Interactions between primary care management systems, IT, and patient care

Dr Piver replied to an opportunity from his local division of family practice to provide bottom-up feedback about primary care intervention programs and incentives. His original response, along with expanded information, is published here in order to share the content with physicians province-wide.

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My feedback about primary care intervention programs and incentives, originally provided to my local division of family practice, is included below. It reflects the evolution of our system's requirement to be seen to address evidence and to provide measurables attesting thereto.

"In response to your lovely questions about what divisions can do regarding our needs, I will offer my feedback/opinion regarding the system-wide evident focus on proxy measurables and the documentation of management, which is predictable given the intended health authority corporate culture. While appreciating the well-intended and worthwhile clinical goals, how do these silos improve on what a rostered primary care team model could provide? I have come to conclude that rostered primary care with payments per patient/year, modified for likely complexity, rather than per service, with access to a team, is the best natural model to allow us to practise primary care medicine for the complex individuals that are humans. The constant stream of apparent innovations aimed at specific disease/comorbidities/determinants-of-health management generally require ever more time spent on administrative/clerical tasks (i.e., constantly learning and applying complicated new specialized documentation and billing add-ons, with our attention focused on screens instead of patients' faces). A practical option like the RACE program is a different and useful process providing more timely and travel-conserving access to specialist support, particularly helpful in rural areas.

I would contrast this with the natural evolution of bottom-up human team-based care, with each regulated profession contributing and innovating in responding to changing local conditions and emerging evidence (as they fulfill their existing continuing education requirements). Examining local epidemiological data and emerging evidence would certainly be valuable, with periodic team participation in making meaning of such data and responding, where appropriate. Naturally occurring innovations could be shared and adopted laterally where chosen, rather than via top-down algorithms, which impose ponderous measurables built into documentation, as the principle, although flow sheets are indeed useful. Ideally all would be based on local discretion and motivation, intrinsic to existing professional standards of care and documentation and satisfaction. Where our proxy measurables cross these lines they are in fact duplicating other existing regulatory

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institutions and their role, while justifying the salaries and bonuses of ever-more information management ensuring the appearance of accountability. The most common frustrations I experience with our EMRs are the idiosyncratic rigid choices in nomenclature, limited options and categories in dropdown menus, fixed smart options, etc. These clearly reflect convenience in harvesting these arbitrary proxy measurables, rather than reality on the ground. Furthermore, the IT platforms are designed with little understanding of their clinical application and variability; thus, they are constantly being patched and 'improved.'"

Further considerations

When I started family practice in 1982, I recall that a GP visit paid approximately $16 to $20 across Canada, and the price of an average house was between $45 000 and $75 000. As we know, office overhead has increased greatly and the cost of housing has multiplied close to tenfold since that time.

Today, patients are often asked to prefill questionnaires in writing, in the name of being more efficient with their primary caregiver's time in our fee-for-service structure. This activity removes the opportunity for the physician to experience the nonverbal cues that a patient provides while delivering their concerns, and to demonstrate their interest in the patient's concerns directly. This may have consequences, as may the one-problem-per-visit policy. A 10- or even 15-minute visit may be perfectly suited for a routine prescription refill or blood-pressure monitoring, or not. Suitability may depend on the need to detect everything from white coat syndrome to noncompliance to new symptoms that a patient may be ambivalent about sharing.

When I was trained in family medicine, I learned that patients bring 1 in 40 symptoms to their family physician's attention and that what they choose to share will likely fall into one or more of the following categories:

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A. The symptom is intolerable with respect to discomfort or interference with functioning.
B. The symptom is causing worry as a possible indicator of a serious as yet unknown disease.
C. The symptom has been around for a while and represents neither A nor B but the patient is now unconsciously at a time when they may need to connect and share with a caregiver and receive reassurance.

Category C may occur more often than ever in a society experiencing an unprecedented prevalence of isolation, loneliness, and alienation. The primary caregiver cannot accurately assess what is the appropriate action with respect to investigation or treatment without being aware of the considerations outlined in categories A, B, and C.

The University of North Carolina has an excellent evidence-based summary outlining guidelines for improving communication skills and the patient-doctor relationship on their website, including easy-to-read tables. The overview states: "There is growing evidence that the key to success in patient care is a good patient-doctor relationship. In this era it doesn't bring in more money but it may help reduce costs for care. The value of good communication skills and the building of an effective relationship with the patient is supported by several medical studies that show that these skills can lead to improved patient and physician satisfaction, better disclosure of important information, greater adherence to treatment, reduced emotional distress, improved physiological parameters and overall better clinical outcomes."[1]

Fundamental research into human communication long ago recognized the important difference between verbal (digital) information and the much more powerful analogic communication (nonverbal messages). Consciously or not, we constantly transmit, read, and are powerfully affected by these analogic messages, especially when in the vulnerable role of a patient. One important example of analogic messages being understood is the caregiver mirroring the patient.[2] When our eyes are necessarily glued to an EMR screen, with the patient facing our backs, it interferes with the kind of presence required for effective care. Our attention is not merely an instrumental resource but critical to being present with our patients. The article "Attention is not a resource but a way of being alive to the world,"[3] which is about emerging research on the failure of instrumental attention, reflects as one example the loss in empathy that is occurring.

The ongoing well-intended evolution in assuring and incentivizing the piecemeal application of evidence-based care makes for ever higher management costs, both to our system and to the physician's administration. The quality-improvement measurables used to gauge if specifications are be-

ing met work for engineered systems such as assembly lines, but there are unintended consequences when they are applied to the very different complexities of natural systems such as primary care, where we only have proxy measures. They cannot capture all of the variables relevant to each unique patient; nor can they measure the interrelationships and consequences with a given patient (e.g., unusual risk or protective factors, personality, culture, trust, compliance, stress). Our humanity and personal connection makes a difference.

A relevant article of value is "Learning narrative-based medicine skills," published in the *Canadian Family Physician*.[4] I also strongly recommend listening to the episode of CBC's *The Sunday Edition* titled "Too long, didn't read – how reading online is hurting our brains."[5] The research findings of Professor Maryanne Wolf, an author and a researcher at Tufts University, explain part of the frustration often felt when trying to talk to someone who is stuck on ticking boxes. Neuroimaging shows how few service providers at the interface between IT systems and the front lines in any domain seem to *get* the meaning of information. We become busy going through the motions as quickly as possible, leaving little room for thinking/feeling about the details or their meaning and implications. I would submit that, at the most basic level, this is how IT impacts our management systems as well as our practices and lives.

Competing interests

None declared.

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