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Editorial

Where Did The Time Go?

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The field of medicine is constantly changing. The direction of that change has significant implications for all who are entrusted with providing care for patients. Although some of the changes in how that care takes place are determined by others, those of us who are devoted to the ideals of medical practice must be advocates for how we think care is best delivered.

In ophthalmology we have seen extraordinary advances in areas such as research, technology, medical treatments, and surgical techniques. There have also been new models for delivering care utilizing ophthalmic technicians, scribes, and other ancillary personnel. The past several decades have also brought changes in reimbursement systems, including HMO's, PPO's and, in the United States, the Patient Protection and Affordable Care Act now being implemented.

The changes in reimbursement in the US over the last several decades have not kept pace with the cost of living and practice expenses, especially notable in payments for office visits and many surgical procedures. Payers have imposed these decreases at the same time they are emphasizing increased quality of care, such as the Physician Quality Reporting System (PQRS) initiative of Medicare. It must be realized that declining reimbursement adversely impacts quality of care.

The qualities of excellent care can be difficult to objectively measure, but certain elements remain essential. These include a thorough history, a complete examination, arrival at an accurate diagnosis, discussion with the patient about the diagnosis and the benefits and risks of treatment alternatives, and time for patient questions. Without these, the patient is not being provided optimal care. In the past, most physician schedules allowed adequate time for these elements. In recent years with the understandable, but undesirable, emphasis on "production," time spent with the patient has decreased.

This is not to say that increased patient volume does not have some positive aspects. It requires attention to increased office efficiency, provides the opportunity to potentially see more pathologic conditions, can increase the number of surgical cases, helps if there is a shortage of physicians, and may increase appointment availability for patients.

With office expenses ever rising, in the setting of years of debt accumulation during training, lesser reimbursement for office visits and surgery has resulted in a change in practice structure. With lower payments per visit, an increase in number of visits per day is required in order to maintain the income generated by a practice. This increase in patient volume has often been achieved with the help of ancillary personnel and a decrease in time spent per patient. Although in theory quality of care can be maintained with shorter patient visits, in reality one or more of the elements has to suffer. We are taught in medical school that very often the correct diagnosis can be made from the patient's history, but history is often delegated or abbreviated when time is lacking. Sir William Osler's most quoted advice is, "Listen to the patient. They are trying to tell you the diagnosis." If a patient comes for a second opinion for a longstanding problem, often it is a detailed history that elucidates the correct diagnosis. A patient with a red eye treated unsuccessfully for "allergic conjunctivitis" may not have experienced itching initially, and that can be the key to look for another cause.

Additional disadvantages of decreased time are professional stress and burnout for doctor and staff, as well as the loss of time for showing and discussing interesting cases with colleagues. Further, taking time to talk with patients is how we get to know them better, something that is an essential element in delivering the best individualized patient care.

An important aspect of ophthalmologic care is that we are caring for a person with an eye disease, not just an eye. The discussion element must not be shortchanged. We cannot just tell a patient on an initial visit, "You may have glaucoma." It's very possible they will spend the next two weeks worrying they will go blind. Time is needed for a discussion to explain what glaucoma is, that we have treatments to lower the intraocular pressure into a safe range, and that they will be monitored on a regular basis to insure that the glaucoma remains well controlled. Ideally, the term glaucoma should not be used until the end of the discussion for, if it is mentioned initially, the patient's anxiety may not allow them to hear anything else that is said. The same principle applies when discussing a new diagnosis of age-related macular degeneration with a patient, and for many other conditions whose names carry concern.

In conclusion, we must work to raise awareness that decreased time with each patient is a consequence of declining physician reimbursement. Quality patient care, in its fullest sense, is being compromised by this loss of time. Another lesson from Sir William Osler is, "The good physician treats the disease; the great physician treats the patient who has the disease." Treating a patient takes time.

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