A holiday gift to primary care doctors: Proof of their time crunch

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The average primary care doctor needs to work six more hours a day than they already do, in order to make sure their patients get all the preventive and early-detection care they want and deserve, a new study

finds.

Primary care doctors' sleep, personal hygiene and family time need to take a back seat, so they can add 29 minutes to each patient appointment, the study shows.

Fortunately, the new study was written as a parody, and is published in the satirical Christmas edition of the journal *BMJ* by a team from the University of Michigan.

No one is asking doctors to work past midnight every night.

At least, not yet.

But the study concludes that if they did, it would give primary care doctors just enough time to work with each patient to discuss and decide which preventive health options they should choose based on the risks, benefits and costs.

The study focuses just on the evidence-backed national recommendations from the Preventive Services Task Force—from colonoscopy and proactive lung cancer screening scans to vaccination and daily aspirin. The researchers built and ran a computer simulation based on real-world data to reach their conclusions.

Unfortunately, all this shared decision making about prevention would crowd out any time to discuss the patient's actual medical complaints. And, the researchers conclude, it would lead 17 out of every 100 doctors to take early retirement each year.

But the authors of the new paper—two of whom are general practitioners themselves—say their findings make a clear point. The idea that primary care doctors can engage in detailed shared decision-making

with every patient, for every proven form of prevention, is completely impossible.

"This may be satire, but it actually allows us to make these points more strongly than we otherwise could," says Tanner Caverly, M.D., MPH is the study's lead author and a general practitioner at U-M's academic medical center, Michigan Medicine. "One of primary care's main roles is that we are the ones who absorb everything that our patients need, and every demand for improved preventive care. Prevention is just one of the things we do."

Caverly worked with fellow U-M primary care physician Rodney Hayward, M.D., and U-M neurologist James Burke, M.D., to create a computer model of the way 1,000 different doctors might spend their clinic time if they each had to take care of 2,000 primary care patients. The patients' medical conditions and levels of illness and disability were based on a sample of data from a real collection of patients tracked in a national study. They also varied many aspects such as the patient panel size and annual work-hours before drawing conclusions.

Caverly and his colleagues modeled the time needed to address recommendations from the USPSTF, a group of health professionals that examines the entire body of research around specific preventive services. The USPSTF makes recommendations of varying strengths to guide clinical care nationwide.

Their recommendations, which are considered the most rigorous and scientifically based, also help guide insurance coverage of preventive services.

"My colleagues and I care a lot about shared decision making, and how to get preference-sensitive care right, but these data show it's a matter of walking a fine line. What we call full-share decision making is not

feasible for these types of decisions, so we have to come up with a model of shared decision-making that is more feasible."

Caverly has studied lung cancer screening, and built a tool with colleagues that can help physicians understand which of their patients really have a decision to make about whether to get a CT scan to check for signs of lung cancer.

The USPSTF made a recommendation about such screening, but actually implementing it in clinical practice can be a challenge because many patients won't get enough benefit from such scans to warrant the worry and potential invasive procedures that they can lead to. But some patients truly could benefit from the scans, and need a strong recommendation from their physician.

"Recommending screening tests and scans is definitely a visible and growing part of the primary care agenda," says Caverly. "But primary care doctors say that one barrier to lung cancer screening, one of the more recent USPSTF recommendations, is they don't feel like they have time to incorporate another big thing to discuss with their patients."

In the VA healthcare system, where Caverly cares for veterans' primary care needs, the electronic medical record system offers digital reminders to physicians about which preventive services their patients need. But even with this help, they don't have time in routine clinic visits to address all of the potentially valuable services at once.

"We need the entire primary care team to help out on preventive issues, and use health information technology to prioritize what we recommend to a particular patient," Caverly says. "We need to use the patient's time in the waiting room, and opportunities outside of time-pressured office visits—and perhaps offer incentives."

In addition to illuminating the issue of how primary care clinics should manage preventive services for their patients, Caverly and his colleagues hope their paper makes another point about physician wellness and burnout.

Shared decision-making as a model for clinicians and patients to cooperate on making a medical decision was pioneered in areas of medicine where decisions are very high-stakes—for instance, decisions about starting chemotherapy for cancer.

But in primary care, the need to have patient-centered care runs up against the time constraint of busy clinics with high demand and short appointment slots.

"We did this as a serious paper written from a humorous standpoint that reinforces the serious issues more sharply," says Caverly. "Now we need to analyze different ways of approaching these discussions with our patients."

He and his colleagues hope their paper will be read by many primary care physicians during their spare moments after they after they finish their last clinic note around midnight. "We wouldn't want them to read it, or this summary of it, during work hours," he hastens to add, "because it would take precious time that they could use to discuss three or four preventive screenings and treatments with a patient."

More information: Tanner J Caverly et al, Much to do with nothing: microsimulation study on time management in primary care, *BMJ* (2018). DOI: 10.1136/bmj.k4983

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