stricken and having difficulty sleeping after her son's suicide. Would it constitute compassionate and high-quality care to focus our limited time together to increase her lipid-lowering regimen, review her answers to the alcohol use questionnaire, and advise her to increase her exercise?[5]

Guidelines and incentives tied to easily measurable clinical "performance" direct our focus away from the most important issues for each patient. They also force us to prioritize interventions with limited or uncertain benefits for asymptomatic, low-risk populations at the expense of interventions with greater benefit for patients with greater needs. For example, one study estimated that five to seven patients with symptoms would need to be treated to improve outcomes for one. For prevention on the other hand, estimates ranged from 40 to 1,000 patients, and even higher for lifestyle interventions.[6]

The UK National Institute for Health and Care Excellence recommends 379 lifestyle interventions, of which almost 100 apply to more than 25% of the population.[7] Only 3% of these are supported by high- or moderate-certainty evidence that the intervention helps people change behavior. More physicians (of all specialties) and five times more nurses than available in the United Kingdom would be needed to follow just the recommendations on lifestyle interventions.[8]

Of course we should engage in discussions about lifestyle, such as smoking habits, when it makes sense in the individual consultation. But physicians and nurses cannot stop all other health care to provide only (mostly inefficient and likely ineffective) lifestyle advice. We suggest two approaches for policymakers to consider the consequences of recommending much more than clinicians have time to implement.

First, guideline panels could carefully consider whether the time clinicians need to implement a recommendation is reasonable compared with other ways clinicians could spend their time, using the time needed to treat (TNT) method. TNT is estimated by considering the time needed to provide the recommended intervention to one individual multiplied by the number of individuals in the population that are eligible for the intervention, expressed as the proportion of the available clinician time that would be needed to deliver the recommended intervention to all eligible patients.[2]

Second, we suggest a set of questions that policymakers could consider when evaluating lifestyle interventions[9]:

- Do the supporting studies provide direct or only linked (indirect) evidence that the intervention will have beneficial effects?
- How likely is it that the benefits in supporting studies will translate into clinical practice?
- Does the intervention cause harm, and what are the opportunity costs?

Without sufficient evidence that benefits outweigh harms, lifestyle recommendations should not be tied to incentives for clinicians.

AMANDA NIKLASSON, MD, Global Center for Sustainable Healthcare, Gothenburg, Sweden, and University of Gothenburg

VICTOR M. MONTORI, MD, MSc, Global Center for Sustainable Healthcare, and Mayo Clinic, Rochester, Minnesota

MINNA JOHANSSON, MD, PhD, Global Center for Sustainable Healthcare, and University of Gothenburg.

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Address correspondence to Amanda Niklasson, MD, at amanda.niklasson@vgregion.se.

There is a strong temptation to avoid allocating scarce time and opportunity to care by simply shifting certain clinical tasks to less trained (and less costly) assistants, to patients themselves, or to artificial intelligence agents. But there is also a shortage of other categories of health care professionals, patients are already feeling overwhelmed with the health care system, and digital solutions have not yet been shown to save clinicians time.[10,11] A more sustainable solution may be to return the responsibility for prevention in low-risk populations to the public health sector through public policies (eg, tobacco, alcohol, and sugar taxes) and community-oriented interventions (eg, smoking bans, people-powered transportation, farmers markets), which help us all to lead healthier lives.

As family physicians, we are responsible not only for the patients we care for, but also for the population we serve. Family physicians must engage in guideline development and policymaking. Our unique expertise can help specialists, politicians, and the public to zoom out from fragmentized, siloed care and see the consequences of unreasonable guidelines and performance measures.[12] It is time for family physicians to lead the prioritization of how we spend our time.

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