

# PRACTICING MEDICINE: A NEW QUALITY OF CARE

The story of how one patient was diagnosed with a life-threatening condition illustrates how the changing healthcare landscape might affect the quality of physician care.

By Sue Romanick, MD

**A**s I entered the exam room to meet Bob for the first time, I smiled with relief. Bob looked pleased to be in our clinic, appearing well-tanned and comfortable. I had already noted the priority that he had scrawled on the intake form for today's visit: "ear wax." I was relieved that this would be a straightforward visit. Because several patients that day had complex issues, I had already fallen behind in my schedule, and my staff had nervously pointed out that the waiting room was full. Yet, I must admit I was curious why Bob had come to me.



Bob knows I am a rheumatologist who deals with autoimmune disorders. Yet, he had insisted on seeing me when he made the appointment. His wife was already a patient, although they had been living in Hawaii for a few months. This visit was rather spur of the moment, so I was happy to help out.

After reviewing Bob's three detailed medical history forms, including his past medical history and medications, my examination confirmed that Bob, indeed, did have impacted ear wax in his right ear. There was no infection, and he appeared to be otherwise healthy. So, we discussed treatment options, and Bob opted for a simple, over-the-counter remedy.

Bob appeared pleased with my assessment. It felt like the visit was over, and I closed my laptop and moved toward the door. Little did I realize that a bombshell was about to drop. As my hand landed on the door handle, all of a sudden, Bob uttered words that have alarmed many a provider: "Doc?" he stated with hesitation and a meek, upward inflexion in his voice. "Can I ask you another question? I have this pain...."

"Oh, and by the way...." How many times has a medical provider heard that? In truth, this can indicate a dangerous path depending on which fork in the road the provider takes. In the current healthcare environment, the right answer was to tell Bob to book another appointment. After all, providers get rated by patients these days. I knew it was unfair to keep my other patients waiting, and I sure didn't want a negative review. Even more importantly, I knew that health insurance companies rate their providers based on customer care, and they collect input from patients about how long their waits are. Yet, simply telling Bob to book another appointment was not the real me. It was not my style to send my patients out the door with a big question mark.

"Pain? Since when?" I asked, trying to hide the disappointment in my voice. My mind was reliving vignettes of life in slow motion. As Bob answered "three weeks," several vignettes played out in my mind, one of which was the "audit."

### **Audits: The Time Thief**

I had to make a decision concerning Bob. My staff was getting impatient looks from the waiting room, and Bob had already used up his appointment time. Would I make Bob my priority or the other patients still waiting to be seen? I felt guilty for making the patients in the waiting room wait, and I felt equally guilty knowing that I would be keeping my own family waiting longer for me to get home that evening.

There is good reason for patients to question whether the days of the kind and patient doctor are on their way out. Being in private practice, I'm already overwhelmed by the impact of healthcare changes due to new regulations that are supposed to help patients get better medical care. The impact of these

gradually adopted changes is being felt in full force by those of us in private practice in smaller clinics (and our numbers appear to be dropping like flies). In large institutions, the impact of these changes may be diluted through the higher numbers of administrative personnel. Yet, discussions with colleagues behind closed doors in both settings suggest a system both burdened and overwhelmed.

Many healthcare providers are dreading, rather than welcoming, the coming changes. For many years, doctors have peered down microscopes to learn why patients are sick and how best to help them. These days, the microscopes are turned around, and doctors are finding themselves subjects of magnification and scrutiny. These microscopes peer down on healthcare providers from different angles to judge their competency in areas unrelated to, and taking the focus away from, providing quality and effective medical care.

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It is unclear who is driving these changes in healthcare. But, insurance companies are playing a large role. These companies regularly perform audits on providers — audits that are conducted by nonmedical personnel who evaluate patients' healthcare records by systematically going through a list of bullet points to ensure benchmarks are met: "chief complaints" — how the reason(s) behind the medical visit are worded; "history of the presenting illness" — the list of descriptors in the story behind the medical problem; "review of systems" — how the rest of the patient's mind and body are doing; a review of medication and other allergies; up-to-date medication lists; past medical and family medical histories; social history; lifestyle issues; the physical examination; the complete medical assessment; and plans and recommendations that specifically document what was discussed, being sure that a recommendation for returning to the clinic was stated and documented. Whew! If the insurance administrator finds even small deficiencies in the audit, the provider may not be reimbursed what would have been customary payment for the visit, even if additional time was spent with the

patient to ensure he or she understood the tests, diagnoses or treatment.

Yet, to date, there has been insufficient evidence that these benchmarks tracked by the audits truly affect quality of patient care. Unbelievably, this shows clear lack of confidence in what providers have been taught in medical school. For providers, it is an apparent exercise in futility that requires even more administrative time, usually after hours or on weekends. Instead of taking their children to the park, providers are in their office wading through health-insurance-generated red tape. In fact, since my office changed from paper to electronic medical records, I am spending an extra two hours every work day trying to meet audit standards for charting. The current goal of recreating an office visit from the list of provided codes requires the coding skills of a librarian and the detailing ability of an accountant. This has nothing to do with real doctoring. It is time that is not reimbursed. And, it is time taken away from patient care.

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And, beware a new “time thief” on the horizon! In addition to providing information for the insurance audits, providers now have to participate in registries that require them to electronically send information about patients’ private health information and treatment to a third party. This is not simply a point-and-click situation. This information must be entered into separate electronic documents. Currently, there is both a carrot-and-stick approach with some of the audits and registries. Not participating can lead to significant financial loss for providers, which translates to even lower reimbursement when reimbursements are already falling.

Why are these audits truly needed? A recent discussion with an employee of one of these companies revealed their real purpose is building profiles of providers and classifying them based on company criteria to determine how much a patient

must pay out of pocket for treatment. For example, a provider who sees more challenging patients might be considered a more expensive provider. If so classified, the insurance company could force the patient to pay more out of pocket for a visit with that provider. So, if a patient has joint pain, the insurance company will steer that patient toward the “cheaper” doctor to both save the company money and to successfully make the patient feel he or she has saved money as well!

Obviously, the insurance company can save money if the patient chooses a cheaper doctor. And, obviously, patients will be tempted to choose a cheaper doctor. But what if a patient has medical issues that are challenging and require more complex, more comprehensive or more compassionate workup? Is it fair that the insurance companies are dictating how patients can choose their providers?

Gone are the good old days when a doctor could look each patient in the eye with sincere compassion and convey concern and empathy. Now, our eyes are trained on the computer screen.

**Reimbursement: Cost vs. Care**

With Bob’s last-minute question still lingering, how my hand wanted to depress that door handle and keep moving! But my feet froze to the floor. Indeed, slowly and thoughtfully, I removed my hand from the door handle, and I turned to face him: “Pain where?” Bob answered timidly, motioning to where his liver should be: “Here. Right here.”

I asked Bob: “How long have you had this pain?” He was a little noncommittal: “I’ve had it about three weeks, Doc. It’s not too bad.” As I stood there, I tried to build a quick mental list of pains that stick around for three weeks. I’d have preferred he had said three months or three days or even three hours. I could have more easily come up with explanations in each of those cases. Then, it would be easy for me to conduct the physical examination to address the usual diagnoses and to order the appropriate tests. But, the quick survey that flashed through my brain came up empty-handed and, instead, raised a red flag that something sinister was going on. I didn’t know what, but I had to find out. I couldn’t just send him home because the red flag would not leave my intuition.

Leaving the exam room door closed, I asked Bob to lie down on the exam table. What could be so elusive that, if serious, I could be missing on examination? I checked his breathing, blood pressure and pulse. They all checked out fine. His heart and lungs sounded normal. There was no swelling in a foot or leg. He was not uncomfortable when I pressed over his liver, nor over the rest of his abdomen. I was stymied.

Three weeks? Could this be a local infection? But, Bob had no fever, jaundice, rash, swelling or any other signs of serious nature. At this point, it would not be unusual for a provider to



order a test such as an ultrasound of the liver and gallbladder, or a flat plate (X-ray) of the abdomen. But, my intuition told me that a history of pain for specifically three weeks was unusual, especially over the liver. These usual tests for abdominal pain could turn out to be dead-ends. Something just didn't add up. So, I did the unusual, even though it could face scrutiny later.

Providers are finding it increasingly difficult to prescribe the best medication for patients without worrying about the patients' insurance companies denying reimbursement. That's why preauthorizations are necessary, but they are also potentially dangerous. I have been in my clinic on a Sunday to discover a non-urgent notice from an insurance company that a medication for which I had written an urgent prescription a few days before (a corticosteroid) had been denied to the patient. When I tried to contact the office number provided to get the necessary authorization, I was met with a recording saying that they were not open on Sundays. In my field, there are conditions like giant cell arteritis for which withholding this type of medication, prednisone, can lead to blindness.

Furthermore, no other medication can be substituted, and it must be given in a timely fashion.

No one can dispute that the required preauthorizations, which involve filling out forms, copying portions of patient records, and spending excessive time on the phone waiting to speak to nonmedical and medical representatives of the insurance companies in order to get an OK for a diagnostic test or specific type of medication, pose a time and administrative burden on medical clinics. A simple understanding of basic human nature would reasonably predict that this burden would result in fewer tests and medications being ordered (and, therefore, decreased healthcare costs) simply because of the "nuisance factor" to providers. Preauthorizations should more aptly be named "deterrents." Unfortunately, these deterrents adversely affect the quality of healthcare.

Fortunately, in Bob's case, the direction I opted to take didn't require preauthorization. I have always learned a lot about patients at the bedside, even when others have opted for expensive tests. Asking Bob to lie back comfortably, I took the stethoscope and placed it gently just below Bob's ribs on the right side of his abdomen. I'm sure that some of my past mentors would have laughed when I did this. The liver itself, even when "sick," does not produce any unusual sounds. But, what I heard was astounding and unusual. It was as if one were listening to someone with a mouth full of food breathing slowly but noisily, in and out, through clenched teeth. But, in this case, Bob's mouth was nowhere near this area!

As soon as I heard this ugly noise, a light bulb went off. Bob had traveled from Hawaii three weeks before, which meant that he had been sitting in a plane for several hours — a set-up for a possible blood clot. But, while Bob had no health factors whatsoever for a blood clot, I could not deny that a blood clot that had originated from a leg during the trip and had traveled to his right lung could produce such a sound, audible only through a stethoscope. The good old-fashioned physical examination that cost nothing beyond the standard visit had

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to be believed. I called the emergency department and reported that I had an emergency for them. They were interested but not totally convinced as Bob had no other signs: no shortness of breath, no true chest pain, no cough, nor any swelling in either of his legs. On top of that, he was trim and fit. Was I sure? Or, could I be wrong?

I explained to Bob that it was better to get checked out even if the odds were low. Two hours later, the emergency room physician called me personally. Bob's workup showed a surprisingly large blood clot in the right lung that would have killed him within 48 hours. It had been growing over three weeks. He was so fit that his body had been able to fully compensate for the increasing loss of lung function. He was admitted to the intensive care unit and started on blood thinners. A life had been saved.

### **"New and Improved" Quality of Healthcare**

Of course, there is more to Bob's story. It seemed that Bob was not through stumping his doctors. He had returned to Hawaii after he was stabilized on his blood thinner medication for the blood clot in his lung. And, he had completed his blood-thinning treatments and had managed to stay out of medical clinics since his clot had resolved. But, almost exactly one year since he had first arrived in my office from Hawaii, he was back for a visit, this time presenting with the telltale look of worry in his eyes and explaining: "Doc, I have a pain in my stomach." Alas, this was not simply a matter of: "Here we go again!"

## *Surely, saving lives and limiting disability reflect the true quality of healthcare?*

This time, when Bob announced abdominal pain, I feared the worst. In fact, I was not deterred by his bedside examination being completely normal. I tried to be extremely thorough. As before, I had to keep the next patient waiting longer while I spoke with a radiologist to schedule an urgent abdominal CT scan that afternoon.

Previously, I had wondered how his clot could have developed so easily without obvious risk factors. I was concerned that his blood could have developed a clotting problem due to some sort of tumor. Surprisingly, none of his doctors in the hospital or his family doctor had ever discussed this possibility with him. Even though it felt premature, I took extra time with Bob to explain why I needed him to see a cancer doctor. He was, of course, shocked that I brought this up so soon in our discussion. But, I knew intuitively that he could better cope with a bad diagnosis if we had the wheels of achieving wellness in motion. Later that evening, after hours, the radiologist phoned me. Bob had a tumor in his pancreas. This is one type of cancer

that can cause the blood to clot unexpectedly. At least Bob was now linked to a cancer doctor in whom Bob knew I had full confidence. That softened the blow of a dreaded diagnosis and allowed Bob to start gaining some sense of control of a serious situation.

Bob's case is not isolated. Serious, unexpected medical diagnoses have been made in our clinic when only simple, routine appointments have been booked. It is increasingly difficult to keep all patients happy all the time, especially those who have difficulty waiting, and we make every effort to ensure patients' expectations for waiting are respected. Yet, had I been on time for some of these patients, I would have missed the unexpected findings in the patient before them that indicated a potentially life-threatening condition. I doubt Bob would disagree with this.

Surely, saving lives and limiting disability reflect the true quality of healthcare? Yet, the simple satisfaction of trying to be compassionate with one patient can be diminished by huge administrative demands imposed by insurance companies. And, there appears to be no way to communicate this to these companies. So, what's my take on where healthcare is going? It is increasingly difficult to be a compassionate and comprehensive physician when I have to keep an eye on the clock and both eyes focused on the computer screen, while keeping at least one eye on the financial bottom line — in a climate in which office expenses and demands on my free time are growing, especially while reimbursements and family time are decreasing. In this healthcare environment, the public should be increasingly concerned about physician burnout.

Some of us have a passion for helping patients, and this is the only thing that keeps us going. Yet, even we are struggling. We continue to hope that "new and improved" healthcare changes will eventually lead to improved medical care. But, this provider is skeptical and remains worried that some patients could end up dying because of it. Remember, we're in this together. Next patient, please! ❖

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*Editor's note: The name of this patient has been changed to protect his privacy.*