Primary care needs more access to doctors, not less

Primary care is increasingly distanced from patients, both physically and emotionally, while increased access is the needed change.

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Almost everyone seems to agree there is a crisis in primary care. Almost one-third of people who want a family doctor can't find one, and even people who have a family physician generally find them quite inaccessible, especially outside regular office hours. Speculation has advanced as to why this problem exists: baby boomers are growing old and need more care; younger doctors are more determined to protect time for their families and themselves; doctors have too much paperwork; and graduating MDs want to be specialists, while family practice residency positions go begging, or family physicians go into hospitalist and ER care, where hours are fixed and access is limited.

We are two older family doctors who believe the most frequently touted solution—train more doctors and pay them more—is unlikely to be sufficient or to solve the fundamental problem. We see a profession increasingly distanced from patients, both physically and emotionally. We believe greater availability to the people who count on us for care is the critical, needed change. We think an important change in how doctors work, and one that has always been part of primary care, is required.

Medical practice is seen as divided into the science and art of medicine. Medical teaching today is driven almost exclusively by specialists and tends to focus on what could loosely be called science—research and evidence, treatments and procedures, and outcomes that can be measured. Recent studies of medical advice given by artificial intelligence suggest that a machine may be nearly as good as (or perhaps even better than) a human for many parts of the technical side of medicine.

But in primary care, the quality of the relationship between caregiver and care receiver is paramount. We believe it is important to people who are worried or suffering to have timely and ongoing access to a health care professional *who knows them* and with whom they have a trusting relationship.

From years of direct experience, we are sure this is deeply beneficial to both parties, and it's also unlikely to be accomplished by a machine anytime soon. In the primary care world where we work, we are advocating for a rejuvenation in professional behavior away from the current overemphasis on science and technology and toward the side of health care we family physicians used to excel at, and a practice where we think humans will be irreplaceable.

What would that look like? Both of us have been personally on call for our patients, at any time, for several decades. This idea prompts gasps of horror from many friends and colleagues: "We're already burned out! Do you want us to be driven mad, or out of the profession?!"

We hear and understand these concerns. However, we know from direct experience that when we are willing to answer the telephone, two things happen: first, our patients are deeply grateful, respect our time, and almost never abuse the privilege of being able to speak to us, and second, our availability makes us more human in our patients' eyes, and them more human in ours. In other words, a relationship of trust develops that is enormously affirming and professionally satisfying.

A recent survey conducted by the College of Family Physicians of Canada found that patients prefer contact with their own family physician within a few days over immediate contact with a doctor they have never met.[1] Care by physicians who have never met the patient results in more ER visits, investigations, hospital use, and referrals (that is, significantly greater costs and some added risk, per visit). Worried patients, rushed through encounters with care providers they don't know or necessarily trust, accept reassurance through more referrals and investigations when a few minutes of

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discussion and explanation from a doctor they know, and who knows them, could often provide all they need.

A visit with a doctor who knows your history, social circumstances, family, work, and school, and something about your behavioral nuances, preferences, and context (familiarity that takes a few years to develop), improves health outcomes over a simple diagnosis and treatment by a practitioner who is a stranger. Available and trusted family physicians are more common in countries such as Costa Rica and the Netherlands, and patient satisfaction is better under those conditions.

There is also a benefit to doctors arising out of this approach. Because it is easier for doctors to deal with familiar patients on the phone, we have experienced a reduction in the sense of futility and professional dissatisfaction causing some of the burnout physicians frequently complain about. Individual physicians in solo and group practices, especially where there is easy access to their services and to a multidisciplinary team, often cite a restored sense of purpose and value.

There are, of course, caveats to our suggestion. While there are benefits to patients and doctors from enhanced access, we understand that the style of practice prevalent during our training many years ago may seem foreign to recently trained doctors. New physician graduates may feel anxious about supplying information over the phone until they have an established practice and have patients with whom they are familiar. While we find unrestricted availability affirming and not wildly burdensome, it may be inconsistent with some doctors' and patients' values or simply unfeasible.

We are advocating for a change in doctors' relationships with patients away from consistent inaccessibility toward greater professional availability and intimacy. We think this can be brought about by doctors improving their personal availability, even if only in parts of their practice. We believe this direction will improve the sense of meaning and purpose primary care practitioners experience, and we have observed how it generates sincere gratitude among patients.

Increased access can be implemented selectively, in stages. For example, unrestricted availability can be limited to certain patients, such as homebound frail elderly people or persons receiving palliative care. Additionally, another physician, nurse practitioner, or nurse can share familiarity with some or all patients so availability can be rotated among trusted professionals. A nurse hired by a health region can take calls outside office hours, contacting the doctor only when necessary. And 24/7 access can be pruned so specified family hours, special days, and other protected times are addressed through a carefully crafted phone message or a referral to a trusted colleague.

An administrator once told us this about frail older people who have decided not to go to the hospital: "It's the relationship of trust that keeps them at home." Our goals in writing this piece are twofold: to suggest to our colleagues that they needn't fear being a little more human toward their patients and to encourage patients to be respectful and protective of doctors' willingness to enter a sustained personal relationship of mutual trust. This can be attained through a collaborative process between patients, family physicians, and other primary care practitioners.

If the tide turns and more doctors welcome closer and more meaningful relationships with the people whose trust we hope to deserve, the benefits to primary care in dollars, emotional satisfaction, and effectiveness will be profound. ■

Reference

1. Nanos. National survey: Summary. Conducted by Nanos for the College of Family Physicians of Canada, March 2023. Accessed 30 November 2023. www.cfpc.ca/CFPC/media/Resources/CFPC-NANOS-Report.pdf.