CLINICAL COMMENTARY

Learning Primary Care

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Toward the end of my internal medicine residency, I asked a colleague how it long it takes to become a seasoned primary care physician. The response I received was three years. I am now three years into a junior faculty position as a general internist, and while the daily practice of medicine has become easier, the challenges certainly continue. The following is a brief commentary on what I have found most challenging entering the world of primary care following completion of residency program focused largely on inpatient medicine.

As a resident, your main responsibility is caring for the patient. The intellectual learning curve is steep, but the day-to-day operations are generally manageable. Residents are not generally faced with the task of implementing care within the constraints of the insurance payer. Outpatient medicine requires developing one's own art of medicine and applying it to the individual patient within their specific coverage. If the patient has a PPO plan, what is their deductible and have they met it for the year? Can the visit be considered 'preventative' and not fall under the deductible? What labs are included in the preventative visit and not applied toward the deductible? Conversely, is the patient under an HMO managed care plan? If so, referrals need to be entered into the electronic medical record (EMR) by the primary care physician. Procedures, certain vaccinations, subspecialty consults, physical therapy treatments, and specialized imaging like MRI and CT require prior authorization by the medical group and must be performed within the assigned network. Lastly, does the patient have Medicare? If so, do they have fee for service Medicare or a Medicare advantage plan? Do they have supplemental insurance? Many of these issues require the assistance of staff with the knowledge of specific plan coverage limits. Insurance coverage and drug formularies annually change, which leads to frustration. As the provider becomes more facile with navigating the subtle nuances of plans, the day-to-day work flow becomes more streamlined, and our patients get more timely access to care.

As I see it, the biggest challenge in patient care is time constraints. Providers must make an impression on new patients in thirty minutes. All the basics of the H&P we learned in medical school are generally performed and in a manner that one hopes will invite the patient to return and establish a long-term doctor-patient relationship. This feels achievable with young, healthy patients presenting for new physical exams but daunting for the seventy-five-year-old Medicare retiree with ten active medical problems taking fifteen medications. Some of the success comes from managing expectations. Sometimes this requires taking the list of complaints and allowing them to pick two or three for that visit. Sometimes it is setting the stage for what you, the provider, think are the most important issues. Even better is finding a way to align the patient's biggest health concerns with what you view as the most pressing. Examinations should remain focused. It may not be necessary to perform comprehensive reflex exams on every patient that comes in for a wellness visit. Office procedures like EKGs, ear lavages, and spirometry should be completed while you are moving onto the next patient. Lastly, it is okay to tell the patient that the knee injection for their osteoarthritis will require another appointment. I have found that over time patients adapt to your style of practice, and you get to know their individual priorities. It is also wise to schedule the follow-up appointment before they leave as this provides reassurance that they will get to topics not addressed. The long-term relationship is critical to help manage all the worries and fears.

On a different note, patients want and deserve access to their doctors. Modern technology and the adoption of the electronic health record (EHR) have made this easier than ever. Email did not eliminate phone messages, and EHR messaging has not eliminated phone and email. Some patients will make contact by more than one avenue for the same issue. Patients need to be informed of what is a reasonable turnaround time for messages, and the anxious patients should be encouraged to make appointments. There is redundancy with email and the EHR messaging system, so I tend to use the EHR. I find it easier because you already have access to the individual's chart while reading and acting on messages. This makes ordering and reporting more convenient. Utilizing the staff for phone messaging is critical. The fewer calls a doctor has to return at end of the day, the better. More time can be spent on reviewing labs, completing notes, ordering studies, and getting home.

Another challenge that took a few years to figure out is caring for the very sick patient or the one with abnormal labs. For example, how do we care for the elderly patient with pneumonia who has stable oxygenation but appears quite ill? Are those patients better off getting admitted and started on intravenous antibiotics? Or is it safe to start an oral regimen and bring them back in 1-2 days? The CURB-65 and pneumonia severity index scoring systems can be helpful but require labs that take twenty-four hours to result. How about the late night page from the lab for a patient with a potassium of 6.1, hemoglobin of 7, or glucose of 425? Can these patients wait to have repeat labs in the office the following day knowing that it will take another business day to have a result?

There are no hard and fast rules. The decision is based on the individual patient, demographics, reliability for follow-up, the practitioners past experiences, the day of the week and timely access to subspecialty care. Of course, all of these decisions are made in order to best ensure patient safety, but overly cautious care can lead to stress, emergency room over-crowding, and overuse of medical resources.

A final hurdle that causes frustration for many doctors is the internet diagnosis. It goes without saying that patients have enormous, unlimited access to medical diagnoses based on symptoms from sites like WebMD, Mayo Clinic, MedicineNet, and even Wikipedia. Often our first instinct follows a coffee cup slogan my wife gave me for Christmas: "Please don't confuse your Google diagnosis with my medical degree." The reality is that paternalistic medicine is vanishing. Doctors are viewed more as service providers. It is up to us to educate patients on the importance of an office visit, avoiding the potential pitfalls of self-diagnosis, and to provide accurate information often in written form. We must do our best to discuss the supplement from the magazine or the herb the patient is getting from their naturopath. We must also understand what the patient is hoping to achieve by taking it. The breadth of information is not going to shrink, so it is up to physicians to adapt and grow.

Despite multiple challenges, primary care remains a very rewarding field. Long-term relationships add richness to the practice and reduce burnout. Physicians need to constantly look for new ways to overcome challenges by utilizing staff, educating patients, and adapting the electronic health record.

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