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The Travails of the Primary Care Physician in the Digital Era

By Mario J. Paredes

The primary care physician was once known simply as the family doctor. In the old days, when family doctors made house calls, they got to know their patients and their circumstances up close. Family doctors and patients forged intimate, personal bonds. This relationship played a vital part in the physician's ability to understand and diagnose the patient's overall condition—both physical and mental. The so-called social determinants of health were readily apparent and instinctively factored into the family doctor's overall diagnosis. The practice of medicine—with the doctor as healer in the comprehensive sense of the word—was a subtle, humanistic art.

Of course, physicians are still called on to practice that art of listening to patients with both mind and heart. Technological innovation, however, with all its benefits, has become an impersonal barrier to this essential cultivation of a finely-tuned, person-to-person, doctor-patient relationship. The Health Information Technology for Economic and Clinical Health (HITECH) Act, passed in 2009, today requires that physicians keep a careful Electronic Health Record (EHR) for every patient—a task that must be completed while meeting with the patient. It is an enormous distraction.

There is no doubt that EHRs have numerous benefits. With state and federal governments mandating the seamless integration of health databases, the patient's critical medical data will be readily available to physicians, specialists and emergency room personnel. This transparency will help avoid unnecessary tests and adverse medication interactions, for example.

Lost in the equation, however, is the human factor. As interactions become increasingly computer-driven, the physician is pushed into the role of record-keeper, entering data to create an electronic portrait of a flesh-and-blood person sitting just across the desk. Sacrificed are eye-to-eye contact and the physician's ability to read body language that conveys essential, deeply human, non-quantifiable information. Empathy, careful listening and a personal connection are hard to achieve when the doctor's eyes are mostly averted.

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What once held the promise of streamlining record-keeping and protecting the patient's well-being across a dynamic electronic grid has become an administrative burden for doctors, even a source of demoralization. Earlier this fall, writing in The Wall Street Journal, Dr. Caleb Gardner, a resident physician at Cambridge Hospital in Massachusetts, and Dr. John Levinson, a cardiologist at the Massachusetts General Hospital and Harvard Medical School, gave the telling example of research showing that first-year physicians spent "a meager eight minutes a day with each of their hospitalized patients while spending hours at the keyboard describing and quantifying those fleeting moments."

Data-driven medicine also amounts to a standardized approach to treating particular medical conditions—formulas that meet the demands of insurance companies or are market-driven, calibrated to accommodate the financial objectives of healthcare organizations. The real personhood of the patient is lost; while many patients may suffer from the same disease, each individual has unique needs and circumstances—determined by a full range of non-medical factors, including behavioral issues—that may affect the progress of a condition in highly particular ways and accordingly require different forms of treatment. A standardized, regulated approach, however efficient, does not cut it.

What is to be done? The role of the primary care physician needs to be rehabilitated, as it were, in this new digital setting. A bold experiment underway in New York State may well hold part of the solution. Advocate Community Providers (ACP) is a non-profit corporation mandated by the New York State Department of Health to serve Medicaid patients in New York City under the provisions of the Delivery System Reform Incentive Payment (DSRIP) program, now in its second year. The objective of DSRIP is to save taxpayers some $17 billion by reducing unnecessary hospitalizations by 25 percent by the year 2020.

Reaching that goal depends on providing Medicaid patients with greatly improved, comprehensive preventive care that ensures their long(er)-term well-being and keeps them out of emergency rooms and hospitals. DSRIP has mandated 25 so-called Performing Provider Systems (PPSs) to strive for that goal. ACP is the only PPS run by a network of independent primary care physicians—rather than massive, inherently impersonal hospital-based systems—who are in an optimal position to offer the kind personalized, attentive care that can make a real difference.

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ACP's network of 3,000 ethnically diverse doctors and community providers, in the majority of cases, operate as independent businesses in the very neighborhoods—Hispanic, African-American, Asian-American—where patients of the same cultural background live and work. This cultural competency on the part of ACP providers, this cultural and ethnic sensibility, is key to providing optimal care: doctors can personally relate to the cultural factors that have an impact, for better or worse, on the medical condition and overall well-being of their patients; they speak the language of their charges, a key factor in establishing trust.

ACP physicians deserve respect and admiration for their commitment to foregoing business as usual; that is, rather than being part of the traditional Medicaid system and billing for tests and office visits, they are assuming the risk of linking their earnings to the long-term well-being of their patients—to a degree of human flourishing that keeps their patients out of the hospital! And here big data come into play: ACP doctors too must keep careful EHRs that are integrated with data on Medicaid claims, enabling the New York State Department of Health to assess the results of DSRIP across massive populations and thus determine and allot performance-based payments for the PPSs and, in the case of ACP, incentives for individual doctors.

There is no doubt that electronic data-keeping is as much of a distraction for ACP doctors as it is for all doctors across the nation. How then to prevent physicians' scarce time and valuable attention from being swallowed up by digital administrative obligations? ACP has a potential answer: Community Health Workers (CHWs) can bridge the gap and reinforce the human touch. The organization wields a growing army of CHWs, our "boots on the ground," who are charged with making home visits to patients, monitoring at-home conditions and supporting medication adherence directives from doctors and encouraging overall patient compliance.

Along with support staff in the doctors' offices, CHWs could assist in interacting with patients by using face-to-face contact as well as technology to document patient symptoms and apply screenings for not-readily-detectable illnesses. This groundwork allows our doctors to go straight to the heart of the matter when they meet with their patients.

There is no ready answer, but the goal is clear: primary care providers—working under DSRIP and, of course doctors and specialists at large—must be liberated from administrative duties in order to devote themselves more fully to their primary role: to have an authentically human encounter with their patients, to truly listen and get a sense of the whole person and their needs. Patients, after all, are so much more than a summation of conditions checked off on a computer screen.