CULTURE

Why Your Doctor Has No Time to See You

BY **SHANNON BROWNLEE** 4/16/12 AT 12:00 AM

Four years ago a 38-year-old adjunct professor at American University named Fred Holliday began suffering from a variety of ailments: he was losing weight, his blood pressure went up. Then he cracked a rib. And he started suffering from debilitating back pain. Each time a new problem arose, the Washington, D.C., resident visited his doctor, who dealt with his symptoms piecemeal. First she prescribed blood-pressure medication. At another visit, she chalked up his fractured rib to violent coughing from a cold he had. Then she prescribed narcotics for his back. When his pain grew worse, she simply increased the dose of painkillers.

After months of this, Fred's wife, Regina, looked up his symptoms on the Web. Together, they pointed to kidney cancer. When the worried couple went back to the doctor, Regina recalls, she walked into the exam room, reading Fred's chart, and without looking up, asked, "Mr. Holliday, do you think you're depressed?" It was a routine question, based on the number of his complaints. Regina started laughing in disbelief. "Of course he was depressed," she says. "She wasn't taking care of him." At Regina's insistence, the doctor ordered an MRI, which showed that Fred had kidney cancer. He died about three months later.

These days, stories like the Hollidays' are cropping up all over, and while most don't have such tragic endings, they are signs that something in the world of medicine is seriously amiss. Unhappy patients gripe about their doctors' brusque manner and give them bad

marks on surveys and consumer websites like HealthGrades and Angie's List. They tell tales of being rushed out of the office by harried doctors who miss crucial diagnoses, never look up from their computers during an exam, make errors in prescriptions, and just plain don't listen to their patients. Studies show a steep decline over the last three decades in patients' sense of satisfaction and the feeling their doctors are providing high-quality care. And things don't seem much better from the other side of the stethoscope. In a recent survey by Consumer Reports, 70 percent of doctors reported that since they began practicing medicine, the bond with their patients has eroded.

At the heart of the problem, say many doctors and policy experts, is the fraying of the doctor-patient relationship. And this is not just a question of touchy-feely good vibes: a growing body of research now points to the critical importance of having a connection to a trusted physician. "There is something in the human body that says we are hardwired to get better when we have a certain relationship," explains Howard Brody, a primary-care physician and director of the Institute for the Medical Humanities at the University of Texas Medical Branch, in Galveston. The good news is that doctoring may have hit rock bottom—and policymakers and physicians who have begun efforts to rebuild it realize that the only way out is up.

Anyone who is old enough to have watched *Marcus Welby, M.D.*, the program about an avuncular doctor that was the most popular show on television in the 1960s, probably remembers his or her own family doctor with at least a measure of fondness. Back then, our doctors knew us and our ailments. They knew when our kids were born, how we felt about our jobs and our spouses, and whether or not we tended toward stoicism or malingering in the face of illness and pain. Today you're lucky if your doctor knows the correct pronunciation of your name, much less your medical history.

At least part of the blame began with the managed-care revolution of the 1980s and ’90s, an initially well-meaning effort intended to improve the quality of medicine and control costs, but which ended up fracturing the doctor-patient bond. Many insurers focused more on cost at the expense of quality. They negotiated lower and lower fees for doctors, who slashed the time spent with patients to fit more of them into a day. Despite the accelerated schedule, this has meant a decline in income for most physicians over the last decades, with primary-care doctors hit hardest. A 2006 report found that inflation-adjusted incomes for all doctors decreased by 7 percent from 1995 to 2003, and by 10 percent for primary-care physicians.

At the same time, many insurers clamped down on access to certain services. This put doctors in the position of telling patients that their insurer would not approve payment for the care they felt they needed, straining the relationship between insurers, doctors, and their patients. Insurers also created restricted networks of physicians—a system that often forced patients to find a new primary-care doctor every time their employer switched insurance carriers.

“If you wanted to undermine trust, you couldn’t have done it better with patients changing both insurance plans and their primary-care doctor all the time,” says Richard Kravitz, a primary-care physician and co–vice chair of research in the department of internal medicine at the University of California, Davis.

It was a perfect storm for dissatisfied patients and burnt-out clinicians, says Thomas Bodenheimer, a doctor and professor at the University of California, San Francisco's School of Medicine. While specialists could often combat falling fees by doing more procedures, primary-care doctors get paid by the office visit, so all they could do was cram more appointments into a day and increase their panel size—the number of patients in their practices. For primary-care doctors to do a good job, says Bodenheimer, panels should be below 1,800. Today the average primary-care doctor in the U.S. is responsible for about 2,300 patients. At so-called Medicaid mills—clinics that see mostly poor patients covered by state Medicaid plans—panel sizes can reach 3,000 per doctor.

Today visits are still short, while treatment regimens for common conditions like diabetes and heart disease are more complicated. The number of required tests and conditions primary-care doctors are supposed to screen for has skyrocketed. It's estimated that a doctor with a panel of just 2,000 patients—and without a strong primary-care team—would have to spend more than 17 hours a day providing all of the recommended care. "When you have only 15 minutes per

patient, then there are home visits and hospital visits, you feel like you're on a hamster wheel," says Bodenheimer. "I was a full-time primary-care doctor for more than 30 years. It almost killed me."

This is not a recipe for optimal care. One Canadian and U.S. study found that doctors interrupt their patients on average within 23 seconds from the time the patient begins explaining his symptoms. In 25 percent of visits, the doctor never even asked the patient what was bothering him. In another study that taped 34 physicians during more than 300 visits with patients, the doctors spent on average 1.3 minutes conveying crucial information about the patient's condition and treatment, and most of the information they provided was far too technical for the average patient to grasp; disconcertingly, those same doctors thought they had spent more than eight minutes. In another study, three out of four doctors failed to give clear instructions on how to take medication. When asked to state medication instructions, half of patients have no idea what they are supposed to do. A Markle Foundation survey released last year found that both patients and doctors agreed that about 30 percent of the time doctors forget important information their patients tell them. And in a now-famous study of physicians' performance, patients received only 55 percent of recommended care for 30 different medical conditions.

At the same time, doctors often prescribe too much of the wrong kind of care. Between 2000 and 2005, the number of CT scans performed annually nearly doubled to more than 75 million a year, many of them given, say experts, out of habit or fear of litigation, not because they were likely to help the doctor make a diagnosis. Prescriptions for antidepressants, which are heavily marketed to physicians by drug companies, shot up over the same period, often for patients who did not have a psychiatric disorder. And polypharmacy—prescribing too many drugs, especially for elderly patients—is rampant.

The time crunch and complexity of care has left the doctor-patient relationship in tatters. And this makes a difference. Numerous studies have found a link between how well the doctor and patient communicate and the patient's sense of well-being, his number of symptoms, and his overall health. For example, Canadian researchers

audiotaped more than 300 office visits with 39 different primary-care doctors. Patients were then asked to rate the visit in terms of the relationship with their doctors. Then the researchers looked at how the patients' health fared over time. When patients reported that their doctors focused on their feelings and worries and listened to them carefully, they not only felt better but objective measures showed they had fewer symptoms of disease.

Good doctors have always known this, says Howard Brody, but only in the last few years have researchers begun to tease apart the particular ingredients that are necessary for this "therapeutic relationship," as it's called. Patients need a doctor who listens, he says, "and who offers an explanation for what's happening that makes sense to them." Truly caring about the patient is also crucially important, and touching the patient during a physical exam helps convey that concern. Finally, he says, "The doctor should help the patient feel more in control of what's going on." When some or all of these ingredients are missing in medical encounters, patients may undermine their own health. Doctors often complain about "uncompliant" patients who stop taking their medications or who fail to make recommended changes in their diet or bad habits like smoking, but the problem really may lie with the doctor-patient relationship.

James Rickert, an orthopedic surgeon in Bloomington, Ind., says he learned this lesson five years ago when he suffered a relapse of non-Hodgkins lymphoma, a potentially fatal form of cancer. His oncologist told him there were two types of bone-marrow-transplant treatments for his relapse, both of which posed serious, sometimes even fatal, side effects. The doctor strongly recommended one type, but when Rickert asked him to explain his reasoning, the oncologist seemed unwilling or unable to elaborate.

"I walked out of his office very upset," says Rickert, now 50. "He either wouldn't or couldn't explain, even with me being a doctor. Because of that interaction, I didn't have the amount of trust I should have." Rickert ultimately decided to go with the recommended treatment, but he began seeing a different doctor, whom he likes and

trusts. After being hospitalized twice last spring with pneumonia that was caused by a drug he was taking, he emailed his new doctor to tell her he wanted to go off the medication. “She called me immediately and explained why I needed to stay on the drug,” says Rickert. He stuck with his regimen and has recently been able to taper the dose without another case of pneumonia.

This therapeutic relationship matters even when the patient isn’t really ill. Many patients, says Vikas Saini, a cardiologist and president of the Lown Cardiovascular Research Foundation in Brookline, Mass., are more anxious than sick, but sometimes “the worried well” can be the most difficult to reassure. That’s partly because Americans have come to equate feeling cared for with being given a test or prescribed lots of medications and procedures. “More care is better in the patient’s mind,” says Saini, and more technological care is best. Any effort to dissuade patients that a drug or test is unnecessary is often interpreted as a sign of a neglectful and uncaring doctor.

“If a patient comes in complaining of vague chest discomfort, saying her heart is ‘fluttering,’ I can often tell there’s nothing seriously wrong in the first few minutes,” says Saini. Even so, he may spend an hour carefully taking the patient’s history and doing a physical exam before attempting to calm her fears. “As a patient,” he says, “if I’m not sure you’ve listened to me, how can I trust that you’re giving me the right drug or the right test?”

despite all the problems, people are not willing to change doctors or even to criticize the medical profession. In poll after poll asking respondents whom they trust, doctors consistently rank at or near the top. In a series of focus groups led by GYMR Public Relations for the Robert Wood Johnson Foundation, patients repeatedly said that even if their relationship with their doctor was poor, they would not want to switch physicians.

The good news is policymakers and doctors have begun to recognize the importance of the therapeutic relationship and devise ways to mend it. Medical schools have traditionally put a premium on

recruiting students who test well, but testing well doesn't guarantee the social skills to listen to patients, says Michael Wilkes, a primary-care physician at the University of California, Davis's School of Medicine. "Students who do well on tests and exams don't necessarily make good doctors," he says. Twenty years ago, Wilkes introduced the "Doctoring Curriculum," a series of courses and seminars that teaches med students to communicate with patients, use critical reasoning when looking at medical studies, and help their patients make decisions about the care they would prefer at the end of life. Most medical schools have not adopted this method, but a few are starting to recruit a different breed of student using a series of short interviews designed to test prospective students' people skills (think speed dating, but without the romance).

Also underway are efforts to reach doctors who are already in practice. A centerpiece of the Patient Protection and Affordable Care Act of 2010 would offer primary-care physicians a little extra pay to act like the quarterback, keeping track of and directing all the care patients get from their various doctors. This model, says the University of California's Bodenheimer, looks very different from the average practice of today. Doctors work with teams of other clinicians, including physician's assistants, nurse practitioners, pharmacists, and care coordinators, leaving doctors with more time to spend with the patients who most need them. "Fifty percent of what we [doctors] do can be done by someone with a lot less training," he says. This so-called medical home model also encourages doctors to use the phone and email to communicate with patients when they don't need to come in—which can free them up to spend quality time with their patients when they do.

Another potentially transformative effort to improve doctor-patient relations is "shared decision making," a formal process for helping patients understand treatment options. For example, women who have been diagnosed with early-stage breast cancer can choose lumpectomy with radiation or mastectomy, surgical removal of the entire breast. Each has pluses and minuses, and patients need to understand the tradeoffs. A brochure or video, called a patient

decision aid, can help, but the patient often needs a good communicator, a doctor or other clinician, who can guide her through the choice.

In an age when surgeons use robots and medicine is growing increasingly technological, time turns out to be one of the doctor's most precious gifts to patients. Just showing up in the hospital room or calling a patient at home a couple of times during the week after an office visit can make a big difference in how patients feel, says UC Davis's Richard Kravitz. With a few small gestures, even a fraught relationship can be smoothed out. After that, he says, "You and the patient are bonded forever."