

priority on trying to do a good job and having a sane life than on making a higher income. The message they're sending is that more money will not be enough to revitalize primary care.

Revitalization will take something more like reinvention, and it will demand creativity and flexibility from all parties — including primary care physicians themselves. These physicians need to learn to work in teams and adjust to the notion that much of primary care can be delivered by nonphysician team members, some of whom are located in nontraditional settings, such as limited-service clinics in retail stores.

In this collection of articles, Starfield describes some of the major policy issues that must be addressed as the U.S. health care system develops a stronger primary care focus, and Roland suggests that there are some features of primary care in the United Kingdom that might warrant adaptation. As we test new concepts in the years ahead, primary care will undoubtedly change dramatically. But if we are successful and wise, these changes should allow key aspects of being a primary care physician to remain the same.

Primary care doctors should once again feel a deep sense of satisfaction when they leave their offices or patients' homes after helping people through difficult times. They should be able to leave work thinking not of their income, or of unanswered phone calls, or of test results that they might have overlooked. They should go home thinking, "This is what I was meant to do."

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## Sustaining Relationships

Katharine Treadway, M.D.

"A growing chorus of discontent suggests that the once-revered doctor-patient relationship is on the rocks."

*New York Times*, July 29, 2008

With its combination of care for acute, undiagnosed illness and complex, multisystem disease, as well as the provision of extensive preventive care, all in the setting of a long relationship built on mutual trust and knowledge, primary care has long been a deeply rewarding profession. But in recent years, this once-extraordinary specialty has seen its ranks diminish as doctors struggle with an increasing amount of paperwork, the explosion of therapeutic options, and a dramatic expansion in preventive care responsibilities. Care is

increasingly fragmented, leaving patients angry and doctors frustrated. The time demands have exploded, which has eroded everyone's ability to develop the personal, long-term relationships that are a great source of satisfaction for providers and comfort for patients. Such relationships can be instrumental in providing effective and efficient care.



My 12-year relationship with one patient and her family had a profound effect on care at the end of her life. When I met Mrs. C, she told me, "I am

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## Transforming Practice

Thomas Bodenheimer, M.D.

Overstressed by large patient panels, many primary care practices are performing below par. In one study, patients explaining their problem to a physician were interrupted after an average of 23 seconds. Fifty percent of patients leave office visits not understanding what the physician has told them. It would take a primary care physician 18 hours per day to provide all recommended preventive and chronic care services to a typical patient panel. As a result, only half of evidence-based care is actually provided.<sup>1</sup> These disturbing findings can be attributed primarily to the overburdened 15-minute clinician visit.

Two solutions come to mind: Re-

duce the panel size to allow more time per patient — the concierge model — which would aggravate the impending shortage of primary care physicians. Or reorganize primary care into a team-based endeavor, off-loading many functions from the 15-minute visit — a solution requiring fundamental payment reform that uncouples reimbursement from the clinician visit and creates incentives for team building.

The latter approach involves a fundamental paradigm shift: rather than spending all day in traditional patient visits, primary care physicians must analyze their patient panel and manage it so as to keep all patients as healthy as possible. To do so, practices need a registry (database) that gives them access to their patients' diagnoses, key clinical data (e.g., blood pressures and cholesterol levels), and

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**TREADWAY CONTINUED**

82 years old. I have lived a good life. I am ready to die. Please do not do anything to prolong my life." As it turned out, her only medical problem



was hypertension. We negotiated an agreement that she would continue to take her medication. She came to see me a few times each year. Occasionally, a new problem necessitated another discussion about not doing "too much." By the time she was 94, she had become quite frail. She no longer wanted to trek into Boston, but she did not want a local doctor. She wanted a visiting nurse to see her occasionally and report to me. She reminded me of my promise not to "do anything." She gradually weakened and spent an increasing amount of time sleeping.

Then one day her nurse called me. Mrs. C's systolic blood pressure was 90. She wouldn't get out of bed. She wasn't eating. She didn't want to have blood work done or come to Boston. Her family supported her decision. I was torn. She had been very clear about her desires, but what if this was something simple that I could treat? I knew I had to abide by her wishes.

Soon, she developed a fever. Suddenly, her family wanted to bring her in. She refused. Her temperature rose higher. She was no longer responsive. I heard the anxiety in her daughter's

voice as she reported this latest development. I offered to come see her that night.

When I arrived, 22 family members were waiting. The anxiety was palpable. Mrs. C was unconscious in a bed in the front parlor. I greeted the relatives, some of whom were also my patients, and went to examine Mrs. C. She was dehydrated, unresponsive, burning with fever. She would clearly die unless I did something drastic. In my mind, I could hear my patient's clear and consistent instruction. I laid my hand on her hot, dry forehead and silently said good-bye.

Then I sat down with her family. "Shouldn't we take her to the hospital?" "What about giving her oral antibiotics?" "We can't just let her die here." The questions poured over me. I said she was quite near death and that to have even a remote chance of reversing her condition, we would have to take her by ambulance to the hospital, draw blood, do cultures, and give fluids and IV antibiotics. It was



unlikely to be successful. I reminded them that she would not want to go to the hospital. I talked about how hard it is to do nothing but said I believed that by being here with her and allowing her to die as she had asked, they were doing something very important: respecting and loving her. How better to die than at home, surrounded by her loving family? We talked about what might happen as death neared. "We don't know how aware

she is," I said, "but in my experience with unconscious ICU patients, it seemed patients knew when those they loved were near." I suggested they be with her, talk to her, say their good-byes. I gave them a prescription for morphine in case she became uncomfortable and said they could page me at any time.

Then I left. The room was calm. People were hugging each other. I had walked into a room of fear and anxiety and left a room of peace — not because of me, Kate Treadway, but because of my role as physician. Had I been the neighbor and said the same thing, it would not have mattered.

Two hours later, the family paged me. Mrs. C had died peacefully. After I left, her family had gathered around her bed, telling stories, laughing, and crying. They had sung her favorite hymns as she slowly stopped breathing. Later, one of the letters I received from her family said, "Without your presence, this moment would have been very difficult for all of us. . . . The firm guiding hand of the doctor was felt."

I could not have been my patient's advocate if I had not known, deeply, that I was doing as she wished. I would not have been "the guiding hand" for her family without their trust. For me, this is the essence of primary care: comprehensive, longitudinal, and relational. Our challenge, as we redesign primary care, is to ensure that we continue to nurture this relationship, which is at the heart of effective medicine.

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