Time matters in caring for patients

Twenty minutes isn't enough

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> The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.
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> Francis W. Peabody[1]

Despite rapidly developing new technologies and advancements in medicine, how we actually care for our patients continues to be our most important professional responsibility. The care of the patient is based on what each patient needs; what is most important for each patient and family; and what patients and their families need to understand to cope with their health, illnesses, and suffering.

The qualities that we physicians bring to our patients and society are many, but most important, we need to be present and engaged with our patients as individuals. The doctor-patient relationship remains the core of our professional responsibility, and our profession. Sir William Osler wrote, "the good physician treats the disease; the great physician treats the patient who has the disease."[2]

We have made incredible progress in diagnosing, preventing, and treating diseases which has reduced deaths and extended the life expectancy to an age never before seen in history. Yet, many factors introduced by our third-party payer system and the corporatization and businessification of medicine adversely affect the doctor-patient relationship. Patient care has become increasingly impersonal, hurried, and commercialized. Doctors and the way we practice medicine are controlled by insurance companies, corporations, health maintenance organizations, and for-profit medical organizations. This results in inadequate time for doctors with patients, and the healing power of the doctor-patient relationship is often impaired or forgotten.

Peter Dans, MD, wrote,

> When the AMA [American Medical Association] agreed to drop its opposition to Medicare and Medicaid in the 1960s, it exacted a promise that the new laws would incorporate its "usual, customary, and reasonable" fee system. This paid disproportionately for hospital visits, surgery, and technologic procedures for treating acute illness, as opposed to office visits for maintenance treatment of chronic illnesses or for prevention. The legislation also accommodated hospitals by agreeing to pay all their costs plus 2 percent. This favored the development and use of costly technology and instrumentation in larger and more complex institutions. Medical care, once considered a "cottage industry" became "corporatized," or in the words of Arnold Relman, MD, editor of the prestigious *New England Journal of Medicine*, a "new medical-industrial complex." No longer could the profession's ethos be set by a Hippocrates, Sir William Osler, or the few distinguished leaders and institutions that dominated it until the 1950s.[3]

The most important way to improve patient care through the doctor-patient relationship is to increase the amount and quality of time for the doctor to spend with his/her patient in the clinic or office.

> What doctors and patients need is more time, not more technology.
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> —Malcolm Gladwell[4]

David Sipress/The New Yorker Collection/The Cartoon Bank

Many organizations and insurance companies purposefully limit or decrease doctor-patient time, and align financial incentives for doctors with the plan's commitment to greater profit, and other goals that are unrelated to those of doctors or patients. Time limitations must be addressed and recognized as a critical requirement in the care of patients. The doctor-patient relationship in which a history, clinical examination, thoughtful communication, diagnostic reasoning, diagnoses and plans, and medical and other caring interventions are made, remains the keystone of care. Effective doctor-patient communication cannot be accomplished in a strict, time-limited, fifteen- or twenty-minute appointment.

Dr. William Watts Parmley observed that the care of the patient is a distinct human interaction that is set apart by its sovereign confidential nature which includes a thorough physical examination; discussions of disability and death that directly relate to the patient; diagnostic tests and therapeutic interventions with which the physician is directly or indirectly involved; and an atmosphere of respect for individual dignity. It is characterized by trust, compassion, humanism, professionalism, and high moral and ethical standards.[5]

Much stands in the way

Limiting the time spent with patients while increasing the "efficiency" and "productivity" of the interaction—the assembly line approach—often destroys any meaningful

doctor-patient relationship. For many physicians who are tied to a computer and the electronic health record, it becomes easier and more "efficient" to spend their limited time with the patient entering information into the computer, and ordering tests and consults (see *The Pharos* Summer 2015 editorial "The tragedy of the electronic health record" pp 2–5). This makes the actual one-on-one time for the patient and doctor even more constricted, and often is very frustrating for the patient. Limitation of time also contributes to dissatisfaction as well as physician burnout. Sufficient time to care for patients and help them—and their families—to care for themselves is what patients, especially those with chronic diseases and socioeconomic influences, need most.

Studies have demonstrated an association between shorter visits and increased rates of medication prescribing, as well as increased risk factors for inappropriate prescribing.[6] In addition, shorter visit length and patient perceptions of rushed doctors who spend less time with them has been associated with an increase in malpractice claims and a predictor of outcomes in malpractice claims.[7] One of the primary sources of physician satisfaction is patient relationships, with the primary source of dissatisfaction being "time pressure."[8] There is a direct correlation between higher physician satisfaction and higher quality of care when physicians explain the treatment plan to the patient, and pay attention to psychosocial aspects of the patient's care. This also results in more moderate prescription rates.[9]

In a 2009 report, Lizner, et al., found that 53% of physicians complained about time pressure during office visits. The time pressure was associated with low job satisfaction, stress, burnout, and intent to leave the practice of medicine all together.[10]

In the current business model, the physician's time becomes a constrainable resource to accommodate greater patient volume for increasing revenue, often at the doctor's expense of working longer hours. The total patient load or schedule has not actually decreased. However, the physician now spends time on distractions—interacting with insurance companies, staff motivation to decrease costs and increase reimbursement, administrative responsibilities, practice controls, charting, working with the electronic health record, ordering tests, writing prescriptions, ordering consultations, attenuating litigation risks, and a multitude of other diversions and responsibilities that restrict face-to-face care of the patient. All of these activities must be completed in a time-limited fifteen- to twenty-minute patient appointment.

Assembly lines are not possible

The business model of an assembly line approach to patient care completely ignores the fact that there is no average patient with the same design, problem, cause, and effect. People are not mass produced, all from the same mold with uniformly engineered parts and systems. Our current standard ignores the individuality of each patient, and the time needed to address his/her health, and medical issues. As Gladwell stated, "What my mother needs is a doctor who knows her and someone who can understand her."[4]

The reasons for inadequate one-on-one time between physicians and their patients are mired in the complexities of an evolving payment system.

Taking into account the amazing advances in science; medical technology; diagnostic testing and interventions; and myriad different medications, with new ones coming out everyday, logic would dictate that the time allotted for patient visits should be much longer. These wonderful advances in medicine have provided us with patients who are living longer—often into their 80s, 90s, and even 100s—and who have multiple chronic medical and psychological issues. However, the business aspects of caring for the patient haven't kept up, and, if anything, have adversely affected patient care.

The history of billing and coding

To further understand the evolution in the care of the patient related to time and reimbursement we must review the creation of the relative value unit (RVU) set by Medicaid, and the Current Procedural Terminology (CPT) set by, and copyright protected by, the American Medical Association.

Historically in America, usual, customary, and reasonable was the standard used to establish health care prices.[10] W. A. Glaser, MD, once noted that "paying the doctor is inherently political."[11] Over time, politics related to public expenditure on health care have involved working out conflicts of interest between the payers for health care and the medical profession—including the interests of medical specialties and special interest groups. This has been evolving for more than fifty years.

Originally, the American health care delivery system, consisting primarily of a country doctor and a local hospital, was developed based on charging customary, prevailing, and reasonable rates. The basic principles were to maximize professional freedom and minimize conflicts with payers.

Medicare payment was very contentious when it was implemented in 1965. Doctors could accept the Medicare payment, or they could bill the patient the difference between their charges and what they received from Medicare.

In the 1980s, it was clear that change was needed. Fee schedules were reviewed and updated based on financial value and negotiations with payers for cost controls. However, the attempt to have competitive markets determine pricing of services resulted in fee schedules no longer being published, and many organizations that had fee schedules eliminated them.

In 1985, politicians with some input from medical organizations decided to replace the customary, prevailing, and reasonable charge system with a formula reimbursement system. A team from the Harvard School of Public Health, the American Medical Association, and several specialty groups were charged with developing a medical reimbursement system to provide fee-for-service utilizing fee schedules. However, they were constrained because it is easy to measure time for visits and procedures, but very difficult to measure complexity and difficulty of the patient and their maladies independent of time.

This extremely intelligent group forgot a very important factor when developing their new system—"Not everything that counts can be counted, and not everything that can be counted counts," as noted by Cameron and Einstein. Time for the doctor-patient *relationship* wasn't included.

The Harvard-based team decided to utilize dimensions of complexity, including judgment, skill, physical effort, and stress due to risk. Specialty groups argued for relative weighting since the fees would determine income. Eventually, they decided to weight the time, practice costs consumed, difficulty, and skill for each procedure. However, the data and information to accomplish this did not, and does not, exist.

The major constraint was budget neutrality, which perpetuated the historical income differentials by specialty. The enactment of the relative value system (RVS) was an imperfect political process because it was designed as a Medicare-only method of paying doctors rather than a comprehensive health insurance system.

In 1992, Medicare changed the way it pays for physicians' services by establishing a standardized physician payment schedule configured on a resource-based relative value scale (RBRVS). Payments for services are determined by the resource costs needed to provide the particular service. The cost of providing each service has three components: physician work, practice expense, and professional liability insurance. Payments are then calculated by multiplying the combined costs of a service by a conversion factor, which is a monetary amount that is determined by the Centers for Medicare and Medicaid Services. The physician work component accounts for, on average, 48% of the total relative value for each service.

The factors used to determine physician work include the average time it takes to perform the service (whatever average is for patients suffering from acute and chronic illnesses); the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient. The practice expense accounts for an average of 48% of the total relative value for each service based on a resource-based practice expense relative value for each CPT code at the site of service. The professional liability insurance RVU accounts for 4% of the total relative value for each service.

CPT codes are a list of descriptive terms, guidelines, and identifying codes for reporting medical services and

procedures designed to provide a uniform language that describes medical, surgical and diagnostic services to bill and inform third party payers. There is a defined code for all health care visits and procedures—office visit; hospital visit; home visit; nursing home or facility visit; surgery; labor and delivery; office procedures; tests; as well as the physician's "cognitive work. "

There are thousands of CPT codes, which, combined with the Resource-Based Relative Value Scale (RBRVS), value physician services using RVUs.

Evaluation and management codes (E/M)—the process by which physician-patient encounters are translated into CPT codes—are defined by the service provided for the patient and include patient type (new or established; setting of service) office, hospital, emergency department, nursing facility; level of evaluation and management service performed. They relate to history, which includes chief complaint, history of present illness, review of systems and past/family/social history, and examination and medical decision-making. These are then categorized by the level for each component.

Billing Codes, Charges, and the Medical Bill					
CPT Code + ICD10 Code + Charges/Fees = Medical Bill					
CPT Code	Description	Physician E & M	Facility Portion	Malpractice Portion	Total
99202	New patient office visit	0.88	0.31	0.05	1.24
Medicare pays $36.879/RVU x 1.24 = $45.73 (physician's compensation for the new patient office visit					
Note: In Medicare contracts, private insurers pay $55/RVU for evaulation and management, and $70/RVU for procedures. Payers reduce payments for secondary CPT codes.					

This is an extremely complex system not necessarily related to the care of the patient, good decision-making, or outcomes.

Medicare allows only for the medically necessary portion of the visit, even if patient care requires more time and effort for patient interactions that are considered "not medically necessary." Only what Medicare considers the necessary direct services for the condition of the patient at the time of the visit can be used in determining the level of an E/M code. Time spent reviewing medical records, talking with other providers, documenting the encounter without the patient present cannot be considered and reimbursed.

Physician time can only be charged for prolonged services after a minimum of thirty minutes beyond the typical time listed in the highest code set. Medicare allows for charges for each thirty minutes over the initial time if it is documented in the medical record. Also, the additional time charges must be face-to-face time with patients, not other work related to the care of the patient.

In addition, the physician payment plan has not established uniform charges by geography, community, or within specialties. Data continues to demonstrate that the same "procedure" can vary dramatically within the same community or region.

Doctor vs. car mechanic—who gives more time?

Confused yet? Let's compare taking your car to a mechanic with going to the doctor for a medical problem. In both situations you have to wait for an appointment unless it is an emergency. However, almost no routine automobile service lasts only fifteen to twenty minutes; but a routine physical examination with a doctor is supposed to fit into that time frame.

Consider the average middle-aged man with hypertension and high cholesterol who drives a 2011 Volvo. The regular maintenance schedule for his car is every 10,000 miles. According to a J.D. Power and Associates 2013 U.S. Customer Service Index (CSI) Study,[12] car owners visit a dealer service department an average of 2.6 times per year. This means that the aforementioned man will most likely see his doctor twice a year for a total of forty minutes, and his car mechanic three times a year, usually for at least an hour or two each time. He will be spending more time with his car mechanic than face-to-face with his doctor.

The human body is much more complex than a car's engine. Humans have millions of interactive parts that have

evolved over long periods of time, and are not designed by engineers and built by factory workers with the goal of having all of them come off the assembly line exactly the same. Choices with car repairs are different from an individual's health and quality of life. It would be nice if patients could spend as much time with their doctors—or more—than they do with their car mechanics.

The medical value to the patient

The medical value to the patient of a service is not considered in how much is paid for the service. There is no financial remuneration to the physician for spending time on outcomes and improving health. The focus is purely on providing services in a specified time allotment with no consideration of effectiveness or elegance. There is no recognition that an "average" patient doesn't exist.

The strict fifteen- to twenty-minute patient visit means physicians frequently spend too little time with their patients to understand them and their suffering, to converse, assess, reason, and communicate with their patients. Extra time for doctors with their patients has been shown to contribute to better outcomes, fewer complications, better overall patient health, decreased emergency room visits, and fewer hospitalizations. A patient coming to see a physician rightly wants the visit to take as long as reasonably required.

The shortened time allotment assumes that every symptom can easily and quickly be translated into a problem with a simple answer and solution. A hurried, task oriented patient visit doesn't address the numbers and complex issues of patients or the caring and humanism of the doctor-patient relationship.

Physicians are taught to use clinical reasoning and logical deduction through evolving dialogue that is critical to understanding, responding, and adapting as part of the care provided. Clinical reasoning involves nonanalytical reasoning combined with analytical reasoning.

Nonanalytical reasoning uses rapid, unconscious pattern recognition based on stored knowledge of examples or "algorithms." It is rapid, intuitive, simple, and usual in routine and uncomplicated patients. Nonanalytical reasoning is prone to bias, errors in diagnosis, and premature closure of the reasoning process.

Analytical reasoning is a complex and time consuming process that requires reasoning with incomplete data, memory, assimilating new information, and excellent human communication. Excellent analytical reasoning is slow, deliberate, sequential, systematic, reflective, laborious, and uses many different cognitive pathways to diagnose complex cases and clinical problems. It is used to arrive at the best or correct diagnosis, and to prevent bias and diagnostic errors. Adequate time is essential for the physician to think and reason about a patient, the illness, suffering, and worries. Time, mindful adaptability, attention to detail, and information on past events, are integral to the physician's role using clinical intelligence, experience and conversation in reasoning on behalf of the patient. The physician needs the time to conduct analytical reasoning in every patient encounter to ensure the best outcomes for all involved.

Lack of adequate time results in the inability to consider all the available information and use analytical reasoning to reach the most accurate diagnosis. In a study conducted by Evans, et al., of 750 patients in a primary care clinic, 98% had at least one expectation before the medical visit —information on their diagnosis and prognosis. Failure to address diagnosis and prognosis was the most common cause of unmet patient expectations. Patients who received the information they were seeking experienced better symptom relief and functional outcomes.[13]

Simply put, patients want a personal relationship with their doctor, good communication, empathy—and time.

It's time for a new system

After twenty-four years of physician billing and compensation using CPT codes and RVUs, which is based on an impression of what average patients need in a visit, we need to review and revamp the system to improve access and quality.

The Centers for Medicare and Medicaid Services (CMS) is making small steps to modify the payment system. Starting just this year, they began covering advance care planning—discussions that physicians have with their

patients regarding end-of-life care and patient preferences—as a separate billable service.[14] This is definitely a step in the right direction, but not enough. CMS needs to revolutionize the entire compensation system and develop a completely new payment system that would reflect the cost to the doctor of providing quality care with better results.

A new payment system would recognize that adequate time for the doctor with the patient is fundamental; that human beings are amazingly complex and more than the sum of their cells, organs, and diseases.

A new payment system would take into account that today's patients usually do not have isolated problems, but come with two, three, or more health issues that are not interconnected. And, that these patients and their families are worried and suffering.

Physician payment reform requires national political leadership and a recognition that the time has come for change. In the over-studied and over-documented field of health care finance, legal and administrative mechanisms need to be drafted and introduced quickly for urgent reform.

We must develop a new, twenty-first century physician payment system for the care of patients that allows the physician and patient the ability to manage their health, suffering, and illnesses in a time period that recognizes and accommodates today's changing health care environment.

Physicians must lead, and have a central role in, the process of devising, designing, approving and implementing a new medical care payment system. Any new system must be considerate of the costs to individuals and society.

This new system must put the patient first, and revenue and profit second.

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