EDITORIAL

TOP Docs: Family Physicians with Competing Demands and the Right Priorities—Individual, Family, and Community Health

A number of studies have examined the effects of competing demands during an office visit on family physician care. Some studies conclude that competing demands drive out top-quality care.[1–5] In fact, there are so many studies that suggest family physicians provide less care than what is recommended by some set of guidelines that I would hate to enumerate them. Usually these studies examine a small set of diseases or process measures. However, more family physicians and fewer specialists in a geographic area are associated with better outcomes.[6–8]

The process is not always deemed "good," yet the outcome is? How could these 2 facts coexist? Because family doctors are TOP docs for meeting competing demands across multiple patients over time and because family doctors are complexity leaders with the right priorities: individual, family, *and* community health.

There are multiple competing demands in the practice of family medicine, including the provision of excellent quality of care in a short period of time across multiple illnesses, both urgent and nonurgent, concurrent with competing demands for meeting patient expectations and earning sufficient income to remain in practice to serve patients and their communities. Community health depends on family physicians being there, directly for improved health as well as indirectly for the economic health of many of our communities.

Family physicians juggle these multiple competing demands well. Thus, they are TOP docs, a term often used to indicate the best doctors by specialty or geographic area or, alternatively, could stand for **T**errific **O**n **P**rioritizing (as suggested by Dr. James Puffer, President of the American Board of Family Medicine).

See Related Article on Page 123.

I would like to explicate my reasoning by using the example presented by the Ani et al[9] study in this issue. It seems counterintuitive that comorbid chronic illness did not account for the diagnosis and treatment of depression in safety-net primary care settings.[9] Furthermore, most depressed patients were not documented as depressed (perhaps another case of underdiagnosis?). Concurrently, however, a documented depression diagnosis was associated with a high rate of drug prescriptions.

One potential reason for the disparate findings is that depression was often documented in the medical record specifically *when* a prescription was given but not otherwise. This documentation could be done to provide written justification for a prescription, as is common, and may be forced in some electronic medical records, ie, no order without a diagnosis. The priority for these physicians may *not* have been taking the time to document other care, time that could be used more productively doing something else.

Another potential reason for the findings of the Ani et al[9] study is that the doctors' top priority was not finding or documenting minor chronic depressions, which are not readily treated.[10,11] Documentation of a diagnosis of depression can have negative consequences for a patient, such as stigma and insurance issues; thus the benefit of documentation must outweigh the potential risks.[12,13] More severe depressions seemed to be the priority; the most severe depressions were documented and treated more often. These are the depressions for which medication treatments are most likely to be helpful.

The Ani et al[9] study could be also taken to mean that these family physicians were "bad," ie, they "underdiagnosed" and potentially undertreated depression. I would like to turn this assessment upside down and suggest that these physicians were excellent at prioritizing, thereby maximizing outcomes over a group of patients and over time.

These clinicians found and diagnosed the most ill patients, who were most likely to benefit from

drug treatment, and they did not document a negative diagnosis in the chart for those less ill with less likelihood of successful drug treatment. Sounds to me like good medicine on the part of these clinicians.

The real competing demands in practice are not necessarily the concurrent chronic illnesses for the individual patient, ie, within one patient or within one visit, but for physician effort for many patients and over time. There are insufficient numbers of family physicians in the United States, and family physicians are often the front line of prioritizing. A familiar choice is to move on to the next patient in the waiting room who could have more important and more curable illness. Another choice would be to document counseling conversations and a potentially negative diagnosis. Most physicians would rather spend time with the patient, or the next patient, than document, any day.

Family physicians have lots of demands on their time, forcing minute-to-minute decision making in busy offices. I think family physicians are actually quite good at this balance. They may miss some (or even many) process items of care or, even more so, skip the documentation of these processes.[14] They tend to miss or purposefully skip those process items that are less likely to make a difference. Documentation or process adherence does not always relate to outcomes.[14–16] Which is more important: time working with the patient to get them to understand and treat their own maladies *or* ordering another test? What about documenting it?

Family medicine is a never-ending round of small learnings and constant molding of the practicing physician. Do "A," and "B" usually happens. If B is good, we keep doing A. Do "C" and negative "D" usually happens, then we stop doing C. For example, if checking the HbA1c does not seem to make a difference, we tend to stop ordering it. If our medical assistant who draws blood is out sick, we may not order the blood test, but we can order it during the patient's next visit. If the patient requests it, that changes the balance again, and we may order it. If the insurer pays based on our rate of completion of HbA1c testing, then we order it. If a new study comes out that suggest that HbA1c testing and feedback to family physicians actually does improve control, by a small percentage, then we loosen our criteria for obtaining the test. Our patients and practice experience are often our best teachers. Thus, family medicine is a constant balancing of knowledge, available resources, patient individuality and demands, and the socio-ecological milieu, including many systems issues.

Family physicians are so good at balancing competing demands that our health care system would do well to learn directly from family physicians about how to prioritize care. Family physicians are inherently, and perhaps often unconsciously, providing "group good" at the expense of completing lower yield items; overall, across many visits and time, with continuity, these family physicians' choices work well for communities and populations of people, decreasing morbidity and mortality. Family physicians have learned which processes yield improved outcomes with fewer resource inputs. This family physician type of care can, and actually does, lower the cost of care while still markedly improving health and improving equity.[8]

Am I ignoring that many family physicians perform what seem to be unnecessary services, from seeing people with colds to botox injections? No. First, there is always messiness and imperfection, and variation in the temperament and personal priority of the physicians in any specialty. Second, let's consider those people with colds, for which there is no specific treatment. Perhaps we see them because we receive more money per minute, so we can afford to see those under-reimbursed Medicare patients with multiple problems or those without insurance. Or do we see them because we sometimes discover and help with other concurrent entities, such as the stress that made the cold more likely to happen? There is a current trial studying stress and patient satisfaction for office visits for upper respiratory infections, considering whether empathy may actually shorten the cold.[17] Perhaps we have learned that there is some payoff for the patient in being seen for a cold over the years … that subtle influence of day-to-day training we undergo with our patients' help.

Given enough time and support, family physicians can readily and almost happily complete all recommended processes of care and produce even better outcomes. But with modest amounts of increased time and support, family physicians can help the United States find the sweet spot for spending in the health care system—the spot where enough money is spent to substantially improve health without bankrupting our system or driving people to go without health insurance and into bankruptcy. With increasing use of electronic med-

ical records and a renewed emphasis on considering populations of people rather than patient visits, all in the form of the patient-centered medical home,[18,19] we can do even better. Family physicians are TOP docs for meeting competing demands across multiple patients over time and are complexity leaders with the right priorities: individual, family, *and* community health.

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