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**Publication Date**

2019

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Patients are Waiting: Temporal Logics and Practices of Safety-Net Primary Care

by

Shannon Satterwhite

DISSERTATION

Submitted in partial satisfaction of the requirements for degree of

DOCTOR OF PHILOSOPHY

in

Medical Anthropology

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

AND

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## Acknowledgements

I am profoundly grateful to the clinicians, clinic staff, administrators and patients who participated in this study and to the leadership of the healthcare network and each clinic in this dissertation for making this research possible. Most of all, I am grateful to each person in this study for giving of their time which, as will become clear, is a profound gift in this context. Throughout my fieldwork, I was acutely aware of the irony of asking people whose work seemed to overflow the time available to spend some of that time talking to me. I want to thank everyone whose stories informed my analysis for their openness, patience and trust. I hope to do their insights justice. Any misunderstandings are my own.

I want to thank my dissertation committee for their guidance throughout my training in medical anthropology and through this particular project. Vincanne Adams encouraged me to pursue my questions about time in the clinic when they were just starting to coalesce. As my dissertation chair, she kept me on track and continuously pushed me to commit to my ideas and articulate them more clearly. Kelly Knight offered insight, encouragement and questioning as an expert in the type of clinical space that I study. She has provided exceptional mentorship in writing and teaching. Ian Whitmarsh fostered my interest in the deeper conceptual roots of population health and care and always offered opportunities to push my thinking in new directions. Dorothy Porter consistently offered both generous support of my project and a critical historical perspective and critique. Lawrence Cohen always provided a compelling mix of enthusiasm about my ethnographic data, careful attention to the concepts I sometimes inadvertently used and a wealth of theoretical resources to turn to.

I am grateful to many other professors and mentors at UCSF, particularly Sharon Kaufman, Deb Gordon and Judith Justice, who modeled how to study health systems and practitioners. I am also indebted to my earlier mentors in medical anthropology and sociology. I am particularly thankful to Joyce Millen for telling me that MD/PhD programs existed and encouraging me to pursue this hybrid path. I am thankful to the experts at the Center for Excellence in Primary Care at UCSF for exposing me early in my medical training to the workings of primary care clinics and the team-based model of care.

My training has been supported by the National Institute of General Medical Sciences (NIGMS) through the UCSF Medical Scientist Training Program (T32GM007618) and by the UCSF Graduate Division. This research project was generously funded by a dissertation fieldwork grant from the Wenner-Gren Foundation for Anthropological Research.

My colleagues at UCSF and Berkeley shaped my work and my experience of this process more than I can say. There is a special kind of relationship built on generous engagement with each other's ideas which I have deeply valued in this program. I want to thank my friends who read and commented on pieces of writing, especially Melina, Naomi, Karina, Nadia, Patricia and Anu. I am grateful for the company and advice of fellow MD/PhD trainees, especially Na'amah, Laura, Dana, Molly, Adeola and Clare.

Finally, thank you to my partner Benjamin and my family and friends for the support, writing company, bike rides and meals shared through this long and sometimes lonely process. And to my grandma, Eileen Rosholt, for telling me about her experiences as a nurse and a patient and her excitement about my career in medicine.

**Patients are Waiting:**  
**Temporal Logics and Practices of Safety-Net Primary Care**

Shannon Satterwhite

**Abstract**

Time is a problem in primary care. Patients and providers alike lament short visits and long wait times. Meanwhile, continuity over time is a defining asset of primary care. Drawing on ethnographic fieldwork in three publicly-run clinics in California and theoretical approaches to temporality and governance, this dissertation examines the multiple rhythms and temporal logics at play in the clinic. Those who work in safety-net primary care are charged with ensuring the health of a socially vulnerable patient population while being attentive to each member of that population. I examine how clinicians and staff negotiate contradictions in the organization of clinical time in part by shifting between temporal frames.

Concern about patients waiting moralizes speed and efficiency in the clinic. This is always in tension with ideals of comprehensive care for each individual. Scheduling practices and management of clinic *flow* rely on a logic that I term *enslotment*, in which patients occupy uniform segments of time. I examine the practices that clinicians and staff use to reconcile patients and the schedule to one another. At the limits of these strategies, the non-congruence between the temporal norms of the clinic and patients' needs generate a sense of temporal fragility.

I describe how a sense of potentially unlimited demand drives efforts to *protect* time through clinical teamwork in ways that are patterned by the valuation of labor time. I also examine the demands that documentation, incentive-backed quality measurement and the

imperative of continuous improvement make upon clinic time. Metrics can generate a sense of urgency around needs otherwise neglected. Meanwhile, the tempos of reporting and payment are often out of sync with the temporalities of sustainable organizational or political change. In this context, I explore how clinic staff confront the limits of time and navigate the contradictions between their obligations to individual patients and the collective under conditions of socially structured time scarcity. *Care over time* through continuity creates space for potential beyond the time pressures of a given clinic session. By taking time as an object of focused inquiry, this analysis traces the logics and ethics of healthcare policy and practice across multiple scales.

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## Preface

In my first practical clinical exam in medical school, I walked into the room to greet a standardized patient (an actor). I knew my task was to determine her diagnosis in fifteen minutes while providing patient-centered, sensitive care. The time flew by. After we desperately wrote our notes in pretend patient charts and left the simulation center, my peers and I wondered: We know that time pressure is ubiquitous in medicine, but is it right to put such a stringent limit on us so early in our training? Later, I was told that the fifteen-minute limit was a function of other factors, not intentionally a lesson. Still, this early experience told me something. So inevitable had the haste of the fifteen-minute visit become in our minds that my fellow students and I assumed that that was what we were being taught. Maybe we were.

The standardized patient I saw was a young and otherwise healthy white woman, not experiencing poverty. She presented with *one* concern.<sup>1</sup> This type of patient is rare to the point of serving as a foil in the clinics that I studied in this dissertation. The clinics in this study are part of the healthcare safety net.<sup>2</sup> Their patients are predominantly people of color living in poverty. They often have several comorbid chronic illnesses. Some are recent immigrants; some are previously incarcerated and some are experiencing homelessness.

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<sup>1</sup> In general, studies have shown that an average of about 3.7 and median of 6 topics are discussed in a typical primary care visit (Young et al. 2017; Tai-Seale, McGuire, and Zhang 2007). Young and healthy patients with few concerns, often between jobs, did seek care in the clinics I studied. However, these visits were rare in comparison to the frequent return visits of older, more medically complex patients (see chapter 7).

<sup>2</sup> See Introduction: Fieldsite and Methods for a formal definition of safety-net clinics and a description of this particular patient population.

The clinicians and staff who work in these clinics are confronted with the harms of capitalism, racism and other axes of structural violence that mark the lives and health of their patients.<sup>3</sup> They are charged with responding to the effects of this violence and doing so quickly with relatively few resources. As I will describe, I find that in the setting of these public health clinics, care for a population takes on a particular ethical valence as care for those who may not otherwise be cared for and as a matter of justice. This also means that failure to provide adequate care (and time) carries significant moral weight for clinicians and staff.

Responsibility for a *population* of patients over time was a founding principle of primary care and is becoming more widespread in healthcare with the growth of “accountable” payment models. In that way, the temporal tensions I describe apply broadly. Still, a particular ethos of community clinics permeates my findings and analysis.

I continue to be drawn to community-oriented primary care despite repeated warnings that the tight schedule and extensive patient needs will cause me to burnout. In medical school, learning about team-based care, I wondered about the perspectives and experiences about my future colleagues in the clinic. My graduate studies offered me a privileged time to learn from those currently in practice and to think critically about the organization of primary care in the safety net through the lens of time.

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<sup>3</sup> For an explanation of structural violence, see Farmer et al 2006.

# Introduction

## *“Is she gonna make it?”*

*When we walk down the hallway to the next exam room, a little boy comes into the hall. Dr. Peterson gives him an enthusiastic greeting. Caleb is preschool age and here with his grandmother for his well-child check. When Dr. Peterson tries to listen to his heart, Caleb refuses to sit on the exam table, wanting to stand and insisting on using the stethoscope himself. Dr. Peterson offers a deal. She tells Caleb that he can use the stethoscope after she listens to him first. After a moment of stillness, Dr. Peterson turns the earpieces around, placing them in Caleb’s ears and leans in for Caleb to reach her heart.*

*Caleb’s grandmother asks Caleb, “Is she [the doctor] gonna make it?”*

*Dr. Peterson laughs. “Come back on a really busy day, and I might need [to have] a more in-depth assessment.”<sup>4</sup>*

Caleb’s check-up was on a day where Dr. Peterson saw seven patients in one afternoon. She was scheduled to see nine, but two did not make it in. Dr. Peterson generally averages about nine patients seen per four-hour session and some days have many more. Their complexity varies, but few appointments are simple. Dr. Peterson’s joking response to Caleb’s grandmother, implying that she might not “make it” on other days, marked that this was a busy day but not *really* busy like it can get sometimes. Moments like these highlight an interpersonal connection and familiarity that was often tangible in the clinic visits I witnessed in my fieldwork, but sometimes difficult to capture. The content of Caleb’s visit also offers a glimpse into the forms of social vulnerability that patients in the safety-net primary care clinics I studied experience and how a trusted primary care provider’s knowledge of those experiences can shape their care. Let us return to that exam room:

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<sup>4</sup> All names are pseudonyms, and some personal details such as gender may have been changed to protect the privacy of the people in this study. See the Methods section for more detail.

*Dr. Peterson pulls out a pen and asks Caleb to copy a circle on the paper that lines the exam table. "You didn't know you were going to have an art test today, did you?" She also asks Caleb to copy an X and a triangle. Caleb can't do the triangle, which is developmentally appropriate for his age. Dr. Peterson explains to his grandmother: "That's what they have to be able to do before kindergarten."*

*Dr. Peterson asks Caleb if he can draw his mom. Caleb draws a stick figure on the exam room table liner. Dr. Peterson offers praise. Caleb declares, "I'm gonna draw my brother and my dad and..."*

*"Wow. I'm gonna look at your chart while you do that," replies Dr. Peterson.*

*While Caleb draws, Dr. Peterson and Caleb's grandmother discuss his weight. Caleb is overweight but his trajectory is improving. Dr. Peterson asks the scribe who is taking notes in the EHR to pull up Caleb's growth chart. She shows his grandmother how the line charting his weight at each visit has plateaued. In a couple years, if this continues, Caleb will rejoin his growth curve. Dr. Peterson thinks it makes sense that the whole family "hunkered down" after what happened. Now, everyone seems to be doing a bit better and losing some of the weight they gained. Caleb's grandmother agrees, reflecting on the health of her children and grandchildren.*

*Listening, I remember that earlier this afternoon, Dr. Peterson had told one of the behavioral assistants that she was seeing a child today whose father had been killed a few years ago. She just wanted to let her know in case they needed support from behavioral health. That child was Caleb.*

*Despite the general feeling of hurriedness in the clinic, this exchange feels calm and focused. Dr. Peterson draws on her knowledge of Caleb's family's experience of losing a loved one to violence to contextualize Caleb's weight and to address the topic with sensitivity. She also takes a moment to talk with Caleb's grandmother about school and when Caleb and his siblings will start different grades.*

*When Dr. Peterson and I leave, our exit feels abrupt. Back at her computer in another room, Dr. Peterson says something aloud about Caleb's assessment and I point out that the scribe is not back yet. He returns a moment later; Caleb needs a letter for school.*

This visit contained many of the typical elements of encounters I witnessed in the primary care setting that I analyze in this dissertation. It was brief but embedded in a longer-term relationship between a provider and her patient. The pace of Caleb's visit was linked to Dr. Peterson's schedule for the day and her obligations to other patients. In this dissertation, I explore how the enactment of primary care is configured by multiple and often conflicting temporal demands and across multiple registers from the logistics of a given visit and session to quality improvement and care over time. I trace the relationship between care for individuals, for the patient population and for healthcare workers within each temporal frame.

Preventive care is a defining feature of primary care. Prevention is generally based on population-level norms for health at particular ages, like those embedded in child growth charts and developmental milestones. These tools, which situate patients relative to a normative trajectory and anticipate risk, are powerful in shaping care practices and assessments of care quality. At the level of a clinical interaction, they are filtered through knowledge of the individual patient. Dr. Peterson's assessment of and care for Caleb were clearly shaped by her knowledge of Caleb's social life that preceded and would continue beyond this encounter. Looking at his growth chart, Dr. Peterson understood Caleb as overweight, but contextualized this finding within a family history of trauma and expressed her concerns and hopes for Caleb and his family to his grandmother. Caleb was screened for his development and monitored for his weight. At certain ages, he may also need other screenings and immunizations. Older patients with several medical conditions or risk factors can require many similar assessments in addition to care for their current conditions. As the possibilities for screening and prevention proliferate, so does the number of activities

ideally carried out by the clinic. This is a source of tension in the clinic as each of these simply takes time.

Dr. Peterson's ability to focus on Caleb and his grandmother was facilitated by other actors. Scribes, who are mostly volunteer students or recent graduates interested in health professions, were present in some of the visits I witnessed, but not the majority. Dr. Peterson also made plans to rely on behavioral health colleagues if Caleb and his grandmother needed more social or psychological support than she could provide. Care in the clinics I studied is provided by interdisciplinary teams. Teams include clerical staff, medical assistants, nurses and primary care providers.<sup>5</sup> They also collaborate with behavioral (mental) health clinicians, pharmacists, nutritionists, and scribes or health coaches, depending on need and the availability of these colleagues, which varied between clinics and over time. Clinical teamwork enables forms of care under time pressure. It also introduces new challenges related to communication, coordination and colleagues' obligations to each other. Team-based care raises unsettled questions about the value of clinic staff members' labor time and the possibility of relational continuity across a team.

In this dissertation, I study how time is morally configured in primary care. Time, of which there is never enough, becomes visible as both the "enemy" and foundation of good care. I trace the everyday ethical frameworks, narratives and strategies that those who work in the clinic mobilize in an effort to realize care for patients as individuals and a collective under socially structured conditions of time scarcity. I argue that time in practice is multiple and that understanding the temporalities of primary care, like social time in

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<sup>5</sup> Generally, when I refer to "clinicians" in this dissertation, I am referring to both primary care providers and nurses.



general, requires attending to multiple scales and temporal registers and the way that people move between them.

### **Timely Care**

While we were with Caleb, another one of Dr. Peterson's patients, Damien, waited. Damien's visit had been scheduled first, but he had arrived a few minutes late and Caleb and his grandmother were early and were seen first. In attempting to provide care for many patients in close succession, clinicians and staff constantly make judgements about adhering to and enforcing the schedule and flexing appointment sequence and timing in ways they consider fair or effective. These judgements both enable care for and serve to discipline patients who are late or otherwise make demands on clinic time that are seen as excessive. These actions are based on complicated and ambiguous notions of timeliness.

On a national scale, access to "timely" healthcare has become a matter of concern in conversations about healthcare quality as well as for clinic and hospital finances (IOM 2015b). My research focuses on the multiple temporalities of primary care in safety-net clinics serving patients who are primarily poor and publicly insured. By focusing on tensions between speed and comprehensiveness and shifting between individual and collective, I interrogate the generic value of "timeliness." What does "timely" care look like for Caleb and Damien? What about Dr. Peterson's other patients who are waiting for appointments, today or in the future? How do Dr. Peterson and her colleagues make things work on the really busy days?

One of the most common matters of concern about patient time is waiting. Phrases like "patients are waiting" encapsulate a demand to provide timely care in two senses: for

patients to be able to obtain an appointment on relatively short notice and for them to spend little time waiting when they come in to be seen. The other patients in the waiting room weigh on clinicians' minds during each encounter. Time management during each visit with individuals whose needs and desires for care frequently exceed the time available is both paramount and often impossible. Meanwhile, the operational goals of the clinic with regard to timeliness include seeing as many patients as possible and remaining as close to on-time as possible, all while hoping to leave patients feeling they spent "enough" time with their primary care provider. In pursuing these contradictory goals, clinicians and staff also accommodate contingencies like staffing shortages and unpredictable demand while hoping to get clinic staff home on time.

### **Time as a Problem**

Primary care in the United States has been described as in "crisis" (Sherman, Moscou, and Dang-Vu 2009; Lazris, Roth, and Brownlee 2018). This sense of a profound problem is often attributed to issues revolving around time. Patients and healthcare workers alike lament short visits and long wait times (Braddock and Snyder 2005; Linzer et al. 2009; IOM 2015b). These temporal concerns stem in part from lower reimbursement for primary care services than specialty care within a payment system that values technological intervention over time-intensive intellectual and affective labor (Laugesen, Wada, and Chen 2012; Sandy et al. 2009). The discordance between the time available for patient care and the time necessary for healthcare workers to respond to their patients' needs contributes to widespread burnout among clinicians and staff (Bodenheimer and Sinsky 2014; Meredith et al. 2015). Burnout, one of many names given to the exhaustion and cynicism experienced by healthcare workers in the face of overwork and moral distress, is associated with declines in

quality and continuity of care (Austin et al. 2013; Willard-Grace et al. 2019; AHRQ 2017).<sup>6</sup>

Attrition due to burnout and low recruitment in anticipation of it may exacerbate an existing shortage and maldistribution of primary care providers (AAMC 2018; HHS 2016; Chen 2009).<sup>7</sup> Time thus figures as the obstacle at the heart of this primary care crisis, a focal point in a complex set of economic, political, professional and clinical issues shaping the structure and allocation of healthcare.

The idea of time as a problem has been taken up as a general diagnosis of our moment. Aren't we all moving too fast and already out of time? Anthropologists have described time under contemporary capitalism as hastening or fragmented (Guyer 2007; Harvey 1989) and oriented around a moral imperative to anticipate (V. Adams, Murphy, and Clarke 2009). Recently, sociologists and anthropologists have questioned narratives of generalized acceleration, calling for greater attention to the uneven distribution of speed in the social organization of time and to the skill involved in reconciling complex temporal rhythms (Wajcman and Dodd 2017; Bear 2014a; Ahmann 2018; Zee 2017). This work builds on longstanding interest in social sciences regarding the relationship between time and power and the use of time as a lens for studying broader social questions (e.g. Fabian 1983; Greenhouse 1996). The hospital has long been a site for studying how politics, economics and expertise shape the structure of time for clinicians and patients alike (Kaufman 2005; J. A. Roth 1963; Eviatar Zerubavel 1985; Frankenberg 1988).

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<sup>6</sup> Importantly, a major study of working conditions in primary care argued that it is the working conditions that lead to burnout that also lead to low-quality care, rather than burnout itself (AHRQ 2017).

<sup>7</sup> The claim of a provider shortage is complicated by the assumptions built into models of supply and demand, the growing population of nurse practitioners and physician assistants and the distribution of providers geographically and between different practice settings (IOM 1996; Carroll 2017; Sandy and Schroeder 2003). I discuss this further below.

In the clinics that I have studied, time is universally felt to be lacking. Yet, time is not simply speeding up. It is also characterized by cycles of rushing and waiting and “spinning one’s wheels.” Further, time is experienced differently by clinicians, medical assistants, patients, clerks and administrators. Engaging with these studies and theories of the varied texture of social time in the social sciences, I begin from the premise that time does not pose the same problem for everyone. The cultural and organizational structuring of time in the clinic has different implications depending on one’s social position. In what follows, I trace some of the uneven manifestations and consequences of the temporal logics organizing primary care as they affect patients and staff in the safety net. I explore how clinicians, clinic staff and administrators negotiate temporal demands and time frames to enable or disallow certain forms of care.

Time is a problem in primary care. It is also a defining resource, as primary care is ideally based on continuous relationships and care over time. This dissertation traces the myriad temporal forms that co-exist in the institutional setting of the primary care clinic. Many observers and participants in healthcare worry that the bureaucratic rationalization of time, oriented toward productivity, threatens care for unique individuals. This critique is certainly present in the clinics that I study, yet I argue that this rationalization is partial and coexists with other logics and practices. Further, if efficiency is understood as enabling care for patients otherwise left without access to it, speed is not so clearly opposed to ideals of care. I examine the demands that each time frame and tempo at play in the clinic makes on practice and the ways they are moralized or configured as matters of ethical action. My goal is to study the ways in which individual, collective and population-focused temporal frames work for providers, staff and patients, as well as their limits. For example, I trace how the

goal of maintaining clinic “flow” or meeting quality reporting metrics structures the possibilities for care for patients as individuals and collectives.

### **“How is time today?”**

Time is both an obvious and elusive topic. In my fieldwork, many found it difficult to describe their experience of time beyond its lack. Some thought I was strange for asking about something they took as obvious: We do not have enough of it. Time is linear. It goes forward. It is scarce. Their frustration showed up in jokes and occasional teasing when clinicians and staff said things like: “It’s [time is] going backwards,” and “How is time today? Is it advancing?”

Rather than suggesting that understanding time in primary care was actually simple or obvious, these moments of humor were, for me, evidence of how sensitive and complex a topic it was. A multitude of ideas about time manifested in subtle ways in people’s responses to me observing clinical work. For example, more than one person suggested that I wear sneakers or even rollerblades to keep up with the nursing staff. When things were not hectic, clinicians and staff members generated superstitious theories about my presence leading to lower demand than usual. People clearly felt that time mattered in varied and profound ways for understanding the work of primary care.

There were also many moments where my interlocutors’ efforts to explain time resulted in contradictions or complicated maneuvers to reconcile multiple ideas. These are not simply instances of confusion. They point to a fundamental feature of time as a social phenomenon. Understood this way, time is multiple. The force and effects of the various forms that time takes result from social relationships. This insight was clearly articulated by

Bourdieu (1977) and underlies anthropological approaches to time shaped by his theory of practice (c.f. Munn 1992). My aim in this dissertation is to draw out this temporal multiplicity as a way of nuancing analyses of work and care in the primary care clinic and inspiring new possibilities for the organization of care time(s).

### **Theories of Time and Bureaucracy**

Anthropologists have long been interested in time and its reckoning in various cultures. The concepts of time and temporality are sometimes used interchangeably. In other cases, they are distinguished, with time implicitly referring to linear, homogeneous, or historical time. Temporality in this distinction is more flexible and references the tempo or movement of time in experience and narrative. I use both terms intentionally to reintroduce the ambiguity of temporality into the concept of time.

Durkheim ([1953] 1974) understood time as a collective representation with its origin in society rather than nature or individual minds. For Lévi-Strauss (1963), time was a fundamental structure of cognition that could ground cross-cultural comparison. For decades, classic anthropological studies of time modeled on these ideas led to debates about the relative or universal nature of time (Leach 1961; Bloch 1977; Gell 1992). In a famous and controversial analysis of time in Bali, Geertz (1973) argued that ideas of personhood, time and proper conduct are interconnected within a given cultural system. Anthropologists have argued that multiple times – associated with nature and with social interaction and ritual – can operate together in a given society and often collapse upon each other (Lévi-Strauss 1963; Leach 1961). The central tenet across this literature is that time is not simply a physical property, but a product of social interaction and an object of

manipulation (Birth 1999; Bourdieu 1977; Greenhouse 1996; Harvey 1989; E. P. Thompson 1967).

Anthropologists and other scholars have theorized how control over time, both in terms of its representation and its uses, is a significant form of power (Davis 2012; Fabian 1983; Greenhouse 1996). David Harvey (1989, 227) writes:

*Those who define the material practices, forms and meanings of money, time or space fix certain basic rules of the social game. I do not wish to imply by this that those who define the rules always win any contest that may ensue.... It is nevertheless the case that ideological and political hegemony in any society depends on an ability to control the material context of personal and social experience.*

This framework has shaped our understanding of the place of time in the operation of clinics and hospitals as sites of power (Foucault [1973] 1994; Frankenberg 1988; L. A. Rhodes 1991; Stevenson 2014).

Time is clearly central to the history, theory and contemporary ethnography of labor (Biernacki 1995; Harvey 1989). Foucault ([1977] 1995, 154) writes that modern disciplinary spaces, including the school, factory and hospital have focused on coordinating ever smaller movements for maximum efficiency, “as if time, in its fragmentation, were inexhaustible.” E.P. Thompson (1967, 60) set the tone and framework for decades of writing on labor history by contrasting the industrial time discipline associated with clocks and “task orientation,” a “more humanly comprehensible” attunement to needs such as those of children or crops. This distinction has been critiqued extensively (M. O’Malley 1992; Glennie and Thrift 1996). Still, classic theories of labor and time discipline, as well as more recent critiques of more “flexible” work relations are vital to understanding clinical settings in which management practices are borrowed from the factory and other industries (Fleming

2016; Crowley et al. 2010; Arlie Russell Hochschild 2001; Emily Martin 1994; Wajcman 2014; Nicosia 2017). Ideas of efficiency modeled on production exist in tension with other lived temporalities in the clinic, shaped by particular morals and norms of the health professions (Frankenberg 1988; Higashi et al. 2013; Knight 2015; Mizrahi 1986; L. A. Rhodes 1991).

Recent anthropological literature on time has included several efforts to characterize our collective temporal orientation in the current moment. Several anthropologists have interrogated ideas of “crisis” that seem to characterize our times (Roitman 2014; Vigh 2008). Guyer (2007, 409), studying economics and Christianity, argues that there has been a shift in temporal thinking towards the very short and long terms with an “evacuation of the near future.” Adriana Petryna (2017) theorizes “horizoning work,” or the forms of knowledge production that manage uncertainty and compel action in response to radical environmental change. Vincanne Adams, Michelle Murphy and Adele Clarke (2009) identify “anticipation” as a particular future orientation and affect that they argue is becoming a hegemonic form. While imagining new futures is a longstanding political practice and a defining feature of modernity, anticipation contains moral imperatives to plan for the unknowable yet forecastable and to work on assuring one’s “best possible future” (256).<sup>8</sup>

Social scientists themselves have long participated in projects of imagining better, even utopian futures (Rabinow 1989; Murphy 2016; Tamarkin 2018). They have also studied how others mobilize imaginaries of future possibility (Kafer 2013; Bear 2016; Kaufman

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<sup>8</sup> Koselleck (2005, 260) writes that in the rapidly changing processual time of modernity, experience always arrives “too late” to learn from directly. Yet, one may think about history “as a totality” (41) and thus plan for the unforeseeable future. Meanwhile, Richard Wilk (2007) and others have observed that what appears as a generalized temporal orientation depends on one’s focus. For instance, in his work on consumption, Wilk observes a contempt for the future rather than an aspiration to act on it.



2013). Karen-Sue Taussig (2013) and her colleagues argue that an interest in potential in anthropology extends from current interest in futurity and becoming back to the beginning of the field (c.f. Biehl and Locke 2017). Modern medicine, self-inscribed in an endlessly progressive narrative, is an important site for studying the politics of potential (K.-S. Taussig et al 2013).

Contemporary anthropologies of time and the forms of expertise that they empirically examine are deeply influenced by historical and sociological theories of modernity. Koselleck (2005) a German historian, argued that in Europe, prior to the Enlightenment, history was considered a great teacher and time was structured by awaiting Judgement Day. In the late 18th century, however, historical processes were considered open to progress. Acceleration toward the future became desirable. It is widely written that modernity is characterized by the compression of space and time (Harvey 1989). The sociologist Anthony Giddens (1990) wrote that modern social institutions are characterized by rapid and wide-reaching change driven in part by a profound and intensifying reflexive relationship between the social sciences and the realities they describe. Meanwhile, power differentials and unintended consequences frustrate the promises of Enlightenment progress.

Social theories of modernity and many more recent claims emphasize time compression or acceleration as a *generalized* feature of contemporary society, driven by capitalism and technology.<sup>9</sup> Recent work in sociology has tried to nuance this framework, suggesting that our experiences of the tempos of work have a non-linear relationship to

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<sup>9</sup> Harvey (1989), for example, attributed a generalized sense of acceleration and volatility to the fundamental processes of capitalism and to a popular culture that drives and feeds off of a sense of ephemerality.

technology. They center the idea of “temporal autonomy” over generalized characterizations of pace (Wajcman 2014; Wajcman and Dodd 2017). Within this framework, it is not only *control* over time but one’s relationship to time that serves as a marker of power. For example, many efforts to respond to “speed up,” from delegation to the creation of “slow” spaces, normalize the exploitation of others’ time (Sharma 2014). This insight complements studies of the waiting that defines experiences of poverty (Auyero 2011; Sanz 2017; A. Cooper 2015), as well as classic studies of how differential control over time in clinical hierarchies shapes clinical care and team dynamics (Mizrahi 1986; L. A. Rhodes 1991). I find that in the clinic, when reflecting on their practice, many are acutely aware of the ways in which “the time of others is always at stake” (Sharma 2014, 142). This awareness can be suppressed by time pressure.

My research focuses on the question of how primary care practice attends to individuals and populations through explicit and informal forms of time organization and allocation. In order to understand daily temporal practices in the bureaucratic context of public healthcare institutions, as well as how the temporality of care for individuals and populations is simplified for administrative purposes, I draw on theories of rationalization, measurement and the social imaginary of states and institutions (Biruk 2012; Scott 1998; Timmermans and Almeling 2009; Weber 1978). The notion of a society that could be improved upon emerged as a particularly modern accomplishment in part through statistics and new methods of quantification (Foucault 1994; Rabinow 1989). Numbers have since come to carry great authority in claims to expertise, in disciplining deviance from the norm and in decision making (T. M. Porter 1996; Hacking 1990; V. Adams 2016). Time, as linear and homogenous, seems to lend itself to quantitative measurement and standardization in

line with such modern aspirations. Yet, the classification of work practices is fraught with ethical and political questions and cannot fully capture the complex temporalities of providing healthcare (Bowker and Star 2000; M. Berg and Bowker 1997; Strauss et al. 1997).

The efficient management of the population by the State is one of many aims pursued through bureaucratization. For Weber ([1958] 2003, 1978), bureaucracy is a system that bases authority on formal rules and positions and thus the logic and goals of a bureaucracy exceed those of any individual officer. In order to remain legitimate, bureaucracies must give reasons for their functioning. Their power to intervene upon individuals is based on a claim to scientific rationality. What is considered “rational” is shaped by the ethics embedded in the institution. Within Western capitalism, for example, it becomes difficult to think outside of the dominant concepts of norms, standards, efficiency and individual responsibility (c.f. Marcuse 1964). These concepts influence the organization of social intervention, including healthcare in this context.

Classically, Weber ([1958] 2003, 181) warned that bureaucracy always irresistibly expands its scope until it becomes an “iron cage.” This expansion is often compelled by the promise that further rationalization will reduce arbitrary human suffering, but the complexity of social life always exceeds bureaucratic solutions (Wilkinson and Kleinman 2016). Melissa Gregg (2018, x) argues that the endless literature on time management techniques offers “a predictable narrative that provides satisfying imaginary resolutions to persistent social contradictions.” It is possible for well-meaning efforts to realize complex and often under-specified ideals like efficient care or quantified “quality” to lead to apparent irrationality (Vohnsen 2017). Imperatives of efficiency and productivity are not simply externally imposed but incorporate one’s sense of skill (Bear 2014b; Hochschild

2001; Gregg 2017). In my research I am interested in how workers understand their skillful negotiation of temporal contradictions in their efforts to provide care. Often, these contradictions stem from the intersecting interests of individual patients, the collective of patients under the clinics' care, the clinic staff and the institution.

### **Anthropology of clinical time**

Social scientific literature on time and healthcare to date focuses on the role of medicine in shaping patients' experience of time and the influence of time pressure on medical education and nursing and psychiatric care in the hospital (Frankenberg 1988; Kaufman 2005; Ludmerer 1999; Mizrahi 1986; Pine 2011; L. A. Rhodes 1991). Higashi (2013) and her colleagues, for example, describe the central place of time in the moral economy of care in a teaching hospital. They argue that while moralized value judgements influence the quality and quantity of care provided to patients, these judgements are not always a matter of viewing patients' behavior as morally wrong. Instead, patients may be judged a poor "investment" of time. Patients reward students and clinicians for their time by making them feel competent. "Unworthy" patients include those do not improve or offer an intellectual or emotional return on investment, for any number of reasons. As students learn to navigate this moral economy, their resistance is constrained by hierarchy and institutional pressure to "move things along" (Kaufman 2005, cited in Higashi et al. 2013:20).

Although time scarcity in the primary care clinic is a frequent refrain in popular and professional writings, clinical ethnographers' discussions of time and temporality have largely focused on inpatient settings (c.f. DelVecchio Good et al. 1994; Mattingly 2010). Sharon Kaufman (2005) describes how medicine constructs time at the end of life by

offering choice about the timing of death. Frankenberg (1988) and Mizrahi (1986) analyze the professionalization of physicians through which they come to exert control over patients through control over time. Mizrahi observes that because of the conflicting roles and responsibilities in clinical training, “no time is the right time” for patient care (106).

Hospitalization takes patients out of the temporalities and routines of their daily lives. The outpatient setting and longitudinal focus of primary care makes the time of the clinic necessarily articulate with the time of life outside the clinic (Knight 2015; Mol 2008; Frankenberg 1988; Stevenson 2014). This allows for care to be stretched over long periods of time, and it presents a complicated set of problems related to patients’ access to care and missed appointments. Ensuring patient “access” is a primary focus of quality improvement efforts. These efforts require grappling with multiple and sometimes conflicting temporal concerns, including clinical urgency, patient convenience and the availability of clinic staff, as well as patients’ abilities to secure time off work and access reliable transportation. Assumptions about time within and outside the clinic intertwine as managers, clinicians and clinic staff balance patient needs with fiscal requirements and clinical capacity.

The titles of two influential works in clinical ethnography: *Getting Rid of Patients* (Mizrahi 1986) and *Emptying Beds* (L. A. Rhodes 1991) both reflect a concern about the pressures, especially in the safety net, to rush patient care in inpatient and emergency settings. Yet the notion of “emptying beds” carries a slightly different valence than “getting rid of patients.” Empty beds may represent care denied but also ensure the possibility of caring for future, additional patients in need.<sup>10</sup> In this sense, Rhodes’ analysis of emergency

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<sup>10</sup> Thanks to Melina Salvador for this formulation.

psychiatry is echoed in my own fieldwork, where increasing *access* was the object of focused intervention, tying temporal efficiency to the ability to provide care for a *population* currently outside of the clinics' care. These examples underscore the tension between caring for individual patients and populations more broadly, a theme to which I return below. My research builds on Rhodes' and Mizrahi's work in inpatient settings by studying the unique and overlapping temporalities of the primary care clinic, with its brief, repeated visits, scheduling practices, blend of acuity and chronicity and the intersection of clinical time with life outside the clinic.

Like many throughout the country, the clinics in which I worked have adopted electronic health records (EHR), increasingly emphasize continuous quality improvement (QI) practices and are dependent upon multiple forms of performance-based funding. The EHR, QI and cyclical patterns of funding directly shape the structure of work and meanings of time that circulate in the clinic (Sinsky et al. 2016). These technologies and policies have intensified the expansion of tracking practices in clinics, including time monitoring (Hirsch et al. 2016; Pine 2011). Many of the temporal practices and technologies that can be observed in primary care have been deployed in the name of efficiency. Several important critiques have addressed concepts and technologies of efficiency in healthcare and global health in order to challenge what is seen as increasing bureaucratization and deskilling of health professionals in the pursuit of profit or fiscal survival (Hunt et al. 2017; Biehl 2013; Pine 2011; Sweet 2012; M. Berg 1997). As I will describe, it quickly became clear that clinicians, staff and managers think of "efficiency" in multiple ways. Many are critically wary of the demand for clinical speed and flawed techniques of quantified accountability. Still, many value certain techniques tied to these bureaucratic ideals when they help to smooth the

chaotic “flow” of clinical work or ensure access and preventive care for a population of patients in need.

### **Background: A brief history of contemporary primary care**

*Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community.*

- Primary Care: America’s Health in a New Era, Institute of Medicine, 1996

The term “primary care” appeared in the U.S. in the early 1960s and has come to carry several meanings (Moore and Showstack 2003; H. F. Stein 2006; McKenna 2012). It refers to a level of primary intervention, as opposed to secondary (specialist or hospital) and tertiary (highly specialized inpatient) care. It also references the aspiration that primary care should be a foundational component of healthcare. Since its inception, primary care has been associated with a set of defining attributes, including being the first point of contact with healthcare and offering comprehensiveness, continuity and the coordination of other health services (Starfield, Shi, and Macinko 2005; Friedberg, Hussey, and Schneider 2010; Epperly et al. 2019).<sup>11</sup>

Family medicine, the physician specialty that replaced general practice in the U.S., became a board-certified specialty in 1969 (Gutierrez and Scheid 2002). The professions of physician assistant and nurse practitioner also emerged in the late 1960s (Greenwood

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<sup>11</sup> These aspirations have not been clearly or consistently operationalized (Bodenheimer et al. 2014). For an example of broad definitions, see Epperly et al. 2019. Also, the establishment in the 1990s of the “hospitalist” as an inpatient generalist responsible for admitted patients divided the traditional role of the general practitioner or primary care provider. While some saw this as necessary in light of the expansion of medical knowledge and for provider work-life balance, others lament it as one of many steps away from continuity (Moore and Showstack 2003; Frey 2018). Nonetheless, even in outpatient primary care, continuity remains a defining feature of care (see chapter 7).

1981). The nurse practitioner role was specifically developed to meet unmet need for primary care (Keeling 2015). Today, physicians, physician assistants and nurse practitioners collectively make up the workforce of “primary care providers” (PCPs). I use this term throughout my dissertation to indicate both doctors and nurse practitioners (NPs).<sup>12</sup> In the setting of this study, NPs are licensed with a broad scope of practice. They practice independently as the PCP for their own patient panel and have the same responsibilities as physicians. In addition to primary care providers, nurses and medical assistants (together called “nursing staff”) play central roles in the provision of clinical services in primary care.

Some tie the coalescence of family medicine in the 1960s to concurrent counter-culture movements, including consumer rights and feminism (Stephens 1989). This decade also saw the establishment of a movement for social change through community health centers as providers of both healthcare and economic opportunity (Geiger 1984). While internal medicine, family medicine and general pediatrics are now firmly established within organized medicine, the social justice ethos that established family medicine and primary care in the 1960s still runs through the self-identity of many in the profession, perhaps especially for those who choose to practice within the social safety net (H. F. Stein 2006).

The Institute of Medicine’s 1996 definition of primary care added the terms “integrated” and “accountable” to prior definitions, reflecting shifts in the 1980s and 90s toward larger health systems linking primary care and specialty services. Hospital and clinic networks are increasingly held responsible for the overall health outcomes of a patient

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<sup>12</sup> Inconsistent regulation and scope of practice debates driven in part by the interests of professional organizations like the American Medical Association and the American Academy of Family Physicians have long complicated the status of nurse practitioners as primary care providers, despite evidence that the care they provide is comparable to or better than that provided by physicians (Wilmont 2013; Swan et al. 2015; IOM 2011)



population through regulatory measures and payment incentives. In the 1990s, primary care providers became known as “gatekeepers” in managed care systems focused on reducing the use of services (Hoff 2009; Bodenheimer and Pham 2010). Health professionals, patients and anthropologists contested the over-emphasis on cost control under managed care, calling for greater attention to care quality and equity (Berenson and Rich 2010; Chassin and Loeb 2011; Shi et al. 2003; Horton et al. 2014; Rylko-Bauer and Farmer 2002). More recently, advocates of primary care frame the field as the foundation of high value healthcare, particularly in response to poor outcomes and – still – high costs (Phillips and Bazemore 2010). I elaborate these histories in chapters 1 and 5.

### **The Chronic Crises of U.S. Health and Primary Care**

The “crises” of U.S. primary care and healthcare more broadly have a long history. Richard Nixon declared a crisis of healthcare costs in 1969 (Millenson 2018). Primary care has been intermittently identified as in crisis since at least 1992 and the terms of the discussion have remained remarkably similar, focused on provider recruitment, time pressure in the clinic and disparities in access to care (Stimmel 1992; Moore and Showstack 2003; Sherman, Moscou, and Dang-Vu 2009). This evokes a sense of a crisis that has become chronic. Recent shifts have renewed interest in and anxieties about primary care. One such shift is the perception, described above, that the provider shortage is worsening.<sup>13</sup> Some argue that the problem is the distribution of providers across care settings more than

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<sup>13</sup> This is subject to debate as the legal scope of practice of nurse practitioners and physician assistants in some states have expanded to fill the gap (HHS 2016). The geographic distribution of providers and their rates of acceptance of uninsured and publicly insured patients also complicate the generalized notion of a shortage that is an important part of the primary care crisis imaginary. According to an assessment on behalf of the local public health department, the county in which this study took place has a higher concentration of primary care providers than the state average and national benchmarks. However, fewer of these providers accepts a high percentage of patients with public insurance. Further, several providers told me that the public clinics struggled to recruit providers given the lower pay and challenges of working in a safety-net setting.

an absolute shortage (Sandy and Schroeder 2003; Carroll 2017). More primary care providers are working part time, exacerbating the sense of a shortage (Hoff 2009). Recruitment of physicians into primary care goes through phases of growth and decline while the population and scope of nurse practitioners has expanded steadily in recent decades (Messinger et al. 2017; Newton and Grayson 2003; HHS 2016; Poghosyan et al. 2013; AANP n.d.). Perhaps the most dramatic shift since 2010 has been expanded access to health insurance under the Affordable Care Act (ACA). This increase in coverage was expected to result in increasing demand for primary care as patients who used to delay care or seek it in the emergency room sought primary care for the first time (HHS 2016; Hofer, Abraham, and Moscovice 2011).<sup>14</sup>

The increase in the insured population under the ACA intensified concern over access to care and high costs. These have turned primary care's emphasis on preventative and chronic care and coordination of other health and social services into a major foothold for payment and organizational reform. The U.S. government has made improving access to and quality of primary care a priority through "Innovation Awards," education support and payment incentives (HHS 2013; CMS 2019). In many ways this is a victory for primary care advocates who have long been fighting for payment structures that support preventive and chronic care services. At the same time, many problems remain, including the difficulty of evaluating or proving the effects of such practice models on quality (Grumbach 2013). Some practicing providers are skeptical as to whether these changes improve health or quality of care. Rather, some argue that the emphasis on particular metrics, backed by financial consequences, impedes their ability to provide what they see as good care (Commonwealth

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<sup>14</sup> The complex effects of the law on primary care supply and demand are still being studied. Predictions and outcomes to date vary by widely by state and setting (Frakt 2017; Katz 2010; Glied and Ma 2015).

Fund 2015). Together, recent changes in the financial and regulatory structures of healthcare raise both hope and concern about their potential effects on elements of the healthcare crisis including costs, access, quality, health disparities and healthcare worker burnout. I address these broader themes in greater detail throughout this dissertation.

A 2015 perspective piece in the *Journal of General Internal Medicine* calling for an end to the 15-minute primary care visit leads with a business adage: “We can do it fast, we can do it well, we can do it cheap. Pick two” (Linzer et al. 2015). Meanwhile, the current logic of health reforms promise that these three features can come together. The logic of “doing more with less” pervades discussions of healthcare value and quality improvement. It has also long been a survival strategy in the safety net (CHCF 2011). This ethnography traces manifestations and consequences of this logic while examining how those working in primary care make sense of their practices of time allocation.

### **Primary Care “Transformation”**

The goals of current primary care practice reforms are lofty. They promise lower costs, higher quality and less provider burnout (Bodenheimer and Sinsky 2014; Gill and Bagley 2013). As Kevin Grumbach (2013) observes, primary care represents 6% of total U.S. expenditures on healthcare, yet it is seen by some as the solution to out-of-control healthcare costs overall. Writings in the medical literature about the future of primary care celebrate and critique the ambitious goals placed on the field’s shoulders. Proposals for “reconstructing primary care” tend to reassert similar principles, as broad or broader than before, adding “immediate and convenient access to care,” as well as a focus on chronic illness monitoring and preventive interventions (Moore and Showstack 2003, 246).

Meanwhile, some of the same authors worry that the political economy of U.S. healthcare poses significant obstacles to realizing the broad, idealist purposes of primary care (Sandy et al. 2009; Moore and Showstack 2003). In particular, incentive-based payments rather than investment in primary care infrastructure leaves practices in a position of gambling on grants and incentives to sustain their practice (Nunlist, Uiterwyk, and Nicoletti 2014).

In a reflection on his 1979 lecture to the Society for Teachers of Family Medicine, Dr. Gayle Stephens (1989, 109) observed that, despite earlier challenges to the institutionalization of general practice, primary care providers shaped medical education reform and:

... either assumed or [were] given the responsibility for alleviating the doctor shortage, correcting the maldistribution of physicians geographically and by specialty... repersonalizing medical care, enhancing distributive justice in medical services and, in some way, controlling costs...

Nearly forty years later, these substantial expectations again define the goals of U.S. primary care reform in response to clinician shortages, lack of access, high overall healthcare costs and profound disparities in health and healthcare. Added to Stephens' concerns is combatting clinician burnout at the same time as expectations for patient care and quality monitoring intensify.

One response to the mismatch between expectation and resources for primary care has been the emergence of "direct" primary care, in which patients pay a membership fee on top of their health insurance coverage in order to ensure longer appointments and greater convenience through short-term appointment access. This model is controversial, in part because it is inaccessible to those who cannot afford it (Doherty 2015). Direct primary care exemplifies an understanding of waiting as negative and of quality care requiring time.

It also crystalizes the unjust connection between wealth and access to timely and attentive care that defines the U.S. healthcare system. Team-based care is a more widespread solution to clinical time scarcity in large health systems. In widely published and incentivized models for reformed primary care practice such as the Patient Centered Medical Home, clinics use interdisciplinary care teams and extensive data collection for ongoing coordination and improvement of care and efficiency (NCQA 2019, Chesluk and Holmboe 2010). In practice, studies have shown that the implementation of new models can place significant strain on clinics and gains can be challenging to sustain despite the appeal of the ideals embedded in the model (Goldman et al. 2018; Donahue et al. 2013; Bitton et al. 2012).

“Team-based” or “shared care” models reorganize clinical labor in relation to time in hopes of “maximizing” the value of time spent in patient care encounters and potentially increasing visit volume (Sinsky et al. 2013; IHI 2017). The goal is to improve quality of care without fundamentally changing the time available, in part by freeing primary care providers from certain tasks. For example, emphasis is placed on clinic staff working at the “top of their license,” with medical assistants and nurses attending to time-intensive activities such as screening and vaccination outreach, addressing common patient concerns, and tackling administrative tasks such as the “prior authorizations” required by insurers.<sup>15</sup> The intent is to focus physician time, understood as the most expensive element of primary care, on services which only they were licensed to provide. It was also seen by some

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<sup>15</sup> Prior authorizations are paperwork that must be submitted to insurance companies for determination of coverage for goods or services. They represent a large portion of the paperwork done in the clinic and are costly to the U.S. healthcare system overall (AMA 2018; Morley et al. 2013).

providers in this study as a way of removing protocol-driven or “transactional” care that contributed to their frustration and risk for burnout.

The discourse of crisis surrounding primary care, and particularly clinician burnout, attributes the phenomenon to a mix of individual and interpersonal traits and to ever increasing expectations without the institutional infrastructure to match. Unsurprisingly, this mismatch is often expressed in terms of time scarcity. Despite the central place of temporality in the primary care crisis and the rich history of anthropological writing on time, little social scientific research has explored this dimension of primary care practice. In this dissertation, I use anthropological tools to closely examine the experience of time scarcity that is largely taken for granted as part of a larger exploration of temporality in primary care. I argue that in primary care practice, multiple temporalities and temporal practices coexist. These create a multitude of contradictions and also enable the partial realization of clinical and organizational goals.

### **Fieldsite and Methods:**

This dissertation is based on ethnographic fieldwork in publicly-run urban primary care clinics in California. The county in which I conducted fieldwork has a number of programs in place that help to ensure access to primary care for the population, including

publicly insured, underinsured and uninsured patients. Still, significant disparities in health and healthcare exist across the county's population.<sup>16</sup>

My fieldwork focused on three community health centers that serve low-income patients and families through a typical model of primary care provision based on scheduled appointments and drop-in urgent care. The clinics I studied form part of the healthcare safety net. Their patients are insured by Medicaid or Medicare, enrolled in a local discount program or uninsured. Many of their patients are socially vulnerable, meaning that their status along lines of oppression like race, class, sexuality and ability put them at risk of ill health and poor access to care (NACHC n.d.b.). These include patients living in poverty who are disproportionately people of color. Some are experiencing homeless or are marginally housed. Patients are provided services regardless of ability to pay (IOM 2000a).

Safety-net clinics are heavily reliant on Medicaid funding, as well as federal and private grants (CHCF 2016). Their patients report high rates of poor health and disability and are likely to face financial, linguistic and logistical barriers to care and needed resources (IOM 2000a).<sup>17</sup> Time pressures are acute in the healthcare safety net, where patients' physical and social needs are vast and resources are limited (Varkey et al. 2009). Clinicians working in this type of setting report a sense of workplace chaos and time pressure, which are associated with healthcare errors and clinician burnout (Perez et al. 2017).

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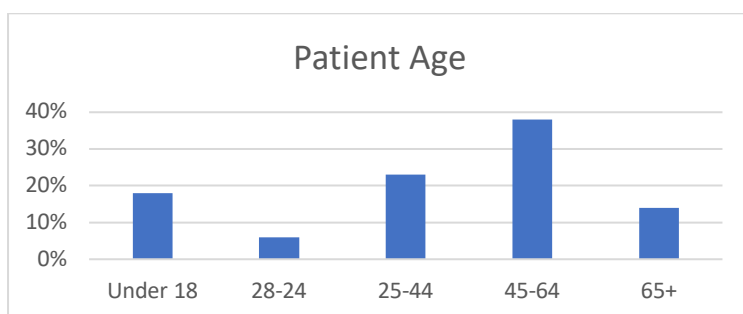
<sup>16</sup> An assessment conducted on behalf of the public health department in 2012 reported that Black residents had the highest mortality rates across nearly every major cause of death. The assessors attributed most health disparities to the social determinants of health, but observed disparities in access to care. While there were many clinics *available* in some neighborhoods with high rates of poverty, patients in those neighborhoods continued to access care in the emergency room, a proxy for barriers to preventive services. Patients in other neighborhoods experienced transportation as a major barrier to care. The report concludes that "there are many health care resources available... however, availability does not necessarily equate with accessibility."

<sup>17</sup> In all of these ways, these clinics are similar to other urban safety-net primary care clinics. Meanwhile, several people in this study insisted that they had *more* resources relative to safety-net clinics in other cities.

My interest in safety-net clinics stems from their explicit orientation to a particular community, which brings questions of individual and population care to the fore. By studying publicly run clinics, I am able to examine the ways in which the financial structure of U.S. healthcare shapes notions of time and its allocation even in the absence of a profit motive. In this setting, profit is replaced by discourses of fiscal sustainability and stewardship. The financial concerns of the health delivery network drive efforts to expand their reach within the county, including to healthier patients. The mission of these clinics from providers' perspectives, while always subject to revision and debate, is broadly understood as oriented by an obligation to serve patients who may not otherwise receive primary care.

### Patient Population

In the 2016-2017 fiscal year, the public network of clinics in which I conducted fieldwork recorded over 369,000 visits for a patient population of approximately 66,000. The patient population was split evenly between men and women. Other demographics are shown in figures I.1–I.3.<sup>18</sup>

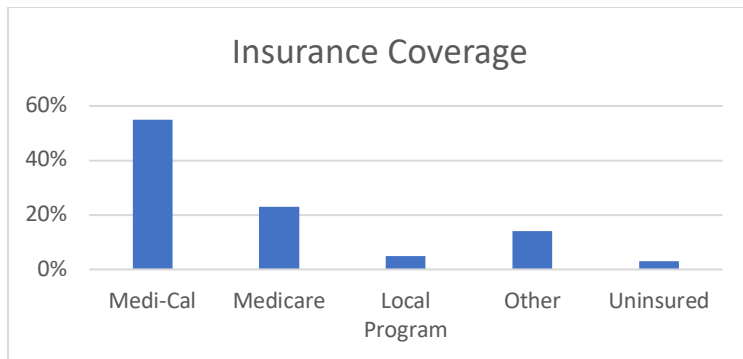


**Figure I.1.** Age of patients seen in primary care by age.

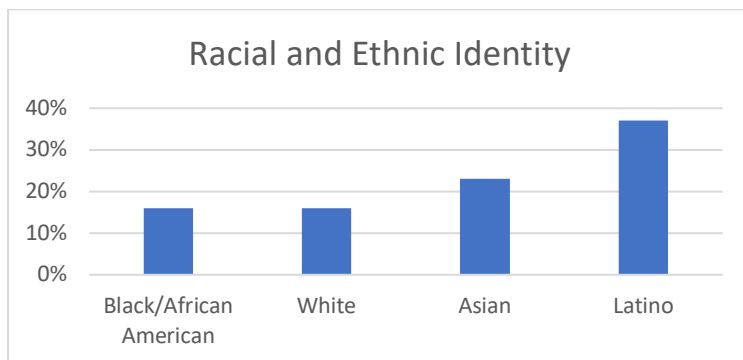
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<sup>18</sup> The data for these figures is from a local health department report. Data collection inclusive of transgender patients has only recently been implemented and was not yet available at the time of writing.





**Figure I.2.** Insurance coverage source for primary care patients.



**Figure I.3.** Racial and ethnic identities of patients in the county's public primary care clinics.<sup>19</sup>

All the clinics I studied serve many patients who are monolingual speakers of Spanish, Cantonese and other languages. Many providers and clinic staff spoke one or more language other than English. If a clinic staff member or clinician did not speak the patient's language, they relied on interpretation over the phone. There were no formally trained in-person interpreters, but staff would often interpret brief interactions for each other.

### Clinic Staffing and Team Structure

Like many other urban safety-net primary care clinics, the community health centers I studied rely heavily on nurses, medical assistants, behavioral health and clerical staff in addition to physicians and nurse practitioners, emphasizing team care and role

<sup>19</sup> In addition, approximately 1% of the patient population is Native American or Pacific Islander. Racial or ethnic identity information is unknown for the remaining patients. Compared to the demographics of the county, Black and Latino patients are overrepresented and white and Asian-American patients are underrepresented.

maximization for clinic staff (Ku et al. 2015).<sup>20</sup> This introduces new complexities into the valuation and organization of clinical time, which I explore in chapter 4. **A glossary of clinic roles is included in Appendix A.**

The clinics that I studied were staffed by 40 or more people, some whom were present part-time. Of these, there were 7–10 primary care providers (all clinically part-time), 3–5 nurses, 6–7 medical assistants and 2–5 front office staff.<sup>21</sup> A typical session would have 3–4 primary care providers seeing patients in clinic. Several sessions per week would also include a phlebotomy lab run by medical assistants, nursing and podiatry clinics, and behavioral health, pharmacy or nutrition consultations.

The staff of each clinic I studied – from management to the front desk – were predominantly women. There were far fewer men, but more than one man serving in each major clinical role across between the sites in this study. The clinicians and staff were racially and ethnically diverse. The composition of each clinic in terms of gender and the racial and ethnic identities of clinic staff and patients varied. These differences mattered in ways relevant to the study, including the ways in which stereotypes about race or gender permeated ideas of timely, time-intensive or difficult patients and which providers cared for them. Language fluency (most commonly in Cantonese, Korean or Spanish) could have a profound effect on the duration of appointments and on patient trust. Meanwhile, most of the themes upon which I focus in this dissertation ran across lines of race, ethnicity and

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<sup>20</sup> Primary care providers (PCPs) in these clinics included internists (MDs who only see adults), family physicians (MDs who see all ages) and nurse practitioners (NPs).

<sup>21</sup> These are estimates, as some staff in each role were hired and left during the course of the study. Along with these roles, each clinic had additional administrative staff, a podiatrist, behavioral health clinicians and assistants, part-time pharmacists and nutritionists, health workers, volunteers and sometimes special program staff and “float” staff supplementing for understaffing (see Appendix A).

gender. In light of this and my obligation to protect the privacy of patients and study participants to the best of my ability, I have chosen to omit or sometimes change identifying traits in the stories that follow.<sup>22</sup>

Ideally, each primary care provider (PCP) would work consistently with one medical assistant (MA). Two of the clinics I studied had a handful of providers who did not have a consistent MA partner because of staffing. Some MAs worked with more than one provider if they had complementary schedules. A stable pairing of a PCP and an MA is called a *teamlet*. Each PCP or teamlet has a *panel* of patients assigned to them. They are responsible for their care and *healthcare maintenance* (vaccination, screening and monitoring of chronic conditions). Active patient panels are expected to be around 1200 per 1.0 full-time equivalent, but no providers were 1.0 FTE.<sup>23</sup> Most of the providers who participated in this study worked closer to 0.6 FTE and had panels around 600-700. Panels were weighted by a calculated complexity based on patients' age, chronic conditions and other variables. Notably, this weighting process affected the total number of patients a provider is responsible for but did not alter the scheduling of all patients into appointment slots of equal duration (see chapter 2).

### Scheduling and Payment

Clinics scheduled 10–12 patients per provider in a 4-hour clinic session. The spacing of appointments was a little bit different at each clinic I studied, but in each case,

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<sup>22</sup> I have tried to use pseudonyms that represent the diversity of the clinicians and staff but have sometimes switched ethnically-marked names and the people they refer to in an effort to prevent identification. I only specifically mention racial identity or language when it was addressed as central to a statement or interaction by those I studied. In most cases, I use the same pseudonym for each person I interacted with throughout the dissertation. There is a limited set of cases in which I have split one person into two or composited two people because not doing so may betray the identity of one or more participants.

<sup>23</sup> This is lower than some of the values cited in the literature for typical primary care panel size, but the literature also highlights that both real and “right” panel sizes are poorly understood (Raffoul et al. 2016).

appointments were all of the same length (15 or 20 minutes). Show rates, or the percentage of scheduled patients that attend their appointments varied by clinic and provider. In one clinic considered to have a high no-show rate, the average rate of missed appointments approached 25%. The significance of this is that appointments were scheduled with a target number of completed visits in mind, assuming an average show rate. As a consequence, all twelve patients might come during some sessions and other sessions, seven.

Patients were also able to drop in during certain hours to be evaluated by a nurse, usually during the first two hours of each clinic session. The nurse could complete the visit alone for common conditions or hand off or “flip” the visit to a provider for both clinical and billing purposes. Thus, some “no-show” visits would be filled in with drop-in visits. Each clinic specified a “Nurse of the Day” and “Provider of the Day.” These people had a regular or near-regular clinical load and were also primarily responsible for seeing drop-ins, responding to absent colleagues’ urgent messages and dealing with other contingencies during that day or session.

These clinics’ scheduling practices are shaped by the fact that reimbursement for primary care is primarily driven by visit volume. The actual funding of primary care services in this system is extremely complicated and based on a combination of reimbursement for services, county funding, project-specific grants, and metric-based incentives. In the meetings I attended, the basis of financing was explained to providers and managers as a lump sum payment to the network per insured patient visit. While payment does not vary based on what happens in each visit, documentation of visit complexity (using a standard 5-point scale) and procedures (like immunizations) helps set the per-visit rate for the

following year.<sup>24</sup> Meanwhile, performance-based funding makes up a smaller but increasing portion of the healthcare network's budget.<sup>25</sup> Some funding that was previously guaranteed is now contingent on meeting certain metric goals. I discuss the use of metrics and incentives in greater detail in chapter 5.

## Methods

Between June 2017 and May 2018, I observed daily practice in clinics over the course of 11 months, spending 2–5 months at each of three clinical sites.<sup>26</sup> I observed clinicians and staff for half-day sessions at a time, multiple sessions per week. I primarily shadowed one particular person for each session in order to see the work from their point of view. At two clinics, I shadowed all members of staff in patient-facing, primary care roles who were present during the study and agreed to participate (PCP, RN, MA, Eligibility, Front Desk, behavioral assistant. For definitions, see Appendix A). At a third clinic, I observed 2–5 people in each role. In most cases, I shadowed each person once, but I developed relationships with staff over time and they would draw my attention to things on other days. In a few cases, I observed people more than once to see different roles they played or variation between days. At all clinics, I also attended staff meetings and trainings. I attended

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<sup>24</sup> This payment structure applies to Federally Qualified Health Centers and is called the Prospective Payment System (NACHC n.d.a.). The health system I studied was in transition to many of their patients being covered under a fully capitated payment model. The process described above characterizes current reimbursement. With recent payment reforms, federal funding for the care of uninsured patients has been reduced and remains based on a fee-for-service model. In California, funding for care of uninsured patients and non-reimbursed services falls under the Global Payment Plan (CAPH n.d.).

<sup>25</sup> Many policy experts have expressed concern that performance-based payment may have adverse effects on health disparities given the influence of social determinants of health and the narrower financial margins of safety-net hospitals and health centers (Friedberg et al. 2010; Chatterjee et al. 2012). See chapter 5.

<sup>26</sup> As community-oriented clinics, each site has developed some of its own practices and protocols. As part of the same healthcare delivery network and oversight structure, these clinics are undergoing a process of standardization that is yet incomplete. Therefore, they vary slightly in their organization, policies and approaches to certain shared challenges. For similar reasons to the use of pseudonyms, I do not specify which clinic is which in chapters that follow. I do specify specific organizational details when they provide necessary context to the analysis.

monthly management meetings with other clinics in the healthcare delivery network to contextualize the work in the clinics I studied within the larger system.

Between September 2017 and December 2018, I interviewed 38 members of clinic staff and management. I sought a range of experiences based on role, training, tenure, gender and racial or ethnic identity. I also drew on my observations to select people with diverse viewpoints regarding clinic policy, practices and workplace dynamics. Returning to the clinics for post-observation interviews allowed me to learn about changes that took place over time. This fieldwork built on earlier research conducted in the summer of 2015 in nine community clinics in the same healthcare delivery network. Data from both periods were incorporated in this analysis.<sup>27</sup> I also reviewed professional literature in medicine, nursing and health policy to contextualize the work in these clinics within broader conversations about primary care policy and practice.

### Scope

My ethnographic data collection focused on the experiences and perspectives of clinicians and clinic staff, including their perception of patients' expectations and experience of care. My choice to focus on clinicians and clinic staff was shaped by my particular interest in the everyday realization of institutional logics and practices related to time.<sup>28</sup> My questions could not be answered by focusing on either patients' experiences or abstract policy discussions. The patients, clinicians, staff members and managers that I encountered

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<sup>27</sup> Data analysis involved coding and iterative analysis of fieldnotes and interview transcripts. This research was approved by the Institutional Review Board of the University of California, San Francisco.

<sup>28</sup> Anselm Strauss and colleagues' *Social Organization of Medical Work* (1997) details how the realization of care work is far more complicated than the formal division of labor and the temporal structuring of work is a product of both structural constraint and negotiation. Tracing these dynamics requires in-depth observation of everyday work practices across clinical roles. (See also: Lipsky [1980] 2010).

are attempting to realize care in a setting of socially structured time scarcity that is not often conducive to their success. I examine how staff's experiences of time and the temporal demands made of them shape their ideas of patients. I also analyze how notions of "the patient" as a figure work to intensify or challenge those demands.

Many have studied the various ideal forms of "the patient" in medical training and practice, from the typified clinical "case" to the standardized patients (actors) who test students' empathic communication and clinical skills (Holmes and Ponte 2011; Taylor 2014, 2011). Historian Charles Rosenberg (2002) describes the challenges of relating idiosyncratic individuals to increasingly narrow disease categories that are required by and enable reimbursement and evidence-based practice. By "patient as a figure," I refer to the ways in which "the patient" or "our patients" or "the patient voice/experience/perspective" are invoked to explain, call for or critique a particular practice (c.f. Kreindler 2015). The patient in these usages is a composite or imaginary character, not a reference to the actual, particular patients cared for in the clinic. The mobilization of this figure often serves to make moral claims, whether for greater dedication and labor from staff or for changes to the organization of care. It can refer to patients as unique individuals or claim to speak for all patients. This leads to the central ambiguity in discourses of "patient-centeredness" that I will address in chapter 1.

When the discourse about primary care is framed in terms of time scarcity, one might assume we have a shared understanding of what that means and of the solutions. However, the stakes differ: Some social science, professional and popular commentaries lament the loss of time for individualized care, understanding bureaucratic care as (primarily) violent (Hunt et al. 2017; Pine 2011; M. Stein 2015). As I have outlined, much of

the professional literature focuses on recruitment and burnout. Finally, policymakers and administrators worry about access and cost containment. These are, of course, gross divisions. Many analyses cross these lines and many primary care clinicians, staff and managers hold multiple perspectives, concerned about each of these things.<sup>29</sup>

The goals and values at stake in the primary care clinic make the complexity of time visible. These goals include addressing acute and chronic, physical and mental health needs, balancing the needs of different patients and providers, promoting equity and social justice, satisfying regulatory and grant requirements and sustaining clinic resources. The purpose of my dissertation is to use anthropological methods and insights to look closely at time in primary care, tracing its multiple meanings, horizons and moral valences.

### **The Shepherd's Paradox**

As I have noted above, the complex relationship between the individual and the population and the link between discipline and welfare are central questions in the study of modern institutions like the State and public health (T. M. Porter 1996; D. Porter 2007; Foucault 1994). Foucault's ([1978] 1990) concepts of biopower and biopolitics described the authority over life exercised through modern forms of governance. Biopower fosters life for the population by disciplining individual bodies. Biopolitics emphasizes the health of the population through the improvement of statistical norms, which can involve the neglect of some in the name of the population. These concepts have profoundly shaped medical anthropological critiques of the healthcare system (Rabinow and Rose 2006).

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<sup>29</sup> A challenge in writing any ethnography is that the variety of perspectives within any group frustrates any general observation. For any such observation in this dissertation, it is likely that I could provide counterexamples. I make general statements about people in certain roles to bring out an overarching trend or difference.



In a different lecture, Foucault (2007) articulated a fundamental ethical paradox that those who work in fields like medicine face in the care and management of populations. The paradox can be understood through an analogy to the shepherd in a New Testament parable. The shepherd must be willing to “leave the 99” to save one sheep who has strayed but must not lose any. There is a contradiction in abandoning the flock to save the one because the shepherd is responsible for the entire flock and each of its members. Daily primary practice is a near-constant enactment of the shepherd’s paradox: there is a simultaneous imperative to provide “patient-centered” care, and to attend to a population of patients such that none are neglected. Within the time and resource constraints structured by the healthcare system and funding for public services, staff and providers make pressured decisions that wrestle implicitly with this paradox.

Critiques of medicine as biopolitics argue that in the eyes of the state and modern disciplinary institutions, individuals are understood in terms of the populations to which they belong. The power of medicine is manifest in the forms of triage that abandon some in the name of others. This power also underlies the demands that medicine makes of individuals to understand themselves and behave in particular ways. These dynamics are clearly at work in my fieldwork. Meanwhile, appeals to patient-centeredness are made both for and against techniques of efficiency. Those who practice primary care are not *only* transparent agents of institutional power aimed at enhancing population health. They carry professional obligations to each and every patient (c.f. Lipsky [1980] 2010).<sup>30</sup>

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<sup>30</sup> Political scientist Michael Lipsky calls those who work in public service positions with direct contact with clients “street level bureaucrats.” He argues that these workers ultimately create and actualize policy as they exercise discretion in their work. Street level bureaucracy in Lipsky’s definition is defined by these role features as well as significant resource constraints, demand that generally exceeds supply and vague or contradictory goals (Lipsky [1980] 2010, 27). The work in the clinics that I study clearly meet this definition and many of Lipsky’s observations are useful here as well.

I focus on the worker and the institution's obligation to serve individuals in a way that is responsive to their needs and preferences, under structured conditions of scarcity, while not neglecting anyone else and while following "recommended" and mandated practices that are based on population-level research and norms.<sup>31</sup> Triage is one of many ways in which this paradox is momentarily resolved. I describe the implications of this dual and often contradictory obligation for the system and its workforce. Of course, this tension also effects patients as ideas of time shape ideas of patienthood (c.f. chapters 2 and 3).

Some anthropologists have turned to "the ethical," in part as a move away from what Ortner (2016) calls "dark anthropology," the vast literature inspired by Foucault's early work on power and focused on the harshness of contemporary life. The anthropology of ethics has become a broad and complex field, debating moral philosophy and the nature of "the good" (Das 2012; Robbins 2007; Fassin 2014; Lambek 2010; Mattingly 2014). Ortner (2016) is critical of this move insofar as it brackets questions of power. However, these forms of analysis are not mutually exclusive. As Kelly Ray Knight (2015, 29) observes, ethical responses to unjust everyday circumstances are "incomplete, made under duress, and often unsatisfactory." This holds particularly true under conditions of socially structured scarcity, the effects of which are manifest in the U.S. healthcare system generally and the health and social safety net in particular (Knight 2015; Farmer 2012). Throughout this dissertation, I attend to the ways in which those I studied make sense of what they do. Often, this entails an appeal to what is right or necessary in the moment. My intent is not to normalize the sense of time scarcity they experience, which is thoroughly structured by politics and

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<sup>31</sup> The questions I am asking here may speak to other fields that face the same paradox. Educators, for example, face a similar set of circumstances, leading to a similar sense of absurdity (Gordon 2016).

economics, but to understand how clinicians cultivate a sense of “good enough” practice within this context (c.f. Scheper-Hughes 1995; Messac et al. 2013).

Following Paul Brodwin (2013), I think of the practice of primary care as a form of *everyday ethics*. Brodwin argues that the commentary of frontline service workers when they reflect on their work are not simply complaints or justifications. They articulate a critique of the system in which they practice, including the social circumstances of their patients and the inequitable structures of healthcare. In my work, this type of commentary was not always explicit. I focus on the *practices* of time allocation and how they articulate a partial, embedded ethics.

### **Time in Practice**

Guided by Bourdieu’s (1977) theory of practice, I understand time and temporal strategies as central to an adequate analysis of practices that resist schematic representation. Bourdieu argued that often social scientists obscure the place of time in practice or create apparent paradoxes by attempting to capture all the elements of a social practice in a single image or description. This line of analysis points to the possibility of multiple forms of time being simultaneously at play (c.f. Mol 2002). At the same time, while clinicians and managers alike recognize the complexity of time in practice, official and singular representations of time have consequences for payment and professional recognition (c.f. Bowker and Star 2000).

My project is not to propose a new ontology of time. Time is already widely understood as a social phenomenon in addition to a physical property. There are demands made on and by time in care that create friction (Tsing 2011). Many actors within primary

care simultaneously hold multiple ideas and experiences of time. On the one hand, time is understood as a (very) limited good with its allocation a zero-sum game. On the other hand, it is sometimes seen as subjective, stretchable or flexible.

These different aspects of time can each be mobilized to make claims about what can and should be done in the clinic. Meanwhile, the assumption that everyone has a shared and singular idea of time and efficiency can obscure the ethical tensions in the care of a large group of individuals that I have described through the shepherd's paradox. The blurring of multiple temporalities and their ethical stakes can frustrate efforts to prioritize. They can also moralize the intensification of labor (c.f. chapter 6). By focusing on practice, my aim is to trace how those who work in primary care navigate contradictions in the organization of time that cannot necessarily be formally resolved.

### **Temporal Absurdity**

In *The Myth of Sisyphus*, Camus (1991) describes absurdity as arising from the confrontation between our desire for unity and meaning and an unreasonable world. Camus writes that many philosophers, faced with the incoherence and contradictions of life have chosen in various ways to escape facing this agonizing reality by negating some part of the equation. Camus argues for lucidity without fatalism, a recognition of contradiction and impossibility without opting out. He ends his essay on the image of Sisyphus walking back down into hell to begin another journey up the hill. He imagines Sisyphus as conscious, aware of the absurdity of his fate and finding meaning in the struggle itself.

Early in my fieldwork, I was struck by the sense of impossibility conveyed in the repeated observation that “there isn't enough time” to accomplish one's tasks and do right

by patients. Yet, in the face of the impossibility of reconciling efficiency and individual care and meeting everyone's needs with limited resources, the people I studied mostly continue to practice and some assure me of their love of what they do, planning to continue for years to come. Providers and staff recognized the compromises in their practice and had ways of summarizing their persistence, such as "not letting the perfect be the enemy of the good." Given this persistence, impossibility was not the right word. Rather, I came to understand primary care practice as an exercise in reckoning with temporal absurdity.

Some critiques of current medical practice center the individual patient-provider relationship and insist that care almost always takes time. From this starting point, within a healthcare system insistent upon speed and efficiency, care inevitably fails.<sup>32</sup> On the other hand, many of the new practice models aimed at rescuing primary care leave the current underlying logics of the healthcare system intact, namely that cost-saving is necessarily a primary goal and that more can be done with less. The first stance denounces the current system while the latter celebrates and insists upon its potential.<sup>33</sup> Both offer an escape from the problem that concerns me, which is: how do people working to provide primary care within a troubled system – as it currently stands – make sense of their work and their time. I do not intend to reify a logic of scarcity by focusing on how people "survive" within it. To be attentive to the experiences of those I studied, I must hold both the sentiment that they absolutely should have more time (i.e. staffing, space and funding) and the urgent understanding that right now they have less and would like to do more with it.

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<sup>32</sup> An example is Victoria Sweet's (2012) book, *God's Hotel*. In her second book, *Slow Medicine*, Sweet (2017) acknowledges the value under certain circumstances of what she calls "fast medicine," or that which is protocol- and technology-driven. I challenge the underlying dichotomy in this formulation (see Conclusion).

<sup>33</sup> Timmermans and Buchbinder (2013) analyze this common phenomenon, in which the potential of a practice or model that has repeatedly caused harm is invoked despite its failure. See also Hoff 2009.

## Outline of Chapters

Chapter 1, “Patients are Waiting,” introduces the terms of care timeliness – waiting, access and “cycle time” or visit duration – as they are understood at an administrative level. I elaborate the shepherd’s paradox as it manifests in conversations about time and patient-centered care, namely the question of how to reconcile the needs of a collective of patients with the individual ideal of patient-centeredness. I examine the implicit and explicit tensions between notions of comprehensive care, access and timeliness within current clinical and payment structures, laying the groundwork for an understanding of how these tensions play out in clinical practice. The sentiment that there is never enough time leads to moral conflict.

In chapter 2, I turn to the schedule for a clinic session, examining how the imperative to see a certain volume of patients is formalized in primary care providers’ appointment slots. I describe how contradictions embedded in the structuring of clinical time are negotiated in the name of “flow.” Although the time allotted to each appointment slot is often insufficient relative to patient need, staff attempt to make do by adapting patients to the schedule and the schedule to patients. I introduce the concept of “enslotment” to describe these practices.

By looking closely at scheduling and time management practices, it becomes clear that many patients who are cared for in the safety net may not be amenable to enslotment and that some clinicians refuse the goal of holding to the schedule. Chapter 3 focuses on the stories of patients who move more slowly than the system allows for, who have, as one nurse described it, a temporal orientation that is “non-congruent” with the flow imperative. Staff’s efforts and reflections on caring for these patients draw out the fragility of the kind

of time and temporal flow that is mandated by clinical organization. Their reflections on non-congruence illustrate a complex hierarchy of values within the temporal economy of the clinic.

In chapter 4, I analyze the practice of “protecting” time within and from clinical care. I describe the ways that clinical work, particularly documentation and outreach, overflow the time available. This type of work always risks interruption by patient care and thus, for some, requires “protected time.” I connect this concept to the broader distribution of time protection in team-based care. I analyze the labor of clerical staff, medical assistants and nurses as they are oriented to keeping the provider in time with the expectations of the health system and mitigating the harmful effects that clinical time pressure has on patients and colleagues. I examine the relationship between this organization of labor and other forms of valuation shaping the temporalities of work and career in each role.

In “Compass and Clock” (chapter 5), I revisit the recent rapid expansion of quality measurement and reporting in light of the clinical context in which metrics are generated and interpreted. Electronic health records (EHR) have been made necessary by, enabled and intensified the turn to metrics. I discuss the place of the EHR as a central object of frustration and promise within this regime. I analyze the temporal demands of metrics, which inscribe clinical practice within a necessarily progressive narrative of constant improvement. The pursuit of numbers is variously experienced as promising better patient care and as a repetitive cycle of intervention and neglect as priorities shift. Documentation and monitoring of practice through metrics are increasing in importance and yet the effort involved in creating and correcting the data appears less visible than direct patient care as a form of labor in the clinic. I describe how metrics function to generate a sense of urgency

around chronic or abstract concerns. I interrogate the temporal relationship between measurement and improvement.

In chapter 6, I examine the case of one implementation initiative, an effort to implement universal screening for depression, substance use and intimate partner violence. The name of the screening tool, Behavioral Health Vital Signs, sought to convey the importance of mental health for patient care. The implementation of the screener raised questions about its significance for individual patients and the broader population. In a context where providers already feel the need to interrupt and contain disclosures of trauma and emotional pain for fear of running out of time or being unable to respond, universal screening seemed both important and risky. This chapter builds on the preceding analyses of clinic flow, metrics and the shepherd's paradox. I argue that by focusing on different scales of time and population, discussions of the screener deferred reckoning with the limitations of clinical time and staffing, bracketing questions about the clinics' capacity to care for individual patients who were identified as suffering. This case also illustrates how moral claims and multiple time frames can contribute to the incremental intensification of labor for clinic staff.

The final chapter turns to the long term in the form of continuity of care. Continuity is a defining feature of primary care. Relationships built over time are what keep clinicians fulfilled as pressures related to clinical responsibility and fiscal sustainability threaten some with burnout. In this chapter I examine the complex relationship between trust and time in the clinic and the forces that enable and threaten continuity. The trust and knowledge generated through relationships over time has a complex and variable relationship to ideals of efficiency in the short term. Relationship is fundamental to the persistent efforts of



clinicians and staff to navigate their many obligations to individuals, population, colleagues and the institution. The potential for *care over time* creates space for action under daunting circumstances.

In a brief conclusion, I retrace the many temporal logics and practices that I have examined in this dissertation as they relate to the shepherd's paradox and theories of scale. I argue that it is necessary to move past false dichotomies in policy and anthropological critique to grapple with the complex relationships between individual and collective care, short and long term, and the limits and potential of care over time.

# Chapter 1. Patients are Waiting: Access, Cycle Time and Patient-Centered Care

When most of us think about waiting in healthcare, we might imagine the waiting room, or the empty exam room – with or without a clock – where we have waited to be seen by a healthcare provider. Another form of waiting pertains to the date of the appointment itself. You might want or need an appointment, but when you call to schedule, the first one available is weeks away. In my research, the terms used for measuring and monitoring these two forms of waiting were, respectively, “cycle time” and “access.” In this chapter, I discuss some of the ways that both forms of waiting are understood and their implications in relationship to the time spent in the patient visit. I trace the responses that measures of time as waiting evoked both administratively and in clinicians’ everyday calculations.

Anthropologists have studied how poverty structures one’s experience of time and self, in part through being made to wait (Auyero 2011; Sanz 2017; A. Cooper 2015). In the United States, access and wait times for appointments vary by socioeconomic status. For example, in studies of private physicians’ offices, children and adults with public insurance wait longer than their privately-insured peers for new patient appointments (K. V. Rhodes et al. 2017). One study has shown that in addition to variations in appointment access, patients with Medicaid also spend longer in the waiting room (Oostrom, Einav, and Finkelstein 2017). Federally Qualified Health Centers, like the clinics in this study, serve patients with public insurance or no insurance and offer greater new patient appointment access than most private offices (Richards et al. 2014). As such comparisons imply, discussions of wait times in this setting are laden with concerns about the just distribution

of healthcare and respect for patients through respect for their time. The clinicians that I studied were aware of these disparities in timeliness and would often comment on them through comparison to their own experiences in private healthcare settings.

While many call for greater investment in primary care generally and in safety-net clinics to ameliorate access to care, many health systems have also turned to streamlining techniques in hopes of increasing capacity without additional resources (IOM 2015b). Lean management is a model of process improvement from Toyota that is currently being widely adopted in healthcare settings, including the clinics that I studied.<sup>34</sup> Francesca Nicosia has described how, as Lean management techniques are implemented in a hospital setting, waiting becomes seen as “the worst of the wastes” (Nicosia 2017). The person waiting could be anyone – a staff member, a patient waiting to be admitted, a patient waiting to go home. In the hospital, patients not leaving limits the inflow of new patients, harming productivity. The necessity of attending to patient experience (as a quantitative measure) within contemporary economic logics of patient choice and care quality evaluation coexists with an imperative to rapidly treat and discharge patients in the name of hospital “flow.”

Meanwhile, based on an assumption about the negativity of waiting, patient experience becomes a *reason* to “move things along” (Kaufman 2005). Nicosia observes that many activities occur during “waiting,” including patients’ preparation to go home. Patients want to be returned home quickly, but not too quickly.

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<sup>34</sup> The adoption of Lean management in U.S. healthcare and research about this model have proliferated in the past couple decades (D’Andreamatteo et al. 2015). Studies have examined the organizational benefits and challenges of Lean implementation using both quantitative and qualitative methods (Nicosia et al. 2018; Yung et al. 2017; Waring and Bishop 2010). The turn to Lean is one of many manifestations of “flexible” work management strategies implemented since the late 20<sup>th</sup> century (c.f. Crowley et al. 2010; Hochschild 2001; Martin 1994)

The tempo and temporal structure of outpatient primary care are similar to and distinct from that of the hospital in a number of ways. Hospitals emphasize reductions in length of stay, analogous to the clinic's "cycle time," which operates on a smaller time scale. What is distinct from the hospital is that clinic time is appointment-based. Payment is based on the number of appointments completed, largely independent of what occurs during that visit. Patients come to appointments in the midst of a regular day, to which they may need to return. Sometimes they miss appointments. In order to maintain both revenue and access, clinics adjust for this by over-scheduling a session based on the average number of "no-shows." As a result, people working in the clinic often hope for a few patients not to show in order for their workload to remain tenable.

Patients arrive for their appointments regardless of current clinic capacity and if there is not space or staff to attend to them, they wait. Once their appointment starts, patients hope to receive time and attention adequate to their concerns – to be cared for not too quickly. Meanwhile, a prolonged appointment for one patient is directly linked to waiting for the patient who follows. This is not an abstract person waiting for a bed in the hospital, but another particular patient likely known to the clinician, for whom they feel responsible. The aspiration that appointments happen close to their scheduled time, combined with an overly-ambitious schedule driven by fiscal and access concerns, creates intense time pressure.

In discussions of access that do not address the question of adequate visit duration, the focus is on patients' waiting and the goal is to meet their needs faster. In the exam room, clinicians are faced with an ethical obligation to the patient in front of them that comes to be in tension with obligations to those outside in the waiting room or awaiting an

appointment. Real concern about both forms of waiting give a positive moral valence to clinical speed at the same time as clinicians and even managers recognize and sometimes resent the economic and ideological underpinnings of clinical time scarcity (c.f. Livne 2014). Thinking about access and the multiple implications of “cycle time” together raises questions about the meaning of “timeliness” and how to reconcile obligations to multiple patients under the heading of “patient-centered care.”

In *Friction*, Anna Tsing (2011, xi) focuses on “zones of awkward engagement” between different and sometimes apparently opposed stakeholders under the banner of certain universals (e.g. liberalism, Nature) that are never truly universal. Universals take on specific meanings in the contexts in which they are deployed and thus do not have uniform effects. In these zones of engagement, misunderstanding and “friction” propel, alter or impede social movements. Universals obscure potentially problematic collaborations even as they offer powerful headings under which contradictory political forms and interests can be united, for better or worse.

I take notions like patient-centeredness and access as universals in Tsing’s sense. The “friction” generated by the various and sometimes contradictory movements under these headings gives traction, simultaneously energizing and constraining the range of possible responses. They can be mobilized by powerful institutions to discipline clinical work and by advocates and activists as urgent imperatives. Clinicians and researchers call for patient-centeredness to mobilize resources necessary for adequate care. Meanwhile, within the context of understaffed clinics and a financial imperative for high visit volume, the same terms can displace labor concerns in the name of patient care.

Below, I trace the varied definitions of access because “access,” like many value-laden terms, carries multiple meanings that may not necessitate the same response. For example, whether “timely” care is evaluated based on convenience, fairness or clinical triage criteria has implications for both outcomes and potential solutions. Often, such distinct orientations are blurred under generic values like “timeliness” and patient-centeredness.

## **Access**

Definitions of access to primary care are multiple. Some providers in this study saw “access” in absolute terms – patients could access a form of care if needed through the nurse advice line, a drop-in visit with a nurse in the primary care clinic, urgent care or the emergency room.<sup>35</sup> Formally, access was discussed in terms of access to scheduled primary care appointments. Access in both senses has historically been challenging for the clinics I studied. For the network that they are a part of, one way that access is measured is by a composite score of patient survey data related to patients’ perceived ability to obtain urgent and non-urgent care as soon as needed and answers to medical questions in the same day. Access as a metric is tracked over time using the Third Next Available Appointment (TNAA), a measure of “return,” non-acute appointment availability (IHI n.d.c.). The third appointment is used to avoid wide fluctuations in the metric due to last minute cancellations. During my research, the average TNAA was on the scale of several weeks and the goal was to have it under two weeks. Access has not always been understood this way.

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<sup>35</sup> While limited, other clinics in the same network do hold evening clinics and offer urgent care and there is a nurse advice line which recently extended its hours.

In 1993, a commission of the Institute of Medicine (IOM) was convened to define measures to track access to personal healthcare. The definition they developed for access was “the timely use of personal health services to achieve the best possible health outcomes” (4). Historically, access was primarily studied in terms of financial and geographic barriers to treatment, including lack of insurance. The 1993 report proposed a number of indicators that might more fully represent disparities in access, including birth outcomes, prevention and early detection of diseases, chronic illness management and “reduced morbidity and pain through timely and appropriate treatment” (2). Here, timely treatment seems to refer to clinically appropriate urgency. The committee urged policymakers to think beyond the rate of insurance coverage and number and geographic distribution of providers to identify other barriers to access that could explain disparities in health equity.

Twenty-two years later, another committee convened by the IOM maintained that among aspects of quality that include safety, effectiveness, efficiency, equity and patient-centeredness, “timeliness is in some ways the least well studied and understood” (IOM 2015b, 1). The 2015 report was commissioned by the Veterans Health Administration after a scandal regarding lack of access and egregiously long wait times for appointments. The committee, charged with reviewing current knowledge about access and scheduling and making recommendations about new standards, identified models that improve wait times with “either neutral or positive effects on the quality of care and patient experience” (3). Among the models discussed in their report are advanced access scheduling, team-based care and phone visits. While describing the complexity of factors hindering access to care,

the committee insists that the solution lies in process engineering and culture change at the level of clinics and health systems.

Between 1993 and 2015, emphasis on quality measurement increased, including for many of the health indicators named in the 1993 report as related to the social determinants of health. Access to insurance coverage also increased through the Affordable Care Act and Medicaid expansions. Between the two reports, there was a shift in definitions of access toward a more technical focus on scheduling, appointment availability and “telehealth” alternatives to in-person care. In the recent health policy literature, concerns about access often focus on difficulty finding a regular provider, access to medical advice after hours and “timely” appointments (Bodenheimer and Pham 2010).

The 2015 report by the IOM’s “Committee on Optimizing Scheduling in Health Care” is subtitled “Getting to Now.” The report concludes with the aspiration that with the correct organizational and process changes, “The basics of a culture of service excellence... will help ensure that every patient – whether they are seeking help immediately or at a later point – receives the right care at the time they need or expect it.” (90). This language contains several important matters of concern related to patient access to healthcare. Timeliness here is rhetorically defined as “now,” though actual benchmarks for appropriate wait times have not been established. The necessity of convenient care is framed in terms of both clinical need and personal expectation.<sup>36</sup>

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<sup>36</sup> One of the challenges that makes definitions of “quality” difficult to establish is that of incorporating or appearing to incorporate the views of all “stakeholders,” which Medicare defines as “consumers, businesses, payers, providers, and state partners” (Centers for Medicare & Medicaid Services 2015a). Perhaps the hardest view to generalize and incorporate is that of the patients (here labeled consumers). The use of patient satisfaction surveys fills this role, though the content of those surveys and their ability to accurately represent the work of healthcare providers in contentious (c.f. Nicosia 2017, Pine 2011).



“Wait time” in discussions of access does not refer to the time spent in waiting rooms. Rather, it emphasizes appointment availability and the time between when one needs or desires an appointment and when one is available. Extended wait times for appointments are associated with worse health outcomes, both directly through delayed care and indirectly through patient dissatisfaction, which may cause some to delay seeking care when it is needed (IOM 2015b). In addition to negative influence on individual patient satisfaction, long waits for appointments are “also associated with higher rates of appointment no-shows” (12), which further exacerbate the access problem.

Concerns about access are deeply embedded in the financial structure of the health system. The format and number of appointments scheduled is structured by fiscal rationalities and dependent on infrastructure like space and staffing. Barriers related to income, employment and transportation leave some patients out of care even if they have access to Medicaid (Syed, Gerber, and Sharp 2013; Hefner, Wexler, and McAlearney 2015) A sense of patients’ vulnerability and logistical barriers to care makes it such that “access” in the clinics I studied establishes a powerful moral imperative tied to productivity as a means of remaining available to the patient population. As one provider, Dr. Lee told me: “[As] a safety-net system we need to get as many patients in as we can. We don't want patients to be out floating around without primary care who should have primary care with us.”

Dr. Lee elaborated the tension between what is possible and what is made necessary by the funding structure of the clinic and the vulnerability of her patients. In order to ensure ongoing care for patients while their providers were on leave or vacation, clinicians took turns providing “coverage,” renewing prescriptions and reviewing test results and messages for their colleagues. Dr. Lee told me that negotiating to have fewer visits of

her own on days when she provided coverage for other PCPs felt like she was taking away slots from patients who needed them. She also described how, even with a panel of patients that was slightly smaller because of her patients' complexity, it was difficult to provide what she felt was adequate care and maintain access:

*Dr. Lee: What we typically use [to measure access is] the third next available appointment – that's a measure of time, waiting for that appointment. We don't want that third next available to be months [away], like mine is now. And then another issue is the acuity of the patients. So, last time I was in clinic I had patients, you know, I felt like every patient, I was saying "return to see me in two weeks, four weeks." And you don't want to do that. Like, those are all slots that will be taken up. You want to say six months or one year. But the fact of the matter is our patients are sick enough and psychosocially complex enough, that [a] patient [who is] by himself and demented and confused, you know, I can't wait two months to see him... he needs to be seen in three weeks! So, but that's a lot [of patients] in three weeks, and that makes my access suck. [Laughter] So, there's just a lot of different things in tension.*

*S: ...[How do] you balance the access with the patient you're seeing?*

*Dr. Lee: You know, about five years ago in our system... [a physician in a leadership position] said, "You know, if you're gonna write two months for follow-up, just write three." [Laughter] "Just do it." And I was profoundly uncomfortable with that because I feel like the most important factor needs to be what the patient needs. And, it's true that that's a completely subjective measure. It's what I think patient needs. Sometimes it's what the patient thinks they need... I think her point was that – that subjective measure of what we think the follow-up interval should be – and, I don't know, she said it's been studied but, again, I don't know if this was in a safety-net setting or whatever, but, she said that primary care doctors tend to be too conservative. The patient can actually follow up later than we think, outside of certain things like, you know in diabetes you should get their A1c in – whatever [time period]. I think she was trying to make a corrective, but it bothered me.*

Dr. Lee had a panel of relatively older patients with several comorbidities. She chronically struggled with poor "access." Dr. Lee's off-hand question about whether the

recommendation to extend follow-up times was studied in a safety-net context marked her belief that her patients may have unique needs compared to the general population. Dr. Lee and her colleagues insisted that their patients' socioeconomic vulnerability, in addition to their medical complexity, made them hesitate to recommend intervals that were too long.

Several studies and models have attempted to make sense of return visit scheduling, but results are mixed.<sup>37</sup> Scheduling practices vary widely and the impact of current scheduling practices on outcomes is poorly understood (Schwartz et al. 1999; Javorsky, Robinson, and Kimball 2014). The absence of technical standards of practice for follow-up intervals in primary care provides Dr. Lee with the flexibility to use her own judgement and to negotiate with patients about an appropriate time. This judgement requires an uncomfortable and implicit process of reconciling one patients' needs with others' access. Dr. Lee's ethical response is to focus her recommendation on the patient in front of her. A similar negotiation is required for managing time within a given visit or session.

### **Cycle Time**

In years prior to my dissertation fieldwork, "cycle time," or the amount of time that patients spend in the clinic, was a major focus for improvement in the primary care clinics in this study. In my dissertation fieldwork, clinic directors seemed to feel that they had made what changes they could, but that remaining constraints made cycle time difficult to "improve" (i.e. shorten). Some of the barriers to better cycle times that they cited included

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<sup>37</sup> A study that specifically tested prolonging revisit intervals showed that, supported by interim visits with nurses, reducing primary care provider visit frequency did not compromise health outcomes (Schechtman et al. 2005). In other studies, higher revisit frequency has been linked to modest improvements in chronic illness process and outcome measures (Asao et al. 2014; Alexander et al. 2010). The authors of the latter two studies acknowledge that their methods cannot account for patient preference regarding visit frequency. Open or advanced access scheduling, a model for reducing wait times, has shown mixed or negative effects on health outcomes for patients with chronic illness (Rose, Ross, and Horwitz 2011; Subramanian et al. 2009).

visit volume requirements, patients’ medical complexity, patients arriving late, staffing and work hour protections for staff.

While the visit time with a primary care provider in the room is, on paper, limited to 15 or 20 minutes, overall visit duration is considerably longer, including the registration process, time waiting to be called into an exam room, the intake process conducted by a medical assistant, the visit with a provider, the discharge process and any waiting in between. “Cycle time” refers to the total duration of a patient’s visit to the clinic, often captured by the electronic medical record. Below is an illustration of the office visit screen of the electronic health record (See figure 1.1). When patients arrive, their visit status (the column pictured here with the colored boxes) is updated to ARR. Then, the “Status” column is updated at each phase of the visit: eligibility done, intake, provider, order discharge. “Duration” on this screen is what is often called “cycle time.” The value automatically turns red after 1 hour, based on an assumption built into the computer program that cycle times should remain under 1 hour.

Visit Type	Appt Time	Patient Name	P/R*	Reason	Sex	Age	Visit Status	Arr Time	Duration	Room	Status
RT	8:00 AM	LIDDELL, ALICE	06DODG	Well Child Check	F	12 Y	CHK	8:03 AM			
RT	8:20 AM	CHESHIRE, CATHERINE	06DODG	f/u BP	F	63 Y	SCHED				
OA	8:40 AM	MARCH, HARRY	06DODG	Post-hosp d/c	M	57 Y	ARR	8:38 AM	1h, 10m	A	Order d/c
RT	9:00 AM	TENNIEL, JOHN	06DODG	f/u DM, HTN	M	56 Y	ARR	8:56 AM	52 m	C	Provider
RT	9:20 AM	HATTER, MADELEINE	06DODG	Rash	F	6 Y	ARR	9:29 AM	19 m	B	Ready
NW	9:40 AM	WHITE, ROBERT	06DODG	Knee Pain	M	42 Y	LATE				
RT	10:00 AM	CARROLL, LEWIS	06DODG	Chronic pain	M	65 Y	ARR	9:45 AM	3 m		Elig Done
RT	10:20 AM	HART, REGINA	06DODG	4 wk post-partum	F	32 Y	SCHED				
OA	11:00 AM	PILLAR, KATIE	06DODG	Cough	F	26 Y	SCHED				

**Figure 1.1.** Reproduction of an office visit screen. Patients are fictional.

This tool has multiple purposes. It allows colleagues to know where a patient may be and who may be with them, based on the room number and status. Providers steal glances at this screen during visits to see how many of their patients have arrived and are waiting to

be seen. It also very roughly captures the flow of patients through the clinic for evaluation and quality improvement.

At each monthly network-wide meeting of clinic management teams, one clinic was asked to present a recent improvement project. At one such meeting early in my fieldwork, the presenting clinic's medical director described cycle time as their "challenging" project. He started by "painting a picture." "Our patients' time is valuable," he said, stating as a truism that time is valuable for "all of us, whether providers or patients." Relatedly, he observed, long wait times have been cited as a major cause of low patient satisfaction (c.f. IOM 2015b; Bleustein et al. 2014). In addition, the presenter said that their clinic management wanted to allow staff to end clinic on time. Then, he added: "Lastly, of course, it's a PIP [Performance Improvement Program] measure."

This was a common technique for framing issues at these meetings. The presenter would lead with one or two moral claims about how improving a certain measure would improve the lives of patients and/or staff, then mention as if offhand that the measure is also a performance-based payment metric. I do not intend to imply that this linking of financially-incentivized initiatives to other patient care values is insincere. Metrics, in theory, reflect opportunities to improve patient care and often entail moral as well as financial value. I return to the temporality of metrics in chapter 5, but for now the salient features that stand out in the discussion that follows are that metrics are based on quantitative averages of processes with complicated underlying variables. Once "improvement" is defined as an increase or reduction in the average, ongoing progress in that direction is imperative.

The presenter's assertion that "time is valuable" implicitly led into the effort to reduce the time patients spend in clinic. In the presentation that followed, *overall* cycle time was discussed as a performance improvement measure, serving as a proxy for waiting. The goal of reducing patient time in the clinic *overall* raised questions about how to distinguish between waiting or wasted time in the visit cycle and time that was beneficial to patients.<sup>38</sup>

The speaker continued, presenting the data from his clinic's quality improvement project, in which cycle time at "baseline" was more than an hour. He broke it down into the averages for different phases: Arrival to check in, total time waiting, intake, time with provider, time with other clinicians, interval from discharge order to departure. The clinic's goal was to reduce cycle time by four minutes. The speaker chuckled – that seemed feasible. They used common quality improvement techniques: a fishbone diagram to identify "root causes" and a PDSA, a small test of an intervention intended to improve workflow. Their interventions included a midway call and chart prep. The midway call is when an MA calls the provider in the exam room halfway through the appointment as a sort of time check and tool for the provider to shift the conversation's direction if needed (c.f. chapter 2). Chart prep refers to reading through recent notes or inventories in a patients' record to know in advance what the patient needs from a preventive or chronic care perspective.

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<sup>38</sup> This goal of reducing time in the clinic appears opposed to approaches that insist that good care often takes time (c.f. Sweet 2017). In my observations, these two views are both present, as articulated in the comments below about not rushing and the effort to distinguish "value-added" time. The distinction itself involves a number of assumptions (c.f. Nicosia 2017).

The presenter explained that the clinic also asked patients not to come in too early and they changed their scheduling template from 15 to 20 minutes per appointment. Asking patients *not* to come early drew laughter from the audience. I took this to reference a perception often expressed during my observations that patient *lateness* was the problem. The clinic presenting this data had a reputation for having a particularly punctual patient population relative to other clinics in the system. The speaker acknowledged that patients often arrived early because they were dependent on family or the bus for transportation. In my observations of other clinics, I also witnessed some early arrivals. When this happened, clerical and nursing staff debated when the early patients should be checked in, as it was their registration in the computer that effectively started the cycle time “clock.”<sup>39</sup>

In the presentation given at the management meeting, the clinic’s choice to change the scheduling template stood out to me because in my discussions of visit duration with clinicians and managers, the schedule seemed relatively fixed. By spacing the visits five minutes further apart, the presenting clinic accommodated the average time their providers were actually spending with patients, an adjustment that at least one of the clinics I studied felt unable to do for a number of logistical reasons, including accommodating late patients (c.f. chapter 2). As the outcome of the presented improvement effort showed, this average did not necessarily represent an adequate amount of time to offer comprehensive care. It was likely shaped by a compromise between the 15-minute schedule and patient needs.<sup>40</sup>

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<sup>39</sup> This study cannot address whether patient punctuality varied significantly by clinic or influenced cycle time. The observation of laughter in the meeting, however, speaks to the perception that patient lateness is a chronic problem. One recent study in a different setting (academic specialty clinics) demonstrated that the influence of patient punctuality on clinic flow is complicated by adjustments in clinician behavior such that there is little absolute effect on average waits, delays or overtime (Chambers et al. 2016).

<sup>40</sup> Studies have shown that the duration of appointments according to the schedule heavily influences their duration in practice (Tai-Seale, McGuire, and Zhang 2007; Tai-Seale and McGuire 2012).

In practice, the interventions failed in the sense that cycle time increased by five minutes to 69 minutes total. The presenter broke it down: The midway call worked okay. The chart prep brought up more issues during visits, making them longer.<sup>41</sup> Patients were arriving even earlier, which extended their cycle time. During the Q&A, other clinic managers wondered aloud if there was a way to ignore the early arrival “problem” and other limitations of cycle time as a measure. For example, using more health services adds to cycle time. The presenter agreed, saying that in light of this, they tried to distinguish wait time from “value-added time.” Similarly, he added that they did not want providers to rush appointments, as “that’s not good care.”

In this clinic’s quality improvement presentation, the logic of efficiency, in which shorter is better, confronts the challenge of distinguishing wasted from “value-added” time, of moving quickly but not too quickly (Nicosia 2017). The distinction of “value-added” also depends on one’s focus: “value-added” time for one patient may mean the “wasted” time of waiting for another. Although everyone clearly understood the limitations of total “cycle time” as a proxy for characterizing “good care,” it was nonetheless a metric that weighed on clinical practice. Several people referred to cycle time tracking as a practice of “shaming” clinic staff and providers for something felt to be largely out of their control. Meanwhile, those with cycle times under an hour received special “recognition” in one clinic’s staff meetings. In practice, cycle time referred to a flawed metric, but it also could reference something more qualitative and ethically laden – patients waiting. In this way, the abstract

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<sup>41</sup> Some providers I had shadowed elsewhere had abandoned chart prep because they felt they were wasting time preparing for patients they may not see after some missed their appointments and others dropped in. MAs also ideally did chart prep or “scrubbing,” identifying patients’ healthcare maintenance needs so that they could offer tests in person rather than having to call the patient later. A limiting factor for MAs was that time for this preparation would not be available if the MA was needed to cover a staffing shortage or a colleague out sick. I return to these themes in later chapters.



idea of cycle time, which focused on the average duration of individual appointments articulated with other temporalities of care such as “flow” (chapter 2).

### **Patients are Waiting!**

Studies like the “cycle time” improvement project just described attempt to ameliorate the gap between patient needs and clinic capacity using existing resources, eventually hitting a limit. At another meeting, an activity focused on reducing patient wait times quickly ran up against this problem and highlighted the tensions between waiting, access and time with patients given the current structure of care. In front of a room full of clinic managers, an administrator on the “patient experience” team put up a slide to transition to the next activity. The slide had “Patients are waiting!” written in a quote bubble on the side. Each clinic was asked to discuss a poster about “patient experience” that was made for them and the discussions were facilitated by someone from another clinic or from the central administration. The posters contained quotes from staff about ways to improve patient experience and quotes from patient surveys. The quotes were represented in colorful quote bubbles pasted onto each poster. In addition to the quotes, the posters included graphs generated based on “service recovery” records (responses to patient grievances) and data from the CG-CAHPS, a standard patient satisfaction survey.

Topics discussed in the comments included services for pain and mental health, care coordination and staffing. Some patients felt disrespected or humiliated due to cancelled appointments or impolite staff. Many of the quotes had to do with wait times and visit duration. For example, staff wrote things like: “Providers are late seeing patients. [They should be] more lenient of [sic] seeing late patients,” and “As a team, we

need to have team spirit [and] be quick to attend to the needs of the patient and to cut down the wait time.” One patient emphasized long wait times, while others emphasized short visit duration, writing things like: “I think appointments should not be defined by the 15-minute time limit I seem to always experience.”<sup>42</sup>

Finally, the posters had attached to them a half sheet of paper on which it said:

*Based on what we know, adopting ICARE for...*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

*will improve patient and care team/staff experience at [health center/clinic].*

The quotes and survey results raised temporal issues that are deeply felt by both patients and staff and are often opposed to one another – the visits are too short, but the waits are too long. It is repeatedly acknowledged in the policy literature that one solution to this mismatch would be to increase the supply of services by training and hiring clinicians and investing in care infrastructure. Yet it is also taken for granted that these solutions are financially or ideologically out of reach in the near future (e.g. IOM 2015b; Shipman and Sinsky 2013). What stood out about these posters was that that the limited options for addressing the problem of patients waiting already seemed built in. By framing the solutions worksheet in terms of “adopting ICARE” to improve patient experience, the activity itself focused on *communication* around waiting.<sup>43</sup>

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<sup>42</sup> These examples are a compilation from two clinics.

<sup>43</sup> Responding to patient feedback could hypothetically entail broader changes. This interpretation of the implications of the activity is informed by focus of the ICARE model on “service recovery” in the moment of the interaction in which a grievance is aired and by the discussion that ensued.

ICARE is a “Service Recovery” model that stands for: Introduce, Connect, Ask, Respond, Exit. Managers and staff at the clinics I studied were trained in this model and scripted techniques for responding to grievances. After the meeting, I realized that while the activity was verbally framed more broadly, the inclusion of the ICARE model suggested something about the possibilities for improving care experience or addressing the fact that “patients are waiting.” The focus was on acknowledgement, apology and communication about existing options. I do not mean to dismiss these as unimportant elements of care. What I am drawing attention to is that solving the underlying causes of patients’ frustrations was already out of reach in this short activity.

The fact that the persistence of delays and patient frustration was already a foregone conclusion was born out in the conversation that followed with one clinic management team. Two central administrators were paired with our group. “Timeliness” quickly became the focus of the conversation. The CG-CAHPS survey data suggested that patients could not get urgent care appointments. Clinic managers contested that idea, insisting that they never turn people away. That said, it can take hours for a drop-in patient to be seen. One strategy discussed in response was to explicitly tell people how long the wait would be for a drop-in appointment and offer to schedule an appointment for another time or refer patients to other resources within the network, such as the urgent care center.

By the end of the conversation, the “actions” written on the prepared slip included: Medical assistants informing patients of wait times when patients are waiting in exam rooms; front desk staff informing patients and updating them about wait times in the waiting room and the creation of a board with information about the nurse advice line and

urgent care options.<sup>44</sup> These “actions,” represented what seemed feasible to clinic staff and administrators. They focused on communication and emotional labor in the face of seemingly unresolvable challenges regarding clinical time. In practice, the explanation given to patients for delays is generally simply that the patient’s provider is behind or with another patient. One cannot acknowledge that most appointments after a certain time are late because of the structure of the schedule.

Emphasis on “messaging” was a recurring theme in discussions of patient and staff satisfaction. In essence, this suggests that part of the problem is that staff or patients misunderstand what was being offered. The purpose of such messaging is two-fold: To inform patients that they *do* have other options for urgent care and to convey to them that what they are receiving when they “drop in” *is* urgent care, thus hopefully improving patient survey responses related to access without needing to fundamentally alter care (Nicosia 2017; Pine 2011). The onus for this communication is placed here on medical assistants and front desk staff. As I will elaborate in later chapters, in my research, responding to patient frustrations with clinic delays was a significant part of clinic staff’s labor that some felt went unrecognized. As one clerical staff member put it, anticipating a very full clinic the next day: “We take the heat out here” (c.f. chapter 4). Meanwhile, in the clinic exam rooms, providers and staff make explicit and implicit decisions to balance concerns about waiting with comprehensive care.

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<sup>44</sup> Remember that two types of appointments are being discussed. Communication around wait times applied to both scheduled and drop-in appointments. What might be considered a reasonable wait for the two types may vary. The information board was geared toward shaping patients’ expectations about dropping in for urgent care and offering other options.

## **A Constant State of Tension**

As Dr. Lee described above, cycle time, access and quality care are often “in tension.” Recall that in the recent IOM report (2015), access was framed as a question of timely care for “each patient.” Although assessing supply and demand was repeatedly emphasized in the report, access was discussed in isolation from the content of the appointments accessed. In my discussions of access with primary care clinicians, a tradeoff between appropriate care for some patients and remaining available to others was always present. People responded in different ways.

I witnessed several providers creating “access” where there was none by having appointments double-booked or by calling patients during or after clinic to follow up on an issue rather than have them come in. Within a clinic visit, providers also hesitated to ask certain patients to return for care that could be provided the same day, in case they did not return. In these ways, concerns about access fed back into the sense of time pressure in a given clinic session. One provider told me about a friend of hers who works in a private clinic. The friend, she told me, says that “their drivers” are that they have a set amount of time and “if we don’t get to your cough, we’ll make an appointment for you to come back next week.” By contrast, here in the safety net, she told me, the focus is on “access” and “I can’t say come back next week,” because there are no appointments available. She says they work “to keep patients out of clinic” through preventative care and addressing several things per visit so that those awaiting appointments can get in. There is a name for this practice: max-packing (c.f. IHI n.d.a.).

*Dr. Lee: [I] find that there is a significant entropy around primary care because- you know, they – one primary care redesign person called it “max-packing.”*

*Like, you know, if you have the opportunity, to pack in as many things as you can for a patient's visit. And that visit is going to take three hours. It just is. You know, if you wanted to do the full, everything, all the immunizations, the breast exam, the Pap smear, inquire about the family history, like really do the beautiful, thorough job that patients deserve, then that actually takes too much time. It takes time that we don't have. And it steals time from another patient. So, it's – I feel like it's a constant state of tension.*

The tension between comprehensiveness and speed is not limited to primary care. It is learned early by medical students and applies across many professions and personal pursuits within and outside of healthcare.<sup>45</sup> Dr. Lee again calls attention to the deep and chronic sense of that tension in her practice, arising from the breadth of the primary care mandate and her simultaneous obligation to each of her patients. While “stealing” was a particularly pointed term, the zero-sum dynamic between patients in clinic time was a recurring theme. Spending too long with one patient risked not only making others wait but short-changing subsequent patients to make up for lost time.

### **[Never] Enough Time**

Fieldnote, Clinic QI Meeting

*Sitting around a small table at their regular QI meeting, clinic managers review the results of a recent “pilot” of a new patient experience survey. It is an electronic survey of patients sent by text after their visits. It asks a series of questions on the common scale of: Never, Sometimes, Often, Always.*

*The survey was rolled out for this clinic on a trial basis one week ago and they already have 17 responses. As they go through the questions, someone happily observes that “No one said never!” to the CG-CAHPS question about getting a routine visit when you needed one.*

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<sup>45</sup> Mizrahi (1986) observes that the relative importance of demonstrating compulsiveness and efficiency varies by stage of training but clinicians are always expected to maintain a basic level of both.

*Some of the questions only have a few responses in the results. Ariana, the practice manager, explains that when the survey went live, all the possible questions were selected, making the survey too long. Ariana went in quickly to 'uncheck,' or exclude, some of the questions.*

*One of the questions Ariana removed from the survey was: "How often did your provider spend enough time with you?"*

*I ask her what her rationale was. Self-conscious of being perceived as a nosey anthropologist and interrupting the meeting near the end, I jokingly add: "No reason I'm asking..."*

*Ariana explains that it was a less important question to her.*

*Dr. Moore adds, reluctantly but matter-of-factly, "We can't offer more time."*

*Ariana agrees and elaborates: There's nothing they can do in response to the question, particularly since the survey is anonymous and cannot be linked to cycle time.*

*Dr. Moore says, hypothetically, "Maybe the patient was there for a half an hour and they still feel it wasn't enough."*

*Among the comments that follow are sentiments I have heard before: "It's all perception" and "It's never enough."*

*Dr. Moore has an idea that she thinks would be good for my "time study." Say, for example, we did ask that question and Dr. A has the lowest cycle times and her patients are all satisfied on the question. Then, we would need to study how she's using her time in visits such that patients feel like it's long enough – "What's the sauce [as in the secret]?"*

*Sadly, Ariana points out, the answers could not even be linked to a particular provider.*

There are a number of elements in this brief exchange that offer insight into the fundamental issues of time in relation to quality of care. First was the response to the access question, "No one said never!" Although surveys like this are supposed to inform efforts striving toward quality or excellence, they also often serve as reassurance about

current practice, conveying the message: things are not terrible. Secondly, Ariana moved quickly to prioritize questions because she did not want to send patients too long a survey. Based on other conversations, this was likely both about respecting patients' time and, in turn, about getting more survey responses back. The CG-CAHPS survey, one of the widely-used standard national tools for measuring patient experience, contains at least 31 questions. The two key reasons for trying this electronic survey were: it was more focused and would offer more real-time information, which was more "actionable," than longer standard surveys like CG-CAHPS that are administered by mail.

Most interesting was how readily the question about "enough time" was dismissed. That is, the perception was that it would not be useful to elicit information about whether or not patients felt enough time was spent with them since it was not actionable. These clinicians and managers did not see any way to add time to the duration of visits and turned to potential elements of "quality" independent of time. Faced with fiscal and logistical constraints, Dr. Moore pivoted to focus on perception and individual provider skills or attitudes that left patients *feeling* that the visit was long enough. In the professional literature, people have tried hard to find "the sauce," the tricks that could be adopted by any provider to increase patient satisfaction independent of true visit duration (Heritage and Maynard 2006; Dugdale, Epstein, and Pantilat 1999).<sup>46</sup> While some call for fundamentally altering the structure of care visits through payment reform, this literature emphasizes communication skills that accommodate time constraints.

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<sup>46</sup> One example that was frequently cited in my own medical training, from an inpatient study, is that whether a provider sits or stands during an interaction impacts time perception (Swayden et al. 2012).



The notion that “enough time” is defined by communication rather than duration is written into the suggested interpretation of the survey question that Ariana excluded. Based on the guidelines from the Agency for Healthcare Research and Quality (AHRQ 2016) the “enough time” question is to be taken as a measure of provider communication quality (See table 1.1). This linking of communication and time could be read both ways. Does the provider have enough time to communicate well (c.f. Ludmerer 1999)? The search for the secret to good cycle times suggests that the link often goes the other way – good communication will leave patients with the *sense* that they had enough time.

**Table 1.1.** AHRQ (2016) CG-CAHPS Quality Measures, emphasis added

<b>Getting Timely Appointments, Care, and Information</b>	
Q6	Patient got appointment for urgent care as soon as needed
Q8	Patient got appointment for non-urgent care as soon as needed
Q10	Patient got answer to medical question the same day he/she contacted provider's office
<b>How Well Providers Communicate with Patients</b>	
Q11	Provider explained things in a way that was easy to understand
Q12	Provider listened carefully to patient
Q14	Provider showed respect for what patient had to say
<b>Q15</b>	<b>Provider spent enough time with patient</b>
<b>Providers' Use of Information to Coordinate Patient Care</b>	
Q13	Provider knew important information about patient's medical history
Q17	Someone from provider's office followed up with patient to give results of blood test, x-ray, or other test
Q20	Someone from provider's office talked about all prescription medications being taken
<b>Helpful, Courteous, and Respectful Office Staff</b>	
Q21	Clerks and receptionists were helpful
Q22	Clerks and receptionists were courteous and respectful
<b>Patients' Rating of the Provider</b>	
Q18	Rating of provider

Policies and actors thus hold simultaneous understandings of time as rigid, uniform and countable as well as subjective, perception-based and manipulable. Similar to the focus on messaging and service recovery in the above discussion, here it is not the time – which seems immovable – but its perception that is the key to patient experience (c.f. Lin et al. 2001). Perceptual manipulability becomes the solution to the inadequacy of linear time – or

labor or space. However, some of those I studied questioned the ethics and effectiveness of this solution.

### **Cycle Time Revisited**

I asked Dr. Silva how much control she felt she had over her time at work. She was laughing before I finished my question.

*Dr. Silva: Uh, I don't have any control over my time at work. I mean, I think that, you know, the minute you walk in the door, you're a prisoner to cycle time... I'm constantly hustling to get through, and... it's never going to change, the amount – like, no matter how efficiently or effectively I work...*

Here, Dr. Silva's feeling of being a "prisoner to cycle time" references the fact that ideals about appropriate appointment duration, embedded in the clinic schedule, are impossible to realize given the scope of her task. She feels like greater efficiency will not solve her problem, perhaps because there is always more that could be done. Cycle time in this usage is both a measure and a short hand for the pressured experience of time in the clinic.

After describing the sense that she is "always hustling to get through... no matter how efficiently or effectively I work," Dr. Silva added, "sometimes I give myself an excuse to just be okay with that." Although she later reiterated her aspiration to stay on time, Dr. Silva here describes a sense that the work expands to fill the time regardless. Sometimes, she surrenders to this idea and the needs of the present patient. As an example, she went on to tell me:

*Dr. Silva: Today I had a patient who was coming in for vertigo. I was dealing with that, but then in talking to him, he sort of disclosed that he lost his son to a drowning accident a few years ago. And, that's a moment where I am like, I know*

*that I have three, four people waiting, but you have to deal with it, because I can't dismiss that and I have to follow that. For you to disclose that sort of information and become tearful during a visit, my responsibility is then to provide support and then try to get behavioral health to come meet with him, because [that's] a lot of grieving that has never really happened, you know? And so, those are the moments where I know I don't have time, or control over [my time], but I'm just gonna deal with the consequences of it by trying to catch up with the next patients.*

She continued, shifting toward more general patterns:

*...I know that I don't have control over my time, and so I always ask my medical assistant to call me and keep me on, because I like to listen to patients and I like to hear what they have to say... So, kinda balancing that with trying to listen to them but not for too long. And so I tend to be the type of person that tries to set an agenda, but I'm okay with letting it go a little bit so that patients feel heard. And so to not get, I guess, screwed at the end of the day, because of that, I use my medical assistant to call me or interrupt me... You know, we have a schedule... 20 minutes per patient. So we make it work.*

*S: At what point in the visit does [your medical assistant] call you?*

*Dr. Silva: Usually she'll call me if I have more than two patients waiting. Yeah. Then, she'll call and say, "Hey, we have three patients," and that's my, like – It sort of takes me out of that zone... I had a provider who once told me that patients can sometimes hypnotize you without you knowing it, or you're just sort of listening to them and you don't know how to interject, and phone calls are a great way to break that... I have her call me, and then, it's like, "Oh, sorry, I'm actually in clinic. Moving on..."*

As I have detailed in this chapter, the suspension of clock time for a patient in need is still always in tension with the rest of the clinic schedule. Awareness of this tension can be more or less imposing – whether the provider is “hypnotized” or acutely aware of the patients waiting outside. In Dr. Silva’s description, “I’m actually in clinic,” seems to mean, “I can’t listen in this way.” Others are waiting and she must move on. In later chapters, I discuss

strategies like the medical assistant's phone call aimed at bringing her back to the schedule. Notably, in Dr. Silva's description, the call is timed by the number of patients waiting, not an absolute delay.

I asked Dr. Silva if cycle time was something she thought of as a metric or in terms of waiting. In response, she explained how waiting begets more waiting:

*No, I don't think of it as a metric. Like, I know there is a metric, but I think of it as patients waiting.... I really want to stick to the time. It's sort of like something to strive for, right? ... I have noticed and I have heard this and it's true, that the more you make a patient wait, the more time you take with that next patient. And so, I know it if I take too long with one patient, I'm going to end up taking too long with the next one too, because [I] feel guilty and so I let them talk more and make them feel like their visit was worth the time that they waited. And so to erase all that... the other thing that I do is, if I feel like somebody is very complex and is going to need a lot from me, and it's gonna mess up my cycle time and make people wait, then I try to see: who can come in and do some stuff for this patient while I see the next patient? 'Cause, I'll see that the next patient is just here for, like, a follow-up on blood pressure. I can do that one quick, and then come back to this patient so that I'm not trying to make the second person feel validated.*

This is another dynamic that complicates the question of "timely" care. Rather than feel pressure to end a delayed patients' visit sooner to get him on with his day, Dr. Silva feels a sort of time debt that must be paid with more attention (i.e. time).

### **Who is "the patient?"**

*"My experience has been that when you're able to put the patient front and center and let their voice, sort of, direct the work and the vision, at least for providers, it seems to be a lot more effective than, like, this," [holding up a chart].*

*– Stephanie, member of the health system administration*

In the quote above, an administrator concerned with patient experience named Stephanie contrasts “the patient” as an individual with an experience and a voice to charts of population- or panel-based metrics. However, during our conversation and in the ethnographic stories in this chapter, at a given time “the patient” as used in this quote could represent any of these: individual subject, collective of patients in a given clinic, population. As discussed in the introduction, one of the ways that Foucault (2007) described the care of individuals and populations was by analogy to the parable of shepherd in the New Testament. The contradiction in “leaving the 99” to save the one sheep that has strayed, yet not losing any echoes in the simultaneous imperatives to provide thorough and attentive care to each and every patient while eliminating waiting – both for access and in the clinic.

The ambivalence between individual and collective in such uses of “the patient” as a figure obscures the fundamental paradox in which attending to one patient’s needs may cause delays for others. Is it “patient-centered” to spend the time that the patient in front of you needs to feel cared for, knowing that three others are waiting outside, potentially feeling disrespected or facing childcare issues because of the delay? Or, is it “patient-centered” to manage your time with this patient, including limiting in-depth discussion or the number of things you can help with today in order to stay on time? Continuity allows for this calculus to be something other than all-or-nothing, but it does not resolve the question of what is needed that day or of how much should be “packed in” now to keep other appointments open (c.f. chapter 7).

These ambiguities in the rhetorical figure of the patient crystalized when Stephanie described an effort to address long waiting times in a clinic through a meeting with members of the patient advisory board:

*Some of the patient advisors were prepped to come into the meeting and... tell the story of what it is [like] to wait for an appointment or in the waiting room. And talk to [clinicians] about the data. [We told them], "This doesn't just have to be your experience. You're speaking on behalf of all the patients in this health center, 30% [of whom] are saying they were able to get seen when they need to." So, patients came in and they spoke... and they described their different instances of: "I had set up child care," or "I had to be back by this time, and I wasn't." [It] was all to drive home the point [that] getting patients in and being able to see them quickly is important, not just for our clinic and for us all to go [home] on time, but for their lives too. And so, the patients told their stories, but... as the stories were wrapping up, [they both] were like, "But, I love my provider and I feel so grateful that the clinic is here, so I understand that..." You know, it was like, "Ugh!" The backfire at the end. It almost validated some assumptions or perceptions that they love us so much and they don't have anywhere else to go, so they'll wait.*

In this moment that Stephanie described, actual patients were invited to occupy the figurative position of Patient, standing in for the patient population. Survey results were tied to their own narratives. Similarly, they were asked to address their primary care providers as a generalized group representing the clinic. Stephanie framed clinic running late as at least partially about an apathy toward the value – economic, moral or otherwise – of patients' time. Because the clinics serve poor patients with few other options for care, she suggested that clinicians and staff may be unmotivated to take their time seriously. She framed patients' waiting as injustice. This concern should be taken seriously given the documented disparities in wait times and the frustration caused by waiting that I have described. The question is: What is required to address the delays? Based on my observations, I question the idea that delays are primarily caused by lack of awareness or empathy. Clinics enacted

the aspiration to “patient-centered” timeliness in other ways, such as through flexible late and drop-in policies and they still understood their own efforts as flawed.<sup>47</sup>

The patient advisors broke with the script at the end of their statements to assert a bond with their providers, expressing appreciation and constituting themselves as generous and understanding. In doing so, Stephanie feels that they undermined the message that their testimony was meant to convey. The patients’ thanks at the end of their presentation may have been shaped by a power dynamic which required them to enact gratitude. It also acknowledged the conditions under which their care is provided. In other words, they were asked to compel the clinicians personally to reduce delays that are not entirely within their control.<sup>48</sup> Waiting must be understood within the context of the constraints and obligations that I have traced in this chapter, accounting for the tensions between speed and attentiveness, efficiency and comprehensiveness, now and in the future.

### **Our Population**

*Liz: I had a patient today in blood draw. I had 27 blood draws in 2 hours. And he was like, “Wow, you're just like a factory. Did you even use alcohol on my arm?” And I'm like, “Of course I did...” I've never had anybody complain that I was too*

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<sup>47</sup> Kreindler (2015) observes that the language of patient-centeredness is often used politically to criticize other groups within the healthcare field while maintaining that one’s own group is “patient-centered.” I am interested in how discussions of care timeliness reflect and extend beyond this analysis (c.f. chapter 2).

<sup>48</sup> In a qualitative study of private and public hospital patients in Australia, Ward et al (2017) observe that patients consistently distinguish their trust in the doctors and nurses working in public settings from their critiques of an underfunded and overburdened system that leads to rushed interactions and long wait times for procedures and between assessments. Patients are aware of the inequities between what they experience in the public system and what they experience or imagine in the private system. They also perceive that the two systems operate on different principles as well as with vastly different resources. They insist on a basic trust in the quality of clinical care provided in the public hospital even in the absence of attentive “service.” There are political reasons that these patients might insist on the value of the public system, just as the patient advisors in Stephanie’s story insist on their gratitude despite delays. A question that merits more in-depth research is how diverse patients in the U.S. perceive their waiting and its effects on their trust in clinicians, care quality and the healthcare system.

*fast. It's just... maybe he wanted something else, but... instead of telling me what he wanted, he was just like "Oh, you just treated me like I was just cattle" ...*

*S: Did you feel like, when he said that, you could pause?*

*Liz: I tried! I was like, "No, of course I did. I'm sorry, you know, we gotta keep it [moving]" – you know – "I'm sorry, I have a big schedule, is there anything else you need? Do you [want] me to get someone for you to talk to?" And at that point, he's just like, "No!" And walks out. It's like, there it goes... when he comes in next time, he's already gonna have a bad feeling about me, so then it just sets up for him to not want to come in to do things. Because even that little tiny bit has such a huge impact on the certain population we work with, that already feel so bad about whatever they're going through that me doing that, you know, versus if you worked at, like, Kaiser or something, they don't care: You know, whatever, I'm just going about my day, I have insurance, I have – But ours are so special, our population, that they need more care.*

Liz's reference to Kaiser was one of many such comparisons made in my fieldwork.

Kaiser stood in for a well-oiled operation capable of meeting needs in a time frame that staff felt was impossible within the public system. However, as noted in Liz's comment, it also stood in for a difference in the socioeconomic position of the patients. This comparison could function to both critique and defend clinic practices – as insufficient in failing to measure up or as unique given the needs of the patients whom it was the clinic's mission to serve. One day, a nurse looking at the clinic schedule commented aloud, "Our patients are so patient. They wait a long time. If it were me, I wouldn't come. If it were at Kaiser, I'd be up there banging on the desk." These types of commentary articulated their awareness that timeliness – in terms of both waiting and attention – is inequitably distributed within an unequal and segregated healthcare system.

One day the provider I was shadowing, Dr. Bennett, turned to me and said, "In terms of time, I'm the worst. You can tell.... I'm just gonna spend as much time as I need... I think



there's a direct correlation... between the time the provider spends and patient satisfaction. I don't know if anyone has studied that." She suggested that such a study would be worthwhile. I told her that I had been surprised at how time is often cited as background in research on primary care, but relatively little research has focused on it directly.<sup>49</sup> She says that gets to her – "They talk about, 'we need to transform primary care,'" but "more time is never discussed." Instead, the focus is on teams and ways of doing more. Some of these strategies are the focus of my dissertation.

The same vulnerability of the patient population that Stephanie earlier framed as a matter of concern with regard to patients waiting also shapes the encounter in the room. This is what sometimes led to a sense of circularity in discussions of cycle time as waiting. "Our patients are mostly black men and other poor patients of color," Dr. Bennett told me. As a group, they have been mistreated and neglected by many systems, including healthcare. "If you're like 'I've got 15 minutes,'" she continued, "they're gonna feel..." She drifted off and then reflected on the implications of this time limit for her patient

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<sup>49</sup> There have been many time-motion studies of primary care focused on the amount of time devoted to certain topics or to face-to-face interaction versus documentation in the electronic health record (e.g. Foo et al. 2017; Sinsky et al. 2016). In my review of the literature, surprisingly few studies directly addressed the questions that Dr. Bennett raises, namely the direct correlation between time spent in visits and patients' experience of care, particularly for socially vulnerable patients. Some studies focus instead on provider attitudes and practice style and many have observed the influence of implicit bias on communication during visits, noting that bias can be exacerbated by time pressure (e.g. Heritage and Maynard 2006; van Ryn and Burke 2000; van Ryn and Fu 2003). Studies of disparities in time related to care focus on the time cost of obtaining care for vulnerable patients (i.e. waiting and transportation time) (E. J. Brown et al. 2015; Ray et al. 2015). Of those studies that have directly addressed the relationship between appointment duration and patient experience, results are mixed, showing a clear correlation between more time and higher quality; no significant difference; or effects that are more dependent on patient expectation than absolute time (Halfon et al. 2011; Misra-Hebert et al. 2015; Lin et al. 2001). One challenge to fully studying this relationship is the notion, discussed above, that there is no additional time to be given. Also, the strong influence that the schedule has on the duration of visits means that the variation in visit duration is often small regardless of need (Tai-Seale, McGuire, and Zhang 2007; Tai-Seale and McGuire 2012).

population. Maybe you do spend more time with white patients, she said, she does not know. But regardless of intent, “it will be interpreted that way,” as bias or neglect.<sup>50</sup>

Social scientists have long been concerned with time discipline as a technique for the intensification of labor. As management practices born in industrial factories have been taken up in service sectors, it has been a challenge to articulate the limits of translating industrial logics to the provision of services in complex, unpredictable environments (Davies 1994; Nicosia 2017). Mark Fleming (2015; 2016) uses the term “neoliberal time discipline” to describe practices that frame workers and unions as the source of delay rather than impossible schedules. In his study of mass transit, “on-time performance” statistics function similarly to clinical metrics to configure drivers as chronically late. In her role as an administrator, Stephanie hoped that patient advisors would identify with the clinic’s data about wait times and that their personal narratives would heighten the moral obligation to address delays. In practice, clinicians I observed were acutely aware of their status as “always-already-late” (Fleming 2015, 52). However, their concern about delays was filtered through an obligation to attend to patients adequately in spite of time pressure. In the right circumstances, providers would make time, even at the expense of other patients.

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<sup>50</sup> As Dr. Bennett suggests, distrust in healthcare and other social institutions, based in history and experience, are understood to influence African American patients’ experience of receiving healthcare. Given well-documented disparities in quality of care and health outcomes according to race, ethnicity and socioeconomic status, many have studied the influence of patient-provider relationships on these disparities, arguing that interpersonal dynamics play an important role (IOM 2002; L. A. Cooper et al. 2006; Benkert et al. 2006). Patients’ satisfaction with medical care varies across racial and ethnic groups with patterns that differ between studies and over time (Saha, Arbelaez, and Cooper 2003). The absolute duration of visits appears to vary less and influence care quality less than the content of the visits and their broader context, though time pressure may exacerbate harmful biases and interpersonal dynamics (Johnson et al. 2004; Ray et al. 2015; van Ryn and Fu 2003).

## **Moralization of Speed**

Many studies of healthcare have critiqued speed and standardization as contrary to affective, individualized care (Timmermans and Almeling 2009; M. Berg 1997; Pine 2011; Hunt et al. 2017). Concerns about the relationship between time pressure, standardization and service work have long been present across sectors (Hochschild 2003; Duffy, Armenia, and Stacey 2015; Abeles and Boaler 2012). Overall, many of those I studied would tend to agree with this type of analysis. And, many clinic staff and clinicians valued efficiency and felt that waiting and access – in the sense of primary care appointment availability – were very real concerns. When the frame is shifted to the collective of patients waiting for care, speed and volume take on a different moral valence.

Economic sociologists have studied the complex relationship between domains often considered incompatible, such as money and intimacy or care (Zelizer 2010; Fourcade and Healy 2007). Roi Livne (2014) draws on this literature in his analysis of hospice care, in which he argues that U.S. hospice practices evolved over time in a manner compatible with both the ethics of hospice and the structure of healthcare payments. Practices that promote the financial interests of the hospice, such as admitting from hospital early and minimizing expensive treatments, are compatible with hospice ethics of reducing harmful, unnecessary treatments and helping people come to terms with dying, to accept it as a natural part of life. The commensurability between economic interests and the hospice ethic helps to positively moralize scarcity. They are related to but not reducible to one another.

Efficiency has long been understood as a good in its own right and a positive valorization of scarcity underlies the idea that resource constraints foster innovation (Weber [1958] 2003; c.f. Neren 2011). In this section, I am interested in how speed, efficiency or visit

volume become moralized as good in the name of patient care and experience, even as the same speed is elsewhere understood as compromising care. Patient experience matters and patients are waiting. One approach to this problem is to address the imperatives and constraints that make it such that patients wait. For example, the reimbursement structure requires high visit volumes, clinics run behind and patients wait in the waiting room. Limited space and staffing pose challenges to further increasing appointment access through visit volume without exacerbating in-clinic delays. The goal of having patients seen in primary care rather than the emergency room – a goal oriented both to cost-effectiveness and continuity of care – increases the responsibility of the clinic for patient access.

At some level, it is easy to read the mobilization of patients' waiting by management as a tactic to push for more productivity. However, in this framing, productivity is not opposed to patient care. Like in Livne's hospice, financial solvency in my fieldwork was explicitly linked to the future ability to offer care. Healthcare providers recognized the ways in which time scarcity and waiting in healthcare are socially structured. Yet, the volume of patients who need to be seen appears irrefutable in the timescale of current clinical practice because of fiscal sustainability and access concerns. As a result, moving on could be moralized as positive because patients are waiting, even though it feels wrong to rush patients or cut them off. The practices of reconciling this contradiction were summarized as "not letting the perfect be the enemy of the good."

In discussions of "patient-centeredness," the "patient" is both empty and overflowing with meaning, subject to multiple interpretations (c.f. Tsing 2011; Nicosia 2017). "The patient" as a rhetorical figure does significant and varied work in discussions of care dynamics and performance. Meanwhile, the complexity of caring for actual patients

troubles the best efforts to quantify, evaluate and manage care work. Providing care to patients in the primary care safety net requires clinicians to constantly weigh the needs of individual patients against each other and those of the clinic and the larger patient population. Discussions of waiting bring this tension to the fore, as the reasons for waiting are often tied to care for another patient within the context of socially structured time pressure.

The healthcare delivery system I studied, like many others, aspires to improve “timely access” to care as a laudable goal. It remains to be seen how the intensification of time pressure in the name of timeliness might influence the temporal moral economy of care (Higashi et al. 2013; Dubbin, Chang, and Shim 2013). How does care look different if “the patient” around whom it is centered is one consumer entitled to on-time appointments, a patient with complex medical needs and unreliable transportation or a metaphor for the whole population which requires increased access? What might time pressure do to clinicians’ estimation of and compassion for patients who seem to be a poor time “investment?” These are questions that I revisit in the chapters that follow as I trace the temporal strategies used in the clinic.

## Chapter 2. Flow-Centered Care

### 2 o'clock, going on 2:20

*Dr. Joyce works on filling out a paper disability form that is several pages long with red boxes for each letter and some free-text boxes. Sections she needs to complete have been highlighted in yellow by the behavioral assistant. She has only seen one patient so far this session, which started at 1 o'clock. Now, it's past 2. Her 1:20 and 1:40 patients did not come. Her 2 o'clock is here. Dr. Joyce does not have a consistent medical assistant due to staffing, but Emma is the medical assistant working with her today. Having stepped out in hopes of intaking the 2 o'clock patient, Emma returns and explains that she's waiting because the patient isn't registered. Dr. Joyce, stretching, says "I feel like we're going to have an onslaught later. Like, the quiet before the storm."*

*This is how her clinics "tend to go," Dr. Joyce tells me. Slow at the beginning, then five people arrive at once "and then I'm here late." Yesterday, she says, her face lighting up as she talks to Emma as much as me, was "so nice." Everyone was "coming at their scheduled slot" in the first half of the session – she methodically slices through the air with her hand in a steady rhythm – "and then my no-shows happened at the end" and she finished early.*

*Emma says "I'm gonna put some pressure on," and walks out toward the front desk.*

*"Now, it's gonna be 2:20" [before the 2:00 visit starts], Dr. Joyce observes to me. She acknowledges that this appointment may not have originally been in the 2 o'clock slot, because of the clinic's practice of shuffling appointments to maximize availability for late and drop-in patients.<sup>51</sup> Waiting for the intake to be done, Dr. Joyce works on the disability form. She will be out of town next week, so it's good to get applications like this started now. After a little while, Dr. Joyce comments: "Now I haven't seen her and someone else is here." – Pause – "I'm getting other stuff done. What can you do?"*

*As we get up to see the 2:00 patient at 2:25, Dr. Joyce says, "Now I have 3 patients here."*

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<sup>51</sup> Tetris-ing is a term used for this practice, promoted by Coleman and Associates (2014). More on this later.

Dr. Joyce points to a somewhat predictable irregularity of clinic flow in contrast to the ideal of evenly spaced appointments that manifested in her story from the day before. Clinicians experience periods of waiting for patients who are running late or miss their appointments. Yet, they might still be behind schedule before walking into the next exam room. In this case, Dr. Joyce made the best of the slow start to her clinic session by working on other tasks. Still, the relaxed start was infused with anticipation of what it might mean later. Notably, Dr. Joyce measures the delay both in time (2:20) and in the number of patients waiting.

### **Two o'clock, again.**

*Towards the end of the appointment, washing his hands after examining Mrs. Anderson's foot, Dr. Wilson says that he heard she felt like she got bumped. Mrs. Anderson, who uses a wheelchair, explains how the medical assistant, Sofia, called both her and another patient back from the waiting room together and let the other patient step on the scale first. She says firmly, "I know you didn't give two people 2 o'clock. Maybe a 2 and a 2:10, something like that." Dr. Wilson smiles and says, "Something like that."*

*I try hard to keep a straight face. Both these patients were scheduled at 2 o'clock.*

To offset the possibility of an end-of-clinic rush, Dr. Wilson' clinic "front-loaded" their schedule fairly aggressively, scheduling appointments closer together toward the beginning of the session. They also double-booked some appointments when slots were not available or in anticipation of "no-shows." Overbooking, or scheduling two patients for the same appointment time, is a common and recommended practice for clinics with high no-show rates like this one (IOM 2015b).

Dr. Wilson and the MA he worked with, Sofia, had reputations for working quickly. The goal of having several patients “roomed” as quickly as possible, though, was a common theme for MAs, who bore a large responsibility for the *flow* of the clinic for the provider they worked with. The day in question, Sofia called two double-booked patients back into the clinic together – an unusual strategy. This upset one of the patients, who voiced her complaint to a nurse, who passed it on to her provider. This encounter and our subsequent conversation highlight the demands of clinic “flow” and the multiple ways in which people related to time in the clinic.

Mrs. Anderson felt that the 2 o’clock appointment slot that day was *her time*. She went on to say that this was “my appointment” and she did not want others called back with her. This basic desire may have been deepened by her vulnerability as a person using a wheelchair. However, Mrs. Anderson also said that she “understood” that Sofia needed to work quickly and that this led her to “cut corners.” Dr. Wilson said that the clinic director would come talk to her about what happened. When Mrs. Anderson began to downplay her complaint, he reassured her that criticism can be useful and that “We try to treat our patients with dignity and respect.”

Mrs. Anderson’s statement about the schedule suggested that, operating from a logic that sees each appointment as belonging to a patient, it would be irrational to book two appointments at the same time.<sup>52</sup> She even allowed that they may be scheduled

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<sup>52</sup> The use of times to refer to patients, like “Dr. So-and-So’s 2 o’clock,” is an example of this type of association (c.f. Zerubavel 1985). Not every patient necessarily shares this idea, and many may be aware of double booking as a common practice. It is possible that Mrs. Anderson’s statement that she “know[s] you didn’t give two people 2 o’clock” was ironic, or that her suggestion that it must have been a 2:00 and 2:10 was intended to allow Dr. Harris to save face (c.f. Das 2012). To me, she seemed sincere. Regardless, this logic of one patient, one slot underlies concerns about patients waiting (c.f. chapter 1) and justifies the late policy, which I discuss later in this chapter.



extremely close together – “maybe a 2 and a 2:10” – but not at the same time. Dr. Wilson intentionally did not confirm or deny this theory. Instead, he used apologetic language, including standardized phrases such as “dignity and respect” to mitigate the harm felt by the patient, caused by the practice of overbooking and the medical assistant’s attempt to prepare patients for the provider as quickly as possible.

Later that day, I commented to Dr. Wilson about the schedule, saying that I noticed double bookings in some places and gaps elsewhere. I trailed off, hoping for his comment. Dr. Wilson gave me what seemed like an intentionally blank stare.

“Is that something you have no influence over?” I awkwardly asked.

Dr. Wilson replied that he does have influence, but he said, “I don’t care.” He told me he wants to “hit the door” with three patients in rooms. “That’s called front-loading. It’s not patient-centered but it’s very important.” He told me that the schedule is built this way in order to get all the work done when it needs to get done, like having labs drawn before 4 o’clock. It’s not physician-centered either, he said, “Some people say, ‘that’s physician-centered.’” He insisted that it is not. Rather, “it’s flow-centered more than patient-centered.”

Dr. Wilson referenced a tendency in conversations about clinical time to see time allocation as a sort of zero-sum game in which providers and patients are opposed to one another and physicians’ power grants them control over their time. His analysis refused this dichotomy. By calling the organization of clinic time “*flow-centered*,” Dr. Wilson pointed to systemic constraints and imperatives that made clinical scheduling a challenge. The framing of temporal possibilities as either “patient-centered” (good, efficient) or “provider-centered” (bad, selfish, inefficient) frames temporal organization in the clinic as a conflict

between two parties, obscuring the ways in which both are subject to particular institutional and economic arrangements.<sup>53</sup> That is not to say their footing is even, not by far. Still, as Dr. Wilson observes, the problem is bigger than both of them and located in the structure of patient care.

These two stories introduce the themes of this chapter concerning the clinic schedule in theory and in practice. An enormous amount of labor revolves around the organization and management of clinic time and “flow” within a given session (half-day). The clinic schedule is provisional, a multipurpose tool for reconciling and coordinating the times of multiple actors: clinicians, patients, the lab courier. I describe how the schedule, as a formal object, is constructed, embedding fiscal imperatives and implicit ethical choices into the allocation of clinic time. In use, it becomes more nuanced as clinicians and staff apportion and maintain time according to multiple logics.

## **Flow**

Cycle time – discussed in chapter 1 – and flow are related but not synonymous.<sup>54</sup> Cycle time accounts for the duration of each visit, for each patient, in isolation and then it is averaged. Flow refers to the overall movement through the clinic, which includes how individual patient “cycles” connect and influence each other. Creating the best possible “flow” involves guesswork and strategy and each clinical team has their own approach to

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<sup>53</sup> It might seem odd to pair “efficiency” with “patient-centeredness,” but this linking appeared particularly starkly when staff and management would comment on spending extended time with patients as “luxury” or imply that clinicians and staff who spent a long time in encounters were being self-indulgent. In such cases, it does not seem like the provider and individual patient are at odds. These comments on indulgence take the “patient” to represent the collective and also reference staff’s obligations to each other (c.f. chapters 3 & 4).

<sup>54</sup> “Cycle time” was discussed in chapter 1. Both of these phrases are widely used in the clinic. The reason I do not refer to “flow” as a fixed kind of time (i.e. “flow time”) is that *flow* as a concept has multiple meanings which each give way to different approaches to time. For example, in this chapter, I distinguish some of these meanings by tracing the differences between an institutional “flow imperative” and “good flow” in the eyes of clinic staff and patients.

clinic time. In this chapter, I discuss the clinic schedule and the concepts and practices that fall under the heading of clinic flow. Much of flow-centered strategy is organized around the appointment slot. I describe these slots and the practices that manage patients' correspondence to them.

“Flow” is a concept widely used in emergency departments and hospitals. Again, Francesca Nicosia (2017, 34), in her in-depth study of the “Turn Toward Value” in American hospitals describes “flow” as a “more delicate description” of the industrial concept of throughput in a model of healthcare based on industrial production. Outpatient, appointment-based care faces challenges to timeliness that are similar to and distinct from those of the hospital and shape clinic strategies for managing “flow.” Across these settings, from the perspective of the health system, optimizing flow improves productivity.<sup>55</sup> Good flow can be “patient-centered” by minimizing wait times, but not necessarily for all patients. Institutionally, the flow imperative as productivity implicitly suggests that every single moment in clinic should always be filled. Things should always be moving, and “waiting” – among staff as well as patients – is a waste.

The norm against idleness embedded in the flow imperative, perhaps unwittingly reinforced when I asked people questions about what they do during slow clinics, rests on a homogenous notion of time in which any task can be done at any time, rather than being appropriate to particular contexts. Of course, each moment of clinic was not visibly busy for everyone. Whenever the pace of clinic was not frantic, some clinic staff would grow self-conscious. Early in my study, an MA told me: “It has been known to happen that when we

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<sup>55</sup> Many accounts of hospital care also highlight other interests of practitioners in managing the movement of patients, such as keeping the census, or number of patients in one's care, low (e.g. L. A. Rhodes 1991; Mizrahi 1986; Sweet 2017).

have someone shadowing us, it gets slow.” After hearing this theory a few times, I started calling it “the observation effect.” During these slower moments, people told me things like:

*“Sometimes it’s so crazy, you can hardly sit down.” “You should sit upstairs and we’ll call you down [to say] ‘It’s happening!’” (MA)*

*“It’s not too crazy. Because normally we go bananas in here.” (Eligibility worker)*

*“Last week, we got swamped.” (PCP)*

*“I don’t normally have this time! I feel like you’re getting a fake impression.” (MA)*

*“Whenever someone is shadowing me, the providers don’t call me”... “I swear I do something!” (BA, said in spite of the pile of paperwork she was working on.)*

These statements were often made while someone was still quite busy, albeit with paperwork or follow-up rather than direct patient care. Less often but not uncommonly, they were waiting with little to do but with an obligation to remain at their post and available on short notice. Sometimes, people were apologizing to me, concerned that I did not get to see much “action.” It seemed uncomfortable to allow for this type of time to be restful, knowing that at other moments the work may quickly become chaotic. One MA working in the lab told me: “You chose a crappy day to shadow me.” I told him that I knew that some days “it’s crazy” and some days it is not. “And that’s info for you,” he said with a nod. Later that session, there was a rush as several providers requested last-minute labs and other staff helped to pack the labs in time for their scheduled pickup. Similar to Dr. Joyce’s session that opened this chapter, moments of “downtime” early in a clinic were often accompanied by a rush later on.

While these commentaries on the observation effect denoted a collective affect in which working at a normal pace could come to feel anxious and wrong, some joked that

maybe my observing them would protect them from chaotic days. Take this morning in clinic:

*At some point, conversation turns to how strange this morning has been. The MA I am shadowing says that "there is a rule around here: you never say the word S-L-O-W," because then it'll get busier. I tell her it was the same in a hospital I used to work in with the word Q-U-I-E-T. I mention that at [another clinic], some suggested that when I followed them it was slower. "That has not been the pattern here," I add with a laugh. She replies, "Except today. The magic worked."*

My ambivalent status as awkward observer of slower moments and good luck charm highlighted a tension in notions of flow in the clinic. While the institutional flow imperative prioritizes volume, from the perspective of staff, good flow is not simply about maximizing visit volume; it entails maintaining a reasonably smooth movement between visits so that the work feels manageable. One provider exaggerated this common idea of good flow by joking that an ideal day in clinic would be: "One patient shows up; I sign my note; and they're healthy." She went on to add that the day she told me this had actually been a good one. It was busy, but she had been able to help several patients with concrete concerns, thanks in part to the initiative taken by the nurse and MA that she works with. "We had a good show rate, but nothing got out of control and we gave everybody at least something that they are working on, and many of these people will have follow-up and see if they're doing well after," she said. As a counterexample, one day a nurse was told she had a drop-in patient for a TB test in addition to her scheduled appointments and another drop-in waiting. She asked me: "You checkin' this flow?"

Good flow also involves caring for colleagues by sharing responsibilities and trying to get everyone to lunch or home at the end of the session.<sup>56</sup> Moments of slowness for some made this possible by freeing them up to help out. In other words, realizing good flow in this sense required moments of waiting or idleness. As one MA said: “It's not always the fact that we're all super busy, so at times like that... some of us just work really well together as medical assistants and understand and we just, just go. And just get it done. And eventually it always ends.” As these many examples illustrate, flow is an amorphous and polyvalent concept. This leads to both flexibility and conflict in efforts to manage it.

## Templates

The “15-minute visit” is standard shorthand for the time demands of primary care. In the clinics that I studied, the spacing of appointments varied slightly from clinic to clinic, ranging from 15 to 20 minutes per visit. The skeleton of a clinician's schedule, called the “template,” at each clinic seemed fairly well established. Few people could explain to me exactly why it was built the way it was, other than in response to billing requirements. There were typically 10 to 12 patients scheduled per PCP per session, some of whom may not appear. Others would drop in. The clinic schedule needed to accommodate each of these patients and all of them as a collective of individuals seeking care.

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<sup>56</sup> Many people in nursing, clerical and management roles, when asked what brought them to work in primary care, cited the normal hours, having previously worked night shift or more all-consuming jobs. This was part of the scramble in the last hour of clinic to get patients through. Enforced by agreements with the staff union and limited options for “covering” the clinic after hours, these strict temporal boundaries were frequently cited by providers as a constraint on scheduling practices. At the same time, some staff wished for alternative schedules that would enable them to avoid traffic or attend to other obligations.

The clinic schedule is a form of quantification.<sup>57</sup> It is an allocation of a fixed amount of time to each patient, at least on paper. Quantification facilitates the dividing up and planning of time based on a norm for visit duration. Planning requires the simplification of complex collective realities. It is hard to imagine the coordination of patients' and clinics' schedules, for example, without some approximation of timing (Zerubavel 1985). Standards such as appointment length can be necessary for complex organizations to “[get] things done” (Timmermans and Almeling 2009, 23). However, the establishment of particular standards is nonetheless an ethical choice with expected and unexpected consequences (Bowker and Star 2000). This choice can be subject to contention.

I asked one medical director to explain the use of equal appointment lengths. He replied:

*So, originally, we had all kinds of appointments because prenatals take this long and new patients take this long – and then, what would end up happening is you would end up having like four 30-minute appointments and all four of them wouldn't show... and it was a waste of time.*

He went on to call these missed appointments “missed opportunities,” a common phrase that combined “no-shows” and appointments cancelled and not filled. “Missed opportunities” has a double valence as both a moral problem (care that could have been given/received) and a financial one (primary care provider time that could and should have been billed for). The logic embedded here is one of efficiency, aimed at reducing waste of time as both potential revenue and potential care. Such moralized framings as “missed

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<sup>57</sup> Eviatar Zerubavel (1985, 1979) observes that not all schedules are quantified. Some adjust by being anchored other activities rather than a point in clock time. Zerubavel extensively studied the historical development and use of schedules and calendars for social coordination and uses the hospital as a key site for understanding the social organization of time.

opportunities” may serve to reinforce the sense that having adequate time for care and administrative tasks is somehow wrong, because more could be done.

The template is structured by fiscal necessity. It is based on dividing the session in such a way that the average of nine patients per session who need to be seen for billing purposes will be seen, accounting for the typical “no-show” rate. The decision to allocate 15–20 minutes per patient was not based on a study of what is required based on patients’ needs and desires, but an estimation of what was possible and necessary for revenue and to meet appointment demand.<sup>58</sup>

Several providers suggested that there should be a way to schedule according to patient need or complexity. There are formalized ways of calculating patient “complexity,” used to adjust the number of patients on a provider’s panel. However, this does not change the goal for the number of patients they see in a session. Elaborating on her idea of scheduling by complexity, one provider suggested:

*I would imagine it’s a very hard thing – administratively – to manage. But... I would imagine in my perfect world that there would be some kind of system where you could say, “Schedule this patient for return, complexity level 4 visit.” And that visit would be a 20-minute visit instead of a 15-minute visit. Like, if we could kind of gauge, this patient will need more time, this one won’t because it’s a quick follow-up.*

In this proposal, the duration of the appointment would be based on the provider’s judgement of the “complexity level” for the next visit. It was interesting that the range of durations she gave was still so narrow, as other scheduling models both real and imagined

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<sup>58</sup> Laura Bear (2014b) studies pilots who guide ships through narrow channels. Similar to Fleming’s (2016) bus schedules, Bear notes that predictive calculations used in tide tables and related tools for navigation have been shaped by financial imperatives, such that “the river seems to have fallen in line with the rhythms of capital and trade” (Bear 2014b, 79). Similarly, patients have to be brought in line with the financial structure of care.



could allocate a wider range of times. Other hypothetical suggestions that providers mentioned to me included automatically adjusting appointment duration based on past appointment lengths using collected cycle time data and having patients' self-triage and request a particular appointment duration (from a range of options).

On the topic of such proposals, Dr. Newton told me:

*Yes, there are those – a few patients where you're like, that patient actually should really be scheduled for a 40-minute appointment, every time, right, if you had a choice. But there [are] sometimes when you're just like – there's no way that you could have predicted that something would have happened the way that it did. And then there's also like all the other parts of the day where it's like, "Oh, that patient didn't show up. So, great! I actually get to see that other one for a little bit longer." And some of the days that works out. And then some of the days it doesn't. But it's hard, like, [some providers say] what if we... looked at how complex the patient was... and give those patients a longer appointment time. Which I kinda get. But I – like, some of my most complex patients, I actually don't have to spend a lot of time with [them], because their disease is really managed, actually, pretty well. Or they have a really good caregiver who is really helpful and, like, brings me all the medicines and sets up all the bottles and it's actually kind of fast to see them. And then, it's this other person who doesn't actually have very many complex medical issues, but has anxiety and you have to spend 40 minutes explaining to them in great detail, like, exactly why you're choosing the things you're choosing in order to work up the thing or maybe not work up the thing that they're talking about. Those are actually the one's that you can't – like, I just don't know how you would ever be able to predict those. Like how could you design a computer system that assigned those people correctly a longer appointment visit, right? I don't know.<sup>59</sup>*

Dr. Newton's response to the idea of variable appointment length based on patients' medical complexity articulated how each of these proposals could fail according to the

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<sup>59</sup> This "just anxious" patient is an interesting figure that seemed frustrating to more than this one provider. Meanwhile, in other instances, staff joked fondly about a patient who was "just lonely" and comes in often or patients who tend to take a long time to see, like Mr. Walker in chapter 3.

clinic's model of efficiency. Appointment duration may be fundamentally difficult to predict from visit to visit as unforeseen issues arise and are resolved. This uncertainty resists any model of formalization, though some models may be more faithful to life than others. Dr. Newton asserts that because of no-shows, sometimes it works out. Often, clinicians and staff wished for no-shows because of this flexibility they created in the schedule, but because those were factored into the number of patients scheduled, the days where every patient came in were particularly overfull.

Dr. Newton explained that the rationale that she recalled for the implementation of uniform appointments was that "We need to give patients choice." In response to my surprised expression at the idea that a logic of "choice" led to identical visits, she explained that the accepted solution to a complex set of scheduling considerations was to make all appointment lengths the same so that any patient could choose any slot on the schedule. In addition to being simpler to administer, this model is encouraged in health management literature based on queuing theory, which says that fewer queues (in this case, visit types) leads to shorter intervals from when an appointment is requested to when one is available (IOM 2015b). Meanwhile, the healthcare network hoped that expanding the roles of medical assistants and nurses and collaborating with pharmacists and therapists would allow patients' needs to be attended to while keeping the primary care provider's time down to 20 minutes with each patient.

Whether visits are scheduled in 15- or 20-minute increments, the shorthand points to a fundamental aspect of current clinical scheduling practices: the "slot." The day is divided into slots to be filled with patient visits. This form of simplification makes scheduling easier from an administrative perspective, as any patient can fit into any slot. I propose the

concept of “enslotment” to refer to the logic embedded in this scheduling practice and the strategies used to maintain it.<sup>60</sup>

Enslotment exemplifies modern bureaucratic logic as famously described by Max Weber (1978). Bureaucracy is based on formal rules and positions. Bureaucratic authority accrues to positions rather than individuals, such that any officer is substitutable. Here, we see the same logic from the perspective of those acted upon by the clinic bureaucracy. “Patient” is one position and any particular patient is interchangeable with another.

Within this logic, *standardized* appointment lengths appear as a logical necessity for *efficient* care. In turn, the norm for appointment length constitutes those that deviate from it as a problem (Hacking 1990). I elaborate on these concepts below. First, I will describe what I have thus far framed abstractly as a variation in complexity and Dr. Wilson’s argument that this variation was paradoxically accommodated by the scheduling practices of the clinic.

When I asked him about other scheduling systems, Dr. Wilson told me:

*Dr. Wilson: The problem [with scheduling] is, the patients don't cooperate.*

*S: What do you mean by cooperate?*

*Dr. Wilson: I mean, they exist, right? They have what they have.*

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<sup>60</sup> In using the term “enslotment,” I am alluding to the idea of employment. As many have argued, stories do not just report events but make meaning in the way they are sequenced (DeVecchio Good et al. 1994; Mattingly 1994). The “enslotment” of patients shapes the meaning attributed to their needs and behaviors in the clinic. *Enslotment* as a set of practices in addition to a logic is parallel to what Holmes and Ponte (2011) describe as “en-case-ing” patients, the process of disciplining uncertainty and turning complex individuals into clear clinical cases that medical students learn to do when presenting a patient’s history.

Dr. Wilson's observation that "patients don't cooperate" with the exigencies of the schedule was not *intended* as a judgement of their behavior.<sup>61</sup> He insisted that there were often structural barriers to patients maintaining their appointments and unexpected needs would arise. Thus, he framed it as a statement of fact: Patients' circumstances do not align with the temporal rationality of the clinic. Any other way of rationalizing clinical time would similarly have to confront the "real world." He illustrated his point by walking me through his clinic that morning:

*[Today] the first patient at 8 o'clock – and, remember, my next patient is at 8:05 – was a brand new patient who requested at the last minute a change [of provider]. He's [in need of language interpretation] with 6 problems and I've never seen the man before. That's not a 5-minute visit. Just FYI. That's a 45-minute visit, right?*

*My second patient, the 8:05, was a routine follow-up for lab check and treatment of low vitamin D...*

Generally, appointments in this clinic were all 15 minutes long, but drop-ins or people who called the call center in need of an urgent appointment could be added on, resulting in phenomena like the appearance of a five-minute appointment on the schedule. This exaggerated what was already a challenge: seeing new patients in appointments that were identical on the schedule to return visits. A double booking with a complex new patient this early in the day may have set the clinic up to run very late, but in Dr. Wilson's description, this was partly offset by a missed appointment in the first hour and a few well-placed "simple" visits. He continued:

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<sup>61</sup> Hacking (1990) traces how the notion of "normal" took on both descriptive and moral valence, becoming both a moral good itself and something to improve upon. Hacking points out that both ideas of the normal coexist in contemporary usage. Thus, "patients don't cooperate," was still a sort of normative commentary. At the same time, Dr. Wilson's claims called into question the viability of any norm or standard in scheduling.

*My 8:15 is an HIV, chronic pain patient in whom I'm tapering opioids.*

*Then I had a no-show.*

*And then I had a woman in her 60s with a recent treatment of colon cancer who has neuropathic pain because of the chemotherapy that she's receiving, [who also] has chronic anxiety, hypertension, alcoholism and social phobia. Right?*

*So, then my 9 o'clock was a really simple guy with well-controlled COPD who has other stuff that – that specialists are taking care of. He could have been a 10-minute visit.*

*And then my 9:15 guy was: at least 12 different medical problems, hasn't seen me since January, missed an appointment in February and comes in expecting to have 6 different problems [addressed].*

*Then I had a 9:30... who is hospital discharge follow-up for congestive heart failure with a-fib with rapid ventricular response. Not a short visit.*

*Then I had – my 10 [o'clock] was a 5 minute [visit]: Young woman, perfectly healthy, basically needed reassurance on a negative pregnancy test.*

*My 10:15 was then a really complicated guy who I'm seeing every two weeks because he's so damn complicated.*

*Then I had... an end-stage cancer patient.*

*And the final patient... was a simple follow-up.*

*So, between the no-shows and the people who did show, you know, the drop-in patients... "The patients don't cooperate" means they have what they have, and they need what they need. Right?*

Dr. Wilson seemed to feel that imagining an ideal schedule was a fairly irrelevant exercise in the face of the clinic's resource constraints and the unpredictability of patients' needs and abilities to keep appointments. By contrast, he acknowledged that many private clinics do have variable appointment lengths with a lower rate of missed appointments and higher exam room and staffing ratios per provider. In his "real-world" example from this clinic, one patient did not come and two were added onto his schedule on short notice. He

described almost alternating between very complicated and relatively simple visits in which many – but importantly not all – of his patients’ needs grossly exceeded the time allotted for them. Dr. Wilson concluded that within the current constraints of his clinic, an ideal schedule could not exist.

*[It] doesn't make any difference how you how you block your time. If we say one's a 5-minute, one's a 15, one's a 45-minute appointment, it doesn't matter because the real world intervenes. You get a new patient in a 5-minute visit and you get an easy patient in a 20-minute visit. And the rest are just all over the place. Because patients don't show. And can't show because of barriers that they face. Right? So, you need to maintain a flexible scheduling mechanism that allows for patients who have no access to care, and who have enormous barriers that they have to overcome, to actually get the care that they need.*

In a context in which increasing the total time and resources allocated to patient care seems foreclosed, Dr. Wilson argues that a front-loaded schedule of equal-length appointments, with the possibility to add patients who drop-in, is at least flexible enough to accommodate the unpredictability of the clinic and of patients’ lives. This is the type of practice he explained earlier as not patient- or provider-centered, but “flow-centered.”

While Dr. Wilson’s comment about “patients not cooperating” with scheduling was intended as a comment on the impossibility of scheduling, the numerical norms embedded in the schedule profoundly shape ideas of proper patienthood and the possibilities for care. The logic of enslotment suggests that clinic time can be understood in terms of identical and interchangeable segments of time. This enables certain practices that increase flexibility in clinic scheduling. Meanwhile, it requires another set of practices aimed at making particular patients interchangeable by managing the time they require, bringing them closer to the ideal of the “slot.”

## Tetris-ing: Order out of Chaos?<sup>62</sup>

One practice oriented toward optimizing flow that operates on the foundation of the slot is Tetris-ing. Tetris-ing is a practice through which enrollment accommodates the unpredictability of patient care *by* treating all patients and slots as the same. The term for this technique is a reference to the classic 1980s computer game in which differently shaped blocks must be stacked as closely together as possible, against the clock. Once the schedule template – the formal model of clinic time – is established, actually scheduling and managing clinic “flow” within these constraints involves skill and improvisation. For “Tetris-ing,” clinic staff work off of a screen where the appointments are spatialized on a grid broken into 15- or 20-minute increments (See figure 2.1). Multiple clinicians’ schedules can be visualized at once, appointments can be moved and the spatialization helps one to see fillable gaps.

	06DODGSON	06ROWLING
8	:00 Liddell, Alice (555)555-5555	Granger, Hermione (555)555-5555
	:20 Cheshire, Catherine (555)555-5555	McGonagall, Minerva (555)555-5555
	:40 March, Harry (555)555-5555	Hagrid, Rubeus (555)555-5555
9	:00 Tenniel, John (555)555-5555	Chang, Cho (555)555-5555
	:20 Hatter, Madeleine (555)555-5555	Longbottom, Neville (555)555-5555
	:40 White, Robert (555)555-5555	
10	:00 Carroll, Lewis (555)555-5555	Myrtle, Mona (555)555-5555
	:20 Hart, Regina (555)555-5555	Dumbledore, Albus (555)555-5555
	:40	
11	:00 Pillar, Katie (555)555-5555	Weasley, George (555)555-5555
	:20	Weasley, Fred (555)555-5555
	:40	

**Figure 2.1.** Clinic “resource” schedule.<sup>63</sup>

<sup>62</sup> tetris.com, the website for the game, describes it as a game “embracing our universal desire to create order out of chaos” (<https://tetris.com/about-us>).

<sup>63</sup> The allusion here to Harry Potter in the second column of the clinic schedule is inspired by one provider’s comment to me that he needed a Time-Turner in order to make it through clinic. The Time-Turner is a device that Hermione Granger uses in the third book of the series to attend multiple classes at once (Rowling 2001). The provider’s allusion to the device marks that the aspirations of the clinic with regard to time remain, in a certain sense, fantastical.

One of the clinics in this study had a role called “flow coordinator.” This person actively “Tetris-ed” appointments to maximize the number of patients seen. The flow coordinator would call every patient on the clinic schedule to confirm that they would attend their appointment. If the patient cancelled (shown as grey in figure 2.1), they would “open” that slot, which could then be taken by a drop-in, late or early patient. If patients arrived early, they might be moved into an earlier slot to make their appointment time available for a later arrival. Tetris-ing was based on logics of both efficiency and care. Patients with an urgent need or running late could sometimes be accommodated by this shuffling. Tetris-ing also increased “productivity” by ensuring that otherwise “wasted” no-show appointments would be filled.

The use of a flow coordinator is a step toward formalization of the improvisational management of clinic time. The position ideally centralizes the control of flow, which is otherwise more diffuse. The written guidelines that I read for the flow coordinator were full of contingencies, pointing to the near impossibility of exhaustively anticipating and preemptively solving flow problems. These guidelines held an appointment as belonging to a patient until they either verbally cancelled over the phone or were not present at the moment their scheduled appointment was supposed to start. If they arrived within the grace period and the person “Tetris-ed” into their slot had not yet been called back, their appointment time was to be honored. The guidelines also tried to reconcile wait times and continuity, estimating that a 1-hour wait was a reasonable trade-off for seeing one’s own PCP. Clinical teams could indicate patients who must be seen no matter what, which may change their movement in the schedule. In practice, I did not see a flow coordinator consult these rules. They exercised judgement about consulting teams, often making decisions



alone. Flow management was a skill, attributed more to some than others. The day I shadowed one person at the “flow” desk, she was disappointed that there were not many opportunities for rearrangement. She would have liked to show me how it is done. Skill in the management of flow was a source of pride.

Across clinics, clerical workers, MAs and providers did something like Tetris-ing more informally. Medical assistants, nurses and providers would see patients in an order based on a mix of first-come-first-served, appointment times, wait times and their predictions about the duration of each patient’s visit. Each drew on his or her own logics of fairness. One provider described the task of managing flow and wait times as “Trying to make everybody happy, including ourselves.” Pursuing the best possible “flow” involves knowledge (or judgement) of patients and their needs to estimate how much time visits will take and how likely patients are to show up, also accounting for the number of patients waiting. This process acknowledges the non-uniformity of patients even as it is enabled by the concept of the slot.

Managing flow could also require attending to other values, such as continuity. One clinic used the same visualization of the schedule (figure 2.1) to work around the call center’s tendency to schedule patients with whoever was available – whether or not it was the patient’s PCP. The clinic management believed that if patients knew their appointment was not with their PCP, they would not come, contributing to the clinic’s low show rate and wasting an appointment that could be given to someone else. So, the clinic developed an informal system where the managers “move them [the mis-assigned patients] to a different column” in the computer. This made the appointment that they were scheduled for appear as available so that one of the provider’s regular patients could be scheduled in that slot. I

asked a manager what would happen if the mis-assigned patients *do* come. She replied that they move things around or use a “no-show” slot for the mis-scheduled patient. “Do they ever have to wait a long time?” I asked, wondering how patients might feel about this tradeoff. She said yes but added that her impression was that if you are not one of the first couple appointments, you will end up waiting anyway. When reconciling the contradictory demands of access, continuity and cycle time, this manager readily resigned to the inevitability of waiting in the name of access and continuity.

Social theorists have argued that formalisms like the schedule often survive because of improvisations that, on their face, run against them (e.g. Scott 1998, Tsing 2011). The spatialized schedule embraces its own contradictions through double booking and Tetris-ing. The spatialization allows for an unexpected degree of temporal flexibility. Conflicts over scheduling and flow point to different ethical orientations to time. These orientations implicitly frame relations between patients and the clinic’s obligations to them in time. For example, in the logic of overbooking, time should be maximally used in a way that minimizes missed opportunities *overall*. In Mrs. Anderson’s logic, each slot of time belongs to a person and showing respect to that person means protecting that time for them. Although I have described them in pure form, these logics are often intermixed, both in official norms and practices like Tetris-ing. There is a tension that runs through discussions of scheduling that stems from the implicit co-existence of these contradictory logics.

### **Agendas and Knocks**

While patients “have what they have,” staying anywhere close to on schedule requires that their needs be adapted somewhat to the schedule, such as how Dr. Wilson sees his 10:15 patient every two weeks to address three things at a time. James Scott (1998)

observes that once modern bureaucracies make necessary but profound simplifications, they then attempt to alter their object of intervention to fit the original simplification. In the strategies described in this chapter, one can witness several efforts to fit patients into the 20-minute “slot.” Yet, it is universally understood by practitioners that “patients don’t cooperate” with their enslotment. Much of everyday practice, then, is devoted to managing the gap between the schedule as written and the contingencies of caring for non-standardizable patients.

The schedule is provisional from the moment it is generated. Providers consistently run behind in such a way that the schedule quickly becomes (relatively) irrelevant, yet its features still have consequences for thinking about patients and care. The clinic schedule is understood as both a multipurpose tool for reconciling and coordinating the times of multiple actors and as a reality requiring enforcement. In the management of flow, patients move between levels of abstraction, from the uniform “slot” rearranged in Tetris-ing, through triage (where they are categorized by acuity or type) to particular patients who are known to require short or long visits, to be easy or complicated, to be anxious, or otherwise temporally constituted. Thus far, I have focused on the management of flow in the “front” of the clinic, with scheduling and Tetris-ing. Now, I will describe some of the enslotment techniques used in the “back” of the clinic by medical assistants and clinicians to manage flow through management of time and patient expectations.

One medical assistant, when asked to describe her role, responded:

*Emma: The best way – the way we’ve been explaining it – is I’m the shepherd and my doctor is the sheep. I basically guide her into what she’s going to go into...*

*I ask her if this was just her analogy or shared in the clinic:*

*Emma: No, I think we got it from someone else, but we've used it a lot more because I'm like, that makes a lot of sense. You know? It's like... I'm the guide dog to the blind person sometimes.*

This was a striking analogy, given the number of times I saw providers move from room to room with seemingly little orientation or control, guided or directed by their medical assistant. A provider at another clinic described how much better clinic goes if she yields control of the sequence of events to someone else. Medical assistants have great influence and also great responsibility for the flow of the clinic.

One manifestation of “shepherding” providers was to defend against undue additions to their schedule. For providers and nursing staff in the “back” of the clinic, Tetris-ing and add-on visits scheduled by the call center restricted the “catch up” time created by no-shows, which were part of the rationale for having so many visits scheduled in the first place. Medical assistants utilized a number of strategies to manage the unpredictable flow of patient care, including defending or “blocking” appointment slots (c.f. chapter 4). This protection of slots runs against the productive logic of flow and could be overridden in the case of urgent patient need.<sup>64</sup> More of the work of shepherding providers focused on movement through existing visits. Their strategies, oriented toward enslotment, relied on both preemption and interruption.

Agenda setting is a preemptive time management strategy that enters directly into the clinical encounter. When they checked in to the clinic, patients would be given a form that said: “Today, I would like to talk to my doctor about...” followed by three blank lines.

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<sup>64</sup> Because of their own obligation to keep the clinic moving, sometimes MAs would get annoyed with the front desk for adding patients on in addition to checking patients in too early or not fast enough. The physical separation of their workspaces contributed to these misunderstandings. I elaborate on the roles of MAs and front desk staff in “protecting” provider time in chapter 4.

The idea was that patients would list three items they would like to discuss, one per line.

Agenda setting is regarded in professional literature as essential to patient-centered practice (Kowalski et al. 2018; Robinson, Tate, and Heritage 2016). The term most generally refers to soliciting all of a patient concerns – not only a chief complaint – early in the visit and then planning accordingly. In my observations, discussions of agenda setting focused on prioritizing concerns and managing patients’ expectations. When I asked Dr. Lee what would be “enough time” with patients, she organized her response around this agenda:

*Dr. Lee: You'll notice that, in my clinic in particular, everyone gets this half-page agenda setting form: 3 items, things I don't want to forget to discuss with my doctor. Enough time with the patient would be to adequately address all the things on their agenda and adequately address all the things on my agenda.<sup>65</sup> Sometimes that happens in 15 minutes.*

*S: How often?*

*Dr. Lee: Maybe a quarter of the time? Usually it's my agenda that suffers, because it's more important to get to the patient's agenda. Sometimes patients come in with 10 things on their agenda. I've had that half sheet written on the front, written on the back. And the fact of the matter is that's their agenda. So, I'll negotiate, talk about, "Okay, what are the 3 things that are most important? Let's have you back next month so we can get to the rest of your list."*

*But it would be better care to address their agenda. Whether it's things, you know, things that... medically valid or not... that's what they want to talk about with their doctor, so, a good visit should be: the patient feeling satisfied walking out, feeling their medical concerns are covered, and the things that I want to cover – their healthcare maintenance and all of that – are covered.*

Agenda setting is both a tool for making sure patients have say in the focus of their visit, and it is also a way of limiting them to three things – as impractical as that sometimes may be.

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<sup>65</sup> As her later comment indicates, Dr. Lee’s “agenda,” included screening and the management of the patients’ chronic conditions, which are not always pressing from the perspective of the patient. She also mentioned in the interview that for some of her older patients, she aims to discuss end-of-life planning.

Medical assistants and providers alike told me about how patients would agree to focus on three items, but then sneak in a few more. Agenda setting is an example of how individual patients are remade in mold of the ideal. A patient is asked to only have 20 minutes' worth of needs because that is what the schedule requires.

Returning to the example of the morning's clinic outlined by Dr. Wilson, he emphasized that he is always aware of how much time he has available, including when he is relatively less rushed and can spend time getting to know a new patient. At the same time, he emphasized that the "correct" amount of time was not endless. In order to be able to see the 11 patients that he saw that morning, he had to prioritize within each visit:

*Today, I did not have any patients waiting in the rooms for longer than they should. There were patients who waited for a few minutes in the room to see me, but nobody was waiting for a really long time. So, there was no pressure on me to go faster than I needed to go, which meant that I got to spend the correct amount of time with each patient. That doesn't mean unlimited time.*

*So, for example, the guy that I identified as extremely complex, with multiple medical problems, my 10:15 patient, we'll just call him Mr. W. I see him every two weeks. At the top of his chart is a task list of all these things that need to get done. And what I do in the visit is, I address his acute issues, whatever they may be – today, he had a new acute issue. And then I take 2-3 items off that task list and get them done. Anything else that needs to get done, I add to the task list in a priority-ranked way. And then I see him back again in two weeks and do the same thing. And gradually, hopefully that task list gets shorter and his needs get met, but at least, you know – There is no way I'm meeting his needs, all of his perceived needs, in a visit. A couple – 6 weeks ago? – he asked me about an herbal preparation that he wanted to take, and I actually looked it up that day, but I didn't get back to him about it until today because it's a low-priority issue. But today, it got up to the top of the task list.*

What stood out to me about this last reflection was the importance of regular visits over time with complex patients in a system that only allows for each visit to be brief. I did not

have the privilege of meeting Mr. W, so I do not know if coming to the clinic every two weeks is a hassle, reassuring or some of both for him.<sup>66</sup> It is possible that to address all of his medical problems in one visit would be more than he could take in. And it could be burdensome to make the trip every two weeks. Regardless of its clinical or personal appropriateness, this limiting of each visit to two to three topics is made necessary by the schedule.

Meanwhile, not all patients' concerns could be easily sorted or left until next time. Often, MAs and RNs were also involved in managing the duration of the visit by facilitating agenda-setting and listening to patients in hopes that they would then feel less of a need to express their concerns in as much detail to their provider. Interruptions were also used strategically as time checks and opportunities to bring about a transition in the visit. Both are illustrated in this brief exchange between Grace and Ryan. Grace, a primary care provider, had worked for a long time with Claire, who recently left. Ryan was filling in as her MA. Grace and Claire were both proficient in the language that this patient spoke, and Ryan was not.

*9:25. We start the visit. Though I cannot understand their conversation, I can watch their body language. Grace seems to be listening, peppering "uh huhs" and just the occasional question. She shows the patient her chart. Eventually, her tone changes. It sounds like she is trying to spell out the plan and go. She says "Okay?" at the end of several questions.*

*At 9:42, Ryan comes in with a tray carrying the patient's vaccine and administers it.*

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<sup>66</sup> I return to the theme of continuity in chapter 7. See page 57n37 for a brief discussion of visit frequency. Models of complex care management and "intensive primary care" are often evaluated based on reductions in hospitalizations (i.e. cost) or improvements in measured health outcomes (Edwards et al. 2017; c.f. Fleming et al. 2019). I was not able to find research on patient perspectives regarding appropriate visit frequency.

*Grace has logged out of the computer but is still listening.*

*At 9:48, Ryan comes in again with the after-visit summary sheet.*

*We leave shortly after that. 3 patients have turned green (arrived) on the office visit screen.*

*"I hope you don't mind," Ryan says to Grace, referring to how he came into the room.*

*"That was great," she replies, adding: "It was nice when Claire could get a chunk of it out of her first."*

Because of the language barrier, Ryan could not do the listening for Grace like Claire had. The hope of such a practice was that during the intake with a medical assistant or nurse, a patient would "get out" their need to talk at a length non-compatible with the clinic schedule. This configured any member of the care "team" as a substitutable listener. Often, thanks to the intentional use of stable PCP-MA teamlets, patients did have close relationships with MAs and RNs (c.f. chapter 7). This did not necessarily mean that they would not want to share the same things with their PCP.

Ryan's intervention, knocking or coming in to begin discharge procedures, is a form of "checking in" that was used by MAs and PCPs as a timekeeping device and exit strategy. I did not interview patients, but one can imagine this technique is felt as disruptive, because it is. That is the point. Sometimes, providers would ask their MA for a "knock" at a certain point in the visit with a patient whose visit they anticipated would run long. Some providers refused this technique and for others this was a fairly universal strategy.

*When Dr. Lam has been in the room with Mr. Doe for 13 minutes, Emma says she is going to go knock. She says she will ask if she can help or, [if it seems like Dr. Lam really needs an out], say "You have five patients waiting." I ask if she says*



*this regardless of how many patients are actually waiting. "I say it all the time," she says, adding, "Maybe not five..."*

In an interview, Dr. Lam plainly explained the purpose of these "check-ins," saying that sometimes when she listens to patients at length, "My medical assistant is knocking on my door asking me for the third time if there's 'Anything else she can do to help me,' which means 'Get out! You have some people waiting for you.'"<sup>67</sup> Notably, this interruption lightly camouflaged as assistance was usually configured as based on the number of patients waiting rather than how far behind schedule the provider was. Whether the number of people waiting was real or fictional, the amount of time elapsed was translated into patients waiting to justify the interruption. This reinforced the idea that visits were not being cut short for time's sake alone, but in the name of other patients.

Lastly, the manipulation of time perception was sometimes made even more explicit as a strategy for coping with time-intensive patients. For example, in one clinic, behavioral health and primary care providers discussed a patient who takes over an hour at every visit and does not seem to make progress:

*Elena, a counselor, starts to offer her time management strategy for encounters with people with personalities like this patient. She calls my attention to what she's about to say: "Speaking about time!"*

*She says that she starts by saying, "I'm happy to spend the next 20 minutes with you." I hear someone say "Ah," like, "how clever." Already, she has set a time limit.*

*Then, she says she has a timer. Again, she frames the visit as "these are your 20 minutes." As a side comment, she asks "Who is going to be happy with 20*

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<sup>67</sup> Emma explained a system that she and Dr. Lam had developed one day while waiting for Dr. Lam to leave an exam room: If the provider doesn't answer the knock, that means she's coming out. "If she puts 'order d/c' and is in there 2 minutes later," then Emma knows she needs to knock again and "get her out." "We have our codes now," she told me.

*minutes? Nobody is going to be happy with 20 minutes,” but part of the trick is to sell it as your undivided attention.*

*The key, she says, is it to make it so that “they are all [always] right for 5 minutes, and then you take control.” So, a lot of nodding and saying you hear them, and then: “We have 15 minutes left, can I talk about this, this and this...” As she acts out this strategy, people laugh and nod. The PCP for the patient in question still looks skeptical that it will work...*

Anthropologist Laura Bear (2014, 73) writes that work does not just happen in time, but “has to mediate diverse temporal rhythms, representations and technologies in an orchestration of human action towards their temporary reconciliation.” This framing nuances simple notions of “time management” and is fitting for understanding clinic flow. Speed and time management are a source of pride for some clinic staff as a form of care or professional expertise. Meanwhile, many factors outside of staff control contribute to “backup” in clinic flow.<sup>68</sup> To observe how workers and managers find meaning and take pride in their negotiation of temporal demands should not obscure the origins of or constraints inherent in their strategies.<sup>69</sup> In this and the following sections, I take seriously the sense of workmanship involved in the management of flow while attending to its unintended

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<sup>68</sup> These factors include short staffing, variable patient needs and limited clinical space. Often, the “backup” was considered inevitable. In some cases, it could be used strategically to connect patients to other resources. During “huddles” with the nurse and the behavioral health team at the beginning of each session, providers would anticipate that they were going to be running late by a certain point in the day. They would ask their colleagues to take opportunities when patients were in exam rooms but they were behind to “check in” with certain patients about particular issues. Other instances were more subtle. For example, I walked into a visit with a provider and noticed the patient already had a band-aid in the crook of their elbow. The provider had pre-ordered labs and the MA had done them while the patient waited. These strategies to make the most of “backup” require that some staff, such as the behavioral health clinicians and the MAs, are able to make themselves available on short notice and to anticipate the provider’s schedule so as not to slow them down. I discuss the temporality of teamwork in greater depth in chapter 4.

<sup>69</sup> Arlie Hochschild (2001) observes that the extraction of labor time at work has been aided by Taylorist “participative management” techniques and company cultural engineering. In continuous quality improvement, workers are “empowered” to become their own time strategists (209). Hochschild concludes by arguing that a shift in Americans’ relationship to time must start with the workplace, where the demands on time stem from. However, they must also involve collective action on the part of workers who participate as “both prisoners and architects of the time bind in which they find themselves” (249).

consequences. Among these consequences are the disciplining of emotion and patient tardiness.<sup>70</sup>

### **Late Patients, Lost Time?**

Tetris-ing and less formal “flow” practices allow for lateness to be understandable and accommodated, until someone decides that it cannot be. Then, there are moral reasons invoked for denying care in the moment to those either far too late or late and unlucky, with no open slot to switch to. The schedule, often malleable, suddenly appears as particularly rigid in the enforcement of late policies. In the context of an already-impossible schedule, patients who arrive late to appointments and policies about late arrival were topics of frequent discussion and frustration. The late policy for scheduled patients acted as an essential boundary to contain what was felt to be potentially untenable demand. Meanwhile, enforcing the late policy was generally explained as a matter of fairness to those patients waiting or who came on time. One PCP explained: “Because if they’re 15-minutes late, you’re already into the next appointment time. And then it penalizes the people who are on time.” Of course, the clarity of this statement is complicated by the fact that often the provider is already running late by the time a (late) patient arrives. The management of lateness was complicated and variable in practice.

#### *Fieldnote, Afternoon Clinic*

*1:34. A call from registration. Emily, the medical assistant I am shadowing, says, “It’s hard to say.”*

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<sup>70</sup> In chapter 1, Dr. Silva described an encounter in which she felt compelled to “follow” a patient’s disclosure of grief. This required her make up for her delay with the subsequent patients on her schedule. In chapter 6, I discuss the felt necessity of eliciting, addressing, avoiding and containing emotions and disclosures of trauma in the clinic.

*After hanging up she explains to me that the 1:20 patient arrived at 1:31. The clinic's "grace period" is 10 minutes. She is hesitant to do their intake now because what if the 1:40 [patient] is on time? This seems to be a general sentiment, but in this particular case she explains that the 1:20 patient is tricky to do the intake for because of her wheelchair.<sup>71</sup>*

*"Late is late," though, she adds, so if the 1:40 patient is 1 or 2 minutes late, eligibility will register the 1:20. In explaining her logic, Emily seems a little defensive. She tells me that even the provider she works with may not understand why she didn't intake the 1:20 patient at 1:34, but she thinks it will throw off the flow. Later, the 1:40 patient no-shows.*

*Emily says, "So I lost that time, but it's a gamble."*

Emily seemed particularly concerned about fairness to subsequent patients. That was her reason for refusing to intake late patients until the next one had been given the chance to arrive. Once, her colleagues were frustrated with her because she did not want to let a patient who was there early move up into a no-show slot. Her issue with that was that the process was not started until halfway through the slot, and therefore she feared they would be late for all the other patients. Despite other's criticism, Emily's interpretation of the schedule exemplifies a logic of fairness and ownership over one's time "slot" that was given as the reason for the late policy in general.

In primary care, the imperative to "move things along" is about productivity or volume, but it is also about staying on time for patients who are waiting (Kaufman 2005, c.f. chapter 1). Patients who are late, unless they are identified as needing to be seen no matter what, might be deemed poor investments relative to the cost of delay for others – both staff and fellow patients. Emily gambled on preserving a slot that, in her mind, belonged to the

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<sup>71</sup> Echoing Mrs. Anderson's intake earlier in this chapter, this is one of many examples of an apparently neutral rule about time potentially normalizing differential treatment of patients who need more time for one reason or another (c.f. chapter 3).

1:40 patient. While Emily was stricter about this than some and lost her gamble, her choice was consistent with her clinic's policy and her own sense of fairness. Meanwhile, the premise of fairness toward other patients obscures the sense of injustice felt by patients who rush to make their appointment and then wait to be seen.

During my research, the expansion of the centralized call center forced a change to individual clinics' late policies because the standard message provided by the call center was that patients would be seen up to 15 minutes late. One clinic's grace period had previously been five minutes.<sup>72</sup> This change in policy sparked extensive deliberation about how to operationalize it in terms of clinic flow. If the subsequent patient arrived early, should they be registered and seen promptly? Or should the clinic wait until the 15-minute grace period ended? They settled on giving preference to the next patient after 10 minutes and seeing the late patient later in the session. I asked one of the front office staff what it is like to tell patients about the late policy. She laughed softly and said:

*Uh, a little bit uncomfortable... It's hard, because it's like, sometimes patients will express that it's— they feel like it's unfair. Especially when we had [a limit of] five minutes. And I understand why the five minutes. Like, I totally understand both sides... 'cause if we keep the late policy short, then it will kind of help everyone else just kinda run... the clinic run more in time. Yet, if a patient sometimes comes, like, 30 minutes early, and then their appointment time arrives. And I'm like, "Hey, your provider's running a little bit behind." So then, it kinda makes them feel like, okay, I came early. I'm not gonna be able to get in early, that's okay, but it's my appointment time now, but now they are running behind. And then when those patients come in, like, 10 minutes late, they're like, "sometimes I've waited 30 minutes for my doctor." And I don't really have anything good to say. I just tell them, "I completely understand." Like, it's frustrating. You're 10 minutes late, and I know you've probably waited more than 10 minutes at times.*

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<sup>72</sup> One MA told me that this new late policy was "really hurting us." Her colleague explained that it interrupts clinic flow "because I have to stop" and deal with the late patient. This idea points back to an implicitly linear, constant motion in ideal "flow."

As discussed in chapter 1, “You’ve probably waited more than 10 minutes at times” is a polite understatement. Many staff were aware of the double-standard inherent in this policy. At the same time, its logic, or at least its necessity, seemed inescapable and rendered implicit the power differential inherent in this organization of time (c.f. Frankenberg 1988).

### **“I can’t find my patient”**

The marked difference between patients’ and providers’ lateness was stark one day when Dr. Lam could not find her patient and clinic was about to end. Mr. Johnson’s visit was at 4:20. If I read the visit status in the EHR correctly, he came early. The clinic does not have a parking lot, and Mr. Johnson must have parked in a short-term space. His lab work was done, but then he had gone out to move his car when he realized he would be waiting to be seen. We saw him shortly after 5:

*We go in to see Mr. Johnson at 5:04.*

*“There you are!” he says playfully.*

*“What do you mean!? I’ve been waiting for you for 20 minutes!” Dr. Lam exclaims. She softens her tone and says that, “You know this,” but “we’re gonna have to cut it short because we’re closed.”*

*During the visit, they discuss his high blood pressure and Mr. Johnson repeatedly mentions anxiety about his finances. At the end of the visit, Dr. Lam tells Mr. Johnson that she knows the 4:20 appointment slot is best for him with his work, but it’s hard “because I’m all alone.” More precisely, there was still a nurse and medical assistant present in the clinic, but Dr. Lam regretted that the behavioral assistant was already gone for the day, as she could help connect Mr. Johnson with social services.*

Dr. Lam had made use of the time waiting for Mr. Johnson to return to the clinic and told me she would be there charting well afterwards as well. Still, her momentary inability to find

her patient when she was finally ready to see him was surprising and upsetting. Throughout the visit, Dr. Lam commented on how much more they could do for him during business hours.

Ryan, the medical assistant, was providing late “coverage” that day because it was known that 5 o’clock would not be the actual end of clinic, though it always remains the goal. I will return to work hour boundaries in a later chapter. What stands out about this encounter is how profoundly different this patient’s “lateness” (absence at just the right time) is from a provider’s lateness, which is chronic and to be expected. This was an unusual occurrence that brings out something implicit in many other clinical interactions. As Dr. Lam told me in an interview, the late policy was both something they enforced out of felt necessity and, “there is an existential problem” with that rule.

When I asked clinic staff about ideal clinic flow and barriers thereto, they consistently mentioned patient timeliness as key to maintaining flow. My goal is not to interrogate the validity or sincerity of the claim that late patients make the clinic run later. Mathematically, it does not seem like a patient arriving 10 minutes late but whose provider is 30 minutes behind has done anything to add further delay.<sup>73</sup> Yet, patient lateness runs up against a logic of rigid, linear time that co-exists with its more fluid, Tetris-able counterpart. The pressure of tightly scheduled visits can foster or reinforce negative feelings toward patients on the basis of their lateness or slowness, even if staff recognize structural or biological causes of that lateness or slowness.

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<sup>73</sup> I directly pressed one provider about this, and she connected the issue to limited room availability (as patients stack up waiting) and the MAs’ need to quickly discharge other patients and intake this one.

In interviews, staff often referenced late buses, lack of parking, and other structural reasons why patients may be late, but needed to bracket this to make the late policy work. Whether configured as a failure of individual responsibility, a matter of fairness or by practical necessity, lateness provides grounds to make some room in the schedule. When clinicians are constantly feeling behind from the start, late patients come into focus as one source of the problem about which something can be done. The late policy becomes a release valve on the pressure of the clinic running late, but raises concerns for bias and questions of fairness when patients often wait long periods but can be denied an appointment on the basis of late arrival.

As discussed in chapter 1, Mark Fleming (2015; 2016) has analyzed how the production of impossible time schedules configures workers as chronically late and inefficient. Like the transit workers in Fleming's study, primary care providers are "always-already-late." Their responses to this state range from ignoring the schedule to valiant efforts to hold to it. In both cases, they must shift much of their work toward other times, spaces and people. They also make demands of patients: to be on-time, to be focused and to be flexible in their expectations for attention. The moments where temporal gambles are won and lost illustrate how the schedule as a pragmatic object shapes ideas of patients and the temporal ethics of the clinic. Clinic strategies highlight the tensions involved in caring for particular, complex patients who "have what they have" while other patients are waiting.

The schedule as a formal object is known to be approximate and serves as a coordination tool. In practice, time becomes visible as both rigid and fluid depending on context. The schedule's formal structure has implications for care, exemplified in enslotment efforts that attempt to make patients keep to the 20 minutes allotted and the enforcement of



the late policy. At the same time, clinicians and staff measure time relationally, as in patients waiting. They skillfully coordinate the temporalities of clinic finance, staff and patient needs to make the most of clinic time for themselves, colleagues and patients as a collective. This more relational idea of clinic flow can both accommodate and exclude patients who are late or need extra attention. In the next chapter, I elaborate on how medical assistants and nurses facilitate care for patients whose personal tempos cannot be brought in line with that of the clinic.

## Chapter 3. Non-Congruence

Many patients' needs exceed the time available in the clinic schedule. This gap is managed in a number of ways, beginning with the strategies described in chapter 2. Still, the *enlotment* of many patients fails or is never attempted. The apparent rationality of normative visit times begins to fall apart if we consider those patients whose personal needs and tempos fall farther than others from the norm inscribed in the schedule. In one encounter that I describe in this chapter, a nurse described one such patient as perceiving time in a way that was "non-congruent" with his and the clinic's approach to time. Non-congruence is an apt descriptor of the ways in which the temporal rationality of the clinic diverges from the rhythms of elderly or complex patients' bodies and needs. When such patients, who are common, present for care, maintenance of both timeliness and care require labor on the part of medical assistants and nurses to keep providers in time with their schedules while ensuring that health problems are not missed.

Scholars who study care work have used various terms to refer to the tempos of interpersonal care and institutional requirements that are often non-congruent with each other and yet both necessary elements of care work. Summarizing some of this literature, Karen Davies (1994) offers clock time and *process time* as two temporal rationalities both central to caring labor in institutional settings. Clock time is the linear, quantifiable time at the heart of planning and measurement. Process time "emphasizes that time is enmeshed in social relations" (280) and is driven by the needs of the cared for, which may not align with the temporal rationality of the institution. "Process time" as an analytic encapsulates a multitude of temporalities that are highly contextual and resist interpretation and anticipation by the clock. Davies is careful to insist that she is not proposing process time as

universally more appropriate to care than clock time. Adherence to clock time can function as a way of respecting and protecting colleagues and taking breaks. Pure process time – letting things take as long as they need – can feel as constraining as can time pressure. However, Davies observes that in the nurseries that she studies, the logic of clock time seems to take increasing precedence as needs increase and staffing is reduced.

In this chapter, I tell the stories of two patient encounters from the perspective of a medical assistant, Emily, and a nurse, Samuel. Their patients, Mrs. Thomas and Mr. Walker, are both people for whom the normative pace of the clinic does not work, yet they are not unusual. Emily felt pressure to complete Mrs. Thomas' intake quickly for the sake of her cycle time. Mrs. Thomas' personal tempo did not match Emily's internal clock. Mrs. Thomas, being elderly with multiple medical conditions and risk factors, is representative of many patients cared for in these clinics. Mr. Walker, particularly on the day I met him, was the most profound example I witnessed of a patient out of sync with the flow of clinic. A frequent visitor due to chronic health problems, Mr. Walker's condition had worsened on the day we saw him. His visit absorbed the majority of a half-day clinic session, putting a strain on Samuel, who described his work that day as both "real nursing" and "fragmented."

Davies' paradigmatic ways of understanding time – by the clock and in terms of a social process – coexist in the clinic. Their relative salience depends on the circumstances, including both patients' and providers' personalities, ethics and needs in a given moment. Mrs. Thomas' and Mr. Walker's biologies, and perhaps personalities, were out of sync with the normative pace of the clinic. This brought out the salience of a process time orientation. Clock time remained important in a profound way, illustrated by Emily and Samuel's anxieties about clinic flow. Both valued attending to their patients' unique needs but felt

that in doing so they might be understood as inefficient or having compromised other obligations to patients and colleagues. The tension between clock and process time gives a framework for understanding the temporality of the care for these two patients.

One patient like Mr. Walker can be understood as unique and in need of extra care time. Nurses like Samuel make this possible by providing the bulk of clinical care, allowing the primary care provider to continue seeing other patients. Nurses' position within the clinic structure allow for that flexibility. However, their relatively flexible time also means that multiple providers and patients may make simultaneous claims on their attention. A sense of chaos, "fragmentation" or disjuncture in clinic stems from the tension between multiple simultaneous demands and the flow imperative.

I address these two cases together because they are both patients whose needs, abilities or personalities conflict with the normative pace of the clinic, a situation true for many. Both patients insist on receiving the attention they need, drawing attention through contrast to the accommodations required by the pace of clinic flow. I examine how Emily and Samuel's labor enabled care for these patients and the relative maintenance of their primary care providers' schedules. In the midst of caring for Mr. Walker, Samuel also relied upon and was called to assist fellow staff members in ways that led the session to feel chaotic and fragmented, but also typical of nursing work in this setting. These stories bring into relief the stakes of clinical rhythms for vulnerable patients' health and the labor of the clinical team under time pressure.

## **“Watch me go!”**

One day, I sat in a charting room with Emily (MA) while the provider she worked with, Dr. Moore, was with their first patient of the session and we were waiting for the second. The second patient’s appointment time had already passed. As we waited for him to arrive, Emily told me about the challenges of managing clinic flow and accommodating late patients. Emily was under pressure to improve her cycle time. She told me that with her patient panel, which includes elderly and medically complex patients as well as children, serving them means taking a long time. The relative ages and complexity of her panel, she said, were not reflected in evaluations of her time management. Later that day, during our interaction with Mrs. Thomas, I could not help remembering Emily’s comments about feeling caught between pressure to speed up her work and her sense of what it requires to be attentive to her elderly patients. Mrs. Thomas was a survivor of cancer who struggled to keep weight on. She was elderly and small but proudly independent and knew how to express her needs. She was a long-time patient of Dr. Moore’s and Emily’s.

### Fieldnote, Afternoon Clinic:

*... When Emily calls her third patient’s name in the waiting room, a petite older woman scoots to the edge of her chair and starts to stand slowly. Emily offers a hand, but Mrs. Thomas refuses, determined to stand and walk on her own. I follow, checking my own pace to match Mrs. Thomas’ as she slowly shuffles behind Emily, across the waiting room towards the hallway where the scale is. She slowly removes her coat, again refusing assistance from Emily, who I can feel is anxious to move things along but hiding it gracefully.*

*When she steps on the scale and sees her weight, Mrs. Thomas squeals and claps. “I worked hard for that!” she says, to me as much as to Emily, telling us that she’d been eating and eating, trying to gain these pounds.*

*Emily asks permission to pick up Mrs. Thomas' coat for her. Permission granted. Mrs. Thomas scoots to the end of the chair and slowly gets up, exclaiming, "Watch me go!"*

*I find myself modulating my pace again to stay behind Mrs. Thomas on the way to the exam room. Mrs. Thomas shuffles slowly, humming under her breath.*

*In the exam room, Emily logs in and charts Mrs. Thomas' vitals on a computer. She asks her usual questions, including, for example: "Have you seen a specialist or other doctor since the last time you were here?"*

*Mrs. Thomas answers instead with her concerns for the day, which center on her feet and hands. Emily says she'll need to take her shoes off so that the doctor can examine her feet, going to the cupboard for a pad to put on the floor.*

*Mrs. Thomas responds, "You'll need to help me, because I can't do it." Emily kneels on the floor and takes off Mrs. Thomas' shoes, telling her that she will need to do her socks. Mrs. Thomas asks her to remove those, too. Emily obliges but comments that she may ask Mrs. Thomas' caretaker to come in from the waiting room at the end of the appointment to put the socks and shoes back on.*

*Before we leave, Emily says that she knows she offers every time and Mrs. Thomas has refused before, but she wants to offer the pneumonia vaccine again. "No, no, no!" Mrs. Thomas says. She tells me she went through shots when she had cancer and she won't do it. Emily documents that the vaccine was declined.*

My witnessing of Emily and Mrs. Thomas' interaction was colored by our earlier conversation. While we waited for the machine to measure Mrs. Thomas' temperature and blood pressure, Emily threw me a glance and I smiled back, trying to convey my understanding. When you are feeling time pressure, even the count up and down of the blood pressure cuff can seem to take forever. Meanwhile, Mrs. Thomas was not extraordinary. My sense of non-congruence between her needs and the goal of "improved" cycle time was heightened by Emily's self-conscious commentary and my own awareness that my witnessing of this interaction could intensify that self-consciousness.

What was clear throughout the intake was Emily's anxiety about her responsibility for managing the flow of her and Dr. Moore's clinic in a manner that others would consider timely. It is possible that my presence made it worse. Emily took pride in being thorough and preparing patients well for their visit, evidenced here by her request that Mrs. Thomas remove her shoes and her repeated offering of the vaccine. She tried to couch this required repetition by reassuring Mrs. Thomas that she knew her preferences but had to ask. Her gesture marked the continuity of their relationship. It also suggested to me that because she knew the answer, she wished she did not have to ask, but it was protocol. Throughout the intake, Emily's orientation to thorough care was in tension with the imperative to move quickly, a tempo out of sync with Mrs. Thomas' way of being.

In the end, Dr. Moore wanted to send Mrs. Thomas to the emergency department because the appearance and exam of her feet was concerning. Before the next patient intake, Emily and Dr. Moore focused on wrapping things up for Mrs. Thomas. All documentation for her visit needed to be done and locked for the people at the hospital to read it. Mrs. Thomas had been vocal about her need for assistance. If she had not been, or Emily had not adjusted her pace to Mrs. Thomas', it is easy to imagine something important being missed. The acuity of her complaint highlights the importance of Emily's questions and assistance.

It is unclear whether a different outcome would have changed Emily's perception of her choice to take the time to remove Mrs. Thomas' shoes. If Mrs. Thomas' feet and hands had looked fine, would it have been a "waste" of time? I was not able to ask her, but based on my interactions with Emily and her pride in being thorough, I do not believe she would have framed it this way. Still, this interaction highlights the tensions between her anxieties

about clock time and the temporality of process, which can be difficult to account for. Taking the time made the intake longer, but also served to save Dr. Moore time during the visit and ensure that the foot exam would happen. I return to the question of whether it was “worth it” below through the concept of a temporal moral economy. First, I will describe the visit with Mr. Walker.

### **Non-congruent**

During my research, one clinic tested a template for scheduling nursing time that estimated thirty minutes per patient (rather than twenty) and limited nurses’ obligation to assist with providers’ scheduled patients until after drop-in hours. Ultimately, this provisional schedule for nurses ran into similar obstacles as those of the provider schedules that it was intended to support. Patients could not be contained by it and nor could providers’ expectations. Mr. Walker was a patient who presented with an acute complication of chronic health concerns. During his appointment, the nurse caring for Mr. Walker was reliant on and involved in aiding other colleagues to keep the clinic moving. I present this couple of hours in as much of their original complexity as I could capture in order to convey the sense of chaos and fragmentation mixed with pride in his nursing skills that Samuel expressed. This series of interactions illustrates the multiple and sometimes contradictory obligations and power dynamics involved in clinical teamwork (c.f. chapter 4).

The afternoon I was set to shadow Samuel (RN), we started with the clinic huddle. The “huddle” took place at the beginning of each clinic session. All clinic staff working that session would gather to review roles and announcements. Then, medical assistants and providers would review their clinic schedules together while team nurses circulated, asking how they could help. This brief gathering served to make sure that clinic staff were present



on time. It also offered a space to collectively anticipate the inevitable contingencies of the day. That day, Samuel and Camila were the nurses working in clinic. Samuel was assigned to support two PCPs, Dr. Chan and Dr. Wright.

We approached Dr. Wright at her computer first. She asked that Samuel help with her patients at 3:30 and 4 o'clock. Again, in this clinic at the time, providers were asked to limit their requests for nursing support in the afternoon to patients scheduled after about 3:20 pm because the nurses would be focused on attending to drop-in patients prior to that time. The nurses marked out 30 minutes to assist each patient. We went to Dr. Chan with little space remaining. Mr. Walker was on Dr. Chan's schedule for 2:20. Mr. Walker was a long-time patient of Dr. Chan's. He was an older man who lived alone with several chronic conditions, including vascular disease that led to chronic wounds on his legs. Mr. Walker was a patient whom Samuel considered one of his own, as he was often actively involved in his care. When Dr. Chan and Samuel reviewed the afternoon's schedule, they readily agreed that Samuel would see Mr. Walker first, even though his appointment was during drop-in hours. Samuel would review Mr. Walker's current medications, provide wound care and start an assessment before involving Dr. Chan. Samuel wrote Mr. Walker down on his schedule for 2:30 and asked Julia, the MA working with Dr. Chan, to do his intake and then let him know when Mr. Walker was ready.

Shortly after 2 o'clock, Samuel wrapped up with his last drop-in patient, a child who was brought in by his mother, dehydrated. Samuel had urged them to go to the urgent care clinic. By the time this family left, Mr. Walker had arrived and Julia was busy with another intake. So, Samuel went to get Mr. Walker himself.

*Standing at his computer, about to go get Mr. Walker, Samuel takes a deep breath and drops his shoulders. He turns to me and says delicately, "He doesn't like to be rushed."*

*"Okay," I say as we walk out to the waiting room. I hold the door while Samuel calls Mr. Walker, who slowly rises from his chair with a cane. I notice that Samuel does not move to offer a hand. After witnessing more of their interaction, I take this as a sign that Samuel knew that Mr. Walker would want to get up on his own. Standing near the scale, Samuel helps Mr. Walker remove the heavy coat and vest he is wearing despite the fact that it is in the 70s today. Mr. Walker wishes he would remove them one at a time.*

*After getting Mr. Walker's weight, we go to room 12. Mr. Walker sits down in a chair under the window. Samuel stands near his computer.*

*2:18: Samuel "arrives" Mr. Walker (updates his visit status) in the computer.*

*Samuel asks Mr. Walker how he is doing, and he replies that he is in pain. Samuel tells him that he is "sorry" that he was in pain. Mr. Walker responds that he does not use language like "I'm sorry," and "joy," which he attributes to a certain "political economy" that he does not agree with. I can tell right away that this is going to be an interesting appointment.*

*Samuel asks Mr. Walker about a slow-healing wound on his leg, his visit from a home healthcare nurse and his medications. He completes a full "medication reconciliation," a review of each medication listed in Mr. Walker's record to confirm whether or not he is taking them or needs refills.*

*As he moves to take Mr. Walker's blood pressure, with the cuff around his arm, Samuel asks Mr. Walker if there's "anything else." Indeed, there is, and Mr. Walker starts to tell him about it. Interjecting, Samuel says he is going to do the blood pressure again because they were talking. Mr. Walker understandably replies: "Don't ask me [to speak] and then say we have to do the blood pressure again." Samuel says, "Okay," encourages him to take a breath, and presses the button.*

Before we went to call Mr. Walker in the waiting room, Samuel's deep breath and warning to me marked his knowledge of Mr. Walker as someone who would take time.

During the visit, it seemed that Samuel had, out of habit, filled the silence as he moved to

take Mr. Walker's blood pressure. I saw this happen many times in other clinical encounters with other clinicians. Perhaps he was also trying to multitask because of the slow pace of conversation. Either way, Mr. Walker responded directly to Samuel's questions and voiced his own concerns without adapting to the habitual flow of the visit, including the blood pressure reading. In the process, he drew my attention to common contradictory habits such as asking questions and then for silence. Any attempt to redirect or rush this exchange tended to have the opposite effect. By refusing to abide his expected role, Mr. Walker highlighted the ways in which many patients cooperate with a model of care based on brief and focused conversation and acquiescence to clinical expertise. Some clinicians might characterize Mr. Walker as uncooperative, though I noticed that Samuel did not. Their interactions were often tense, and Samuel later told me that "he [Mr. Walker] pushes buttons all the time," but he said it with a laugh.

*Throughout their conversation, Mr. Walker speaks slowly, repeating himself and either speaking through or calling out Samuel's attempts to interrupt. Each time, I feel the tension in the room grow a bit thicker.*

*Mr. Walker begins talking about recent changes he has made to his eating habits. While Mr. Walker talks, Samuel glances at the chart of his vitals, including weight, up on the screen. I see it at the same time as he does – a weight loss of about twenty pounds in two weeks. Samuel gives me an alarmed look but does not interrupt Mr. Walker.*

*At some point, Samuel asks him, "Are you telling me that you are intentionally eating less?" Mr. Walker emphatically says yes and reiterates parts of his explanation, an explanation which to my ears does not add up. Samuel mentions the significant weight loss, expressing concern. Mr. Walker replies that he's always told that his weight is down, and he attributes this to what he believes is a healthy diet. Samuel tries to distinguish between a general downward trend and this drop, but Mr. Walker is not convinced.*

*Samuel tells Mr. Walker that we will move him to room 3 for him to see the doctor, but he says he will go check it first to make sure it is clean.*

*When we leave the room, Samuel sighs heavily and looks at me.*

*I respond: "You're a saint."*

I surprised myself as I said it. What about this interaction made me respond in this way? Part of it was Mr. Walker's sometimes aggressive tone and the mounting tension in their dynamic, difficult to convey here in writing but summarized when Samuel later laughed and told me that "he pushes buttons." There was more to it than that, though. My reaction was a statement about Mr. Walker's refusal to meet the implicit expectation of patients to accommodate or at least acknowledge the time demands of the clinic. It was also meant as a gesture of care and validation for Samuel, acknowledging his patience and potential exhaustion.

The expectation that patients adjust to clinical time demands is often gestured to in patients' apologies and expressions of gratitude for a caregiver's time. By contrast, Mr. Walker's insistence on speaking his mind in his own time and his strong reaction to Samuel's relatively restrained attempts to move things along were jarring. At the same time, Mr. Walker's way of interacting with Samuel was a more extended and intense version of dynamics that often arise in the clinic. Taking care of people with complex conditions and social situations, many of whom, based on experience, distrust clinicians and the health system, is tiring. One of the ways that I witnessed clinicians coping with this exhaustion was through humor and mutual affirmation. My comment to Samuel was not intended as a judgement of Mr. Walker, but a validation that providing this type of care can be challenging.

When Samuel excused us to check on room 3, I noted this as a marker of his knowledge of Mr. Walker's deep concerns about hygiene. I also suspected it doubled as a strategy for creating a moment to think. Perhaps he was already beginning to note that something was off relative to Mr. Walker's usual behavior. Samuel drew on the chronological charting of Mr. Walker's weight to establish a sudden physical shift. For Mr. Walker, his low weight was a product of his healthy diet, which he seemed to feel healthcare providers sometimes misunderstood. He seemed confident in the logic of his more recent dietary changes, despite how confusing they were to Samuel and me. Mr. Walker's medical complexity and general tendency to speak at length on his diet and philosophy made it a challenge to recognize and distinguish a possible new, acute issue from his general state of health. Today, he was slightly more talkative than usual and making a little bit less sense.

*About 2:45. On our way back from inspecting room 3 to collect Mr. Walker, Samuel says to me, "We're still on time..." His tone implies, "for now."*

This comment about being "on time" (for now) reasserted the provisional schedule, in which Mr. Walker was supposed to be cared for in 30 minutes, despite this being obviously untenable. This allusion to the schedule was striking because this visit seemed destined to follow its own rhythm, incommensurate with the plan.

*We walk slowly with Mr. Walker to room 3. Grabbing an absorbent pad and spreading it, folded, under Mr. Walker's feet, Samuel helps remove his shoes and stocking socks. Samuel inspects both of Mr. Walker's calves, where he has chronic skin damage from vascular disease and some slow healing wounds. He tells Mr. Walker that he is going to get some scissors. When we leave, we return to room 12 first.*

*Samuel tells me, clicking a few things on the computer as he speaks, "I find that, with patients who need their own pace, [in] my own mind, I have to check in*

*about my own biases [regarding] timing. Because their perception of time is non-congruent, so you have to [modulate]. It can be hard on a busy day.”*

Samuel could read Mr. Walker’s repetitions and insistent slowness as frustrating or entitled. However, he articulated another framing that enabled him to maintain his patience and compassion. Samuel described Mr. Walker as having a “non-congruent” time perception. This framing did a lot of work to articulate that this encounter was taxing without *expressly* blaming Mr. Walker. Rather than perceive Mr. Walker as operating within the same temporal frame, which would imply a disregard for Samuel’s time or the times of other patients and providers, Samuel labelled his own expectations around time as “bias.” This subtly suggested that it was the irrational expectations built into the schedule, rather than Mr. Walker, that were out of place. Meanwhile, his allusion to “a busy day” marked that his expectations were also tied to a number of institutional demands upon his time.

*Still in room 12, the small room where Samuel sees patients and charts, Samuel uses the speakerphone to call the home care provider listed for Mr. Walker in the EHR. She tells him that they have transferred his care to someone else. Samuel acknowledges that – Mr. Walker has told him – but asks her if she knows what the wound care regimen and schedule were that the new nurse would be using. Before leaving the room. Samuel takes a drink of water and instructs me to do the same, asking if I am doing okay.*

Samuel’s advice and question for me returned the small gesture of care I had extended in acknowledging his patience earlier. His reminder to drink water also seemed to make a point about how easily one could lose track of one’s own needs in the clinic. Samuel demonstrated that he may be used to it, but I was not. Before we went to consult with Dr. Chan, Samuel went out to the front desk to check in with the clerk and to let her know that he was busy, even though he still had a slot at 3 o’clock “open” according to the schedule.

The payment for primary care services continues to center on the number of visits completed by primary care providers. Nurses, whose time is not directly tied to billing, are asked to absorb some of the more time-consuming elements of patient care in order to keep the primary care providers in time with the norms for patient visit volume (c.f. Sharma 2014). This offered Samuel the degree of flexibility and autonomy necessary to care for Mr. Walker. Using his 3 o'clock slot for the same patient would not have direct financial consequences. At the same time, Samuel knew that the other provider on his team, Dr. Wright, expected him to care for her patients at 3:30 and 4. This was an example of the paradoxical tension between visibility and control in the monitoring of work (Bowker and Star 2010). Nursing labor, which is not closely measured, may be taken for granted while its relative invisibility also offers flexibility (c.f. chapter 4).

It was in anticipation of Mr. Walker's complexity and his "non-congruent" time orientation that Samuel was involved in assessing Mr. Walker in the first place. Although Mr. Walker was already known to require a lot of attention, which could pose problems for addressing other clinical responsibilities, Samuel did not overtly resent him for it. If anything, Samuel found patients like Mr. Walker most rewarding. I return to this below. But first, we need to finish the visit. We went to fill Dr. Chan in on the visit so far.

*2:52. Samuel leans against the desk to Dr. Chan's left as they talk. Samuel reports the 20-pound weight loss that he noted in Mr. Walker's chart.*

*"In two weeks?!" Dr. Chan asks. They discuss the possibility that the weight was measured with his coat on last time, but then Dr. Chan looks back in the record and observes that it was Samuel who did the weight last time, "so it's real."*

*Dr. Chan comments that it is strange that his home health nurse did not notice. Samuel replies that there had been a change of nurses – he just got off the phone with the old one.*

*“He seems a little off,” Samuel says, broaching his concern about Mr. Walker’s non-linear discussion of his health concerns and diet. He tells Dr. Chan that usually Mr. Walker talks a lot, but he stays on topic. This is different.*

*Dr. Chan sounds a little skeptical, commenting that “he’s always...” then trailing off. “...Like that” is implied.*

*Samuel insists: “It’s a little bit up from what I am used to seeing.”*

This interaction encapsulates the benefits of team-based continuity (c.f. chapter 7).

The continuity of Samuel’s care for Mr. Walker is highlighted in juxtaposition to the change in his home health nurse. Samuel’s long-term relationship with and consistent attendance to Mr. Walker bolstered his and Dr. Chan’s trust in the data upon which their clinical concerns were based. In several respects, what had Samuel and eventually Dr. Chan worried was a subtle intensification of many features of Mr. Walker’s “baseline.” He is always thin, always talks and is always “a little off,” but this time something was worse.

Especially in older patients, an illness can cause changes in someone’s cognitive status, called delirium. Dr. Chan and Samuel began to suspect that something like this could explain the concurrent changes in Mr. Walker’s weight and behavior:

*Dr. Chan accepts Samuel’s assessment and thinks aloud. She asks him if he thinks Mr. Walker will give a urine sample so that they can look for an infection that could be “making him altered.” Samuel thinks that they can get Mr. Walker to give a sample to test this theory. They agree to go back together to look at Mr. Walker’s wound.*

*As Dr. Chan gets up, Samuel clarifies, “I haven’t opened [the bandage] yet.” Mr. Walker has now been here for nearly an hour and Samuel had planned to assess his wound before consulting Dr. Chan, but the visit has not gone according to plan. Dr. Chan makes a surprised sound but doesn’t comment.*

*They go into room 3 together and Dr. Chan asks Mr. Walker about giving a urine sample, explaining their concerns. As Mr. Walker explains his reasons for thinking*



*he's fine, Dr. Chan is a bit more assertive in redirecting the conversation. Sometimes her attempts backfire, inciting more comments from Mr. Walker.*

*Samuel and I step out for a moment to get sterile scissors from a suture removal kit – the extra degree of hygiene will make Mr. Walker more comfortable. When we get back, Dr. Chan is asking Mr. Walker again about his willingness and ability to give a urine sample. Eventually, he agrees to do it. Before that, though, Dr. Chan and Samuel will inspect his wound.*

*The wound is on the back of Mr. Walker's calf, and he is seated in a regular chair. There is a lot of awkward crouching and switching of positions and angles to get a good view. Samuel holds Mr. Walker's leg up for Dr. Chan to see. We step out into another room to get a wound care bin. Samuel comments that he's sweating. "That was a workout," I say. "It's good," he replies, "I feel like I'm actually doing some nursing."*

Samuel's warning that he had not yet had a chance to remove the bandage acknowledged a deviation from the plan and from his formal role, which is partially to make the interaction with Mr. Walker as brief as possible for Dr. Chan. It also marked that Samuel was serious about Mr. Walker being more "off" than usual today. Although his wound was chronic, it took on new significance in the context of this acute change in his behavior.

Samuel's pride in "actually doing some nursing" referenced the hands-on work of wound care in contrast to much of primary care nursing. As I discuss elsewhere, some nurses that I spent time with felt that their skills were underutilized as their jobs increasingly involved interfacing with pharmacies and insurance companies on behalf of patients and other forms of operational "troubleshooting" (c.f. chapter 4). Many nurses valued patient education as a central element of their role. Still, they also seemed most in their element when tangibly responding to acute conditions. Samuel often commented on the importance of triage and the appropriate use of nursing skills.

*~3:12. Samuel uses supplies from the wound kit to clean ointment off of the wound for a clearer look. Dr. Chan eventually excuses herself with a plan in place. Mr. Walker asks Samuel for a urinal to use in the room, rather than moving to the restroom. After a couple digressions, Mr. Walker suggests we return in 5 minutes.*

*“He gave me 5 minutes,” Samuel says as he walks more briskly back toward room 12. “We’re going to use my 5 minutes.”*

*In the hallway, Samuel sees another patient, Mr. D, and greets him with a pat on the shoulder.*

Mr. Walker’s suggestion of a return time seemed like an attempt to assert control over the visit. As he partially acquiesced to Samuel and Dr. Chan’s care plan, Mr. Walker suggested the pace at which things should happen. Samuel’s response in the hallway simultaneously validated Mr. Walker’s claim and made light of it. Samuel seemed to respect Mr. Walker for his assertiveness, even though he knew that five minutes was a tall order given his other duties, of which Mr. Walker was unaware.

Now an hour into the visit, this was one of the first chances Samuel had to re-orient himself to his other tasks outside of the visit with Mr. Walker. Not surprisingly, it was more than 5 minutes before we returned. Five minutes here was a placeholder, but the tasks that Samuel hoped to complete within that time frame already exceeded its limits. Further, once he left the room with Mr. Walker, he became available to others for help with clinical tasks.

*Back in room 12, Samuel checks the schedule on the screen. At some point, he comments to me: “This is a bit disjointed, [which] makes it hard.” Nicole, a health worker doing intakes and discharges for Dr. Wright, pops in through the open door. She says that Mr. D, one of Dr. Wright’s patients, needs a flu shot. She holds out a label with his name on it and “flu IZ” handwritten in the corner. When Nicole leaves, as quickly as she came, Samuel tells me to mark that down as a knock. “That’s a typical knock,” he says, even though the door is open.*

Samuel's observation that things were "a bit disjointed" was one of many he would make on his feeling of temporal fragmentation. It is unclear whether what was "hard" in this setting was keeping up, providing coherent care to Mr. Walker, or giving me a sense of how his time is supposed to go. Earlier, Samuel had taken a moment to make his electronic schedule match the plan for the afternoon, telling me that he was a time-oriented person and that this helped ground him. That schedule quickly became irrelevant. It was interesting that he made this comment about his work being "disjointed" at a point in Mr. Walker's visit that had thus far included few interruptions. An influx of varied requests that would keep us from returning to Mr. Walker for a while began with Nicole's "knock" for a flu shot.

Earlier that afternoon, before Mr. Walker arrived, I had started a tally of interruptions, including phone calls and knocks, which Samuel felt were an under-recognized part of nurses' workflow. By referring to them here as "knocks" even when they were direct verbal requests, Samuel made sure that I noticed each request but avoided the more negative connotation of "interruption." A "knock" referred to when others came to him for help in an unpredictable way, which may interrupt his train of thought or his work on something else. Health workers like Nicole are not licensed to give injections. Medical assistants are, but they require "verification" by a nurse or provider to be documented. Accommodating "knocks" was thus central to the nursing role.

*Samuel changes Mr. D's visit status to "arrived" – Nicole should have done this – before going to see him in the room just across the hallway. With Mr. D's adult son providing language interpretation, Samuel runs through standard screening questions about the flu shot. Having confirmed that he could be immunized, Samuel goes to the med room to put together a tray of supplies.*

*As we arrive in the med room, Emma, another medical assistant, is finishing up putting together a vaccine tray of her own. She asks Samuel to verify an*

*immunization for her, again handing him a sticker for the patient in question. Samuel turns to me and says: "That was a knock. What she just did is a knock." Emma looks at me but doesn't ask, nor does she look confused. Samuel stores the sticker on his arm so that he can log his verification of the vaccine in the Emma's patient's chart later. While he collects things from the fridge, Emma verbally runs through all the screening she'd done and the timing of her patient's shots, information Samuel would need to judge the appropriateness of the immunization.*

*We return Mr. D's exam room, where Samuel administers the flu shot. Before we leave, Mr. D's adult son asks if he can ask a personal question. Samuel says yes and then says, "Wait, is this a question about your dad or about you as a patient?"*

*"For me, but not as a patient. Just for general knowledge," the son replies.*

*After a nearly imperceptible pause, Samuel accepts. The patient's son shows him a mark on his own arm, saying he accidentally had contact with an oven cleaning chemical and was worried it was "eating my flesh." Samuel looks at it but is not concerned, explaining that he probably had a burn and it may be a little infected. He refers him to the back of the bottle of oven cleaner to contact the company for information about exposure.*

*The son repeats his question and concern about it eating his flesh and Samuel seemingly can't resist a joke. He says that "unless it's a bacteria from a swamp," he doesn't think it's concerning. He tells him to just put some Neosporin on it, working his way toward the door.*

The joke about the flesh-eating bacterium seemed lost on Mr. D's son. I understood the comment as a sign of Samuel's stress wearing through. His question – is this about your dad or you? – attempted to cordon off his responsibilities in this room and moment, when he was already behind. At the same time, he could not refuse, and he may not have wanted to. As a healthcare professional, it was difficult for him to refuse to offer help, even if his patient's son's personal question was technically not his responsibility. Throughout my research, I noticed that nurses in particular were implicitly expected by others to be

available for these kinds of questions. I regularly saw nurses answer health-related questions from family members and from colleagues during busy moments of their day.

*Back at his computer in room 12, Samuel says to me: "On top of all the things I've told you, the knocks," you have to timestamp things, "before the person who asked you for it locks the note." He adds that nurses can be paged and "the expectation is" that they check urgent electronic messages (TEs) between patients. Samuel finishes charting about Mr. D's flu vaccine and looks up the record for the child that Emma vaccinated, adding his authorization and a timestamp to the flu shot on that note. He checks his TEs. He has 2 urgent messages, but says he will do those later, already walking back toward room 3.*

*When we re-enter the room, Mr. Walker says, "You should try waiting in one of these exam rooms." He says that they should have a button one can push when ready.*

*Samuel lights up and looks at me, gesturing as if writing. I nod and write down: nurse call button.*

*"I completely agree with you," he tells Mr. Walker. I could not tell if Samuel was asking me to advocate for call buttons or gesturing his instructions to note Mr. Walker's suggestion for Mr. Walker's benefit.*

*Samuel says we are going to take the specimen to the lab and then be back. From the lab, we go back to room 12 and Samuel charts the results of the urine dip. On our way to collect labels for the lab specimen, Samuel reflects, "If we had a drop in in that [empty 3 o'clock] slot..." it would have been really hard.*

*In the waiting room, Samuel recognizes another patient and says hi. Later, in the hallway, she nudges Samuel in a friendly and familiar way.*

Though as an observer I cannot always capture all of the things that clinicians and staff are keeping track of, it became clear when we returned to the room with Samuel's computer that he was silently monitoring a number of patients and tasks that needed to be done before we returned to see Mr. Walker. Had there been a call button in room 3, it is hard to know how that would have changed the sequence in which Samuel managed his

multiple responsibilities. At this point in the afternoon, he appeared increasingly overwhelmed.

*We return to the lab, where Samuel relabels the specimen and puts it in the fridge. Then, we go to report the findings of Mr. Walker's test to Dr. Chan. They do not suggest infection but suggest dehydration or malnutrition. Dr. Chan thinks aloud for a moment, ultimately saying that she wants Mr. Walker to go to the emergency department (ED) for fluids, but she knows he won't. She asks Samuel to ask him, but Samuel resists, suggesting that Mr. Walker may respond better hearing that from her.*

*Dr. Chan stares for a moment, glancing repeatedly at her computer screen and then stretches with her head back like she's struggling with herself as she agrees to go back to see Mr. Walker together.*

*3:41. We return to room 3. Dr. Chan says, "Okay," and outlines the situation as she sees it. "Usually, when I see these things, I'd be asking that patient to go to the ED for fluids," she tells Mr. Walker. As she had anticipated, Mr. Walker immediately and adamantly refuses. Dr. Chan accepts his refusal and negotiates to draw labs today in clinic and have him come back next week. She asks him to eat and drink more in the meantime.*

*After the doctor leaves, Samuel replaces the wound dressing on Mr. Walker's leg. For his comfort, he offers Mr. Walker tubes of antibiotic ointment and moisturizing cream to take home. As we leave room 3, Samuel tells me he will find someone else to do the labs.*

*Later, we run into Julia, the medical assistant working with Dr. Chan, in the hallway. Samuel, sounding a little strained, tells her, "I really need to move on." She nods and agrees to draw Mr. Walker's labs.*

Both in their private consultation and in the exam room, Samuel and Dr. Chan drew on their knowledge of Mr. Walker to craft a plan that might help them make progress in his care and the rest of their clinic. They both simultaneously tried to protect their own time. Dr. Chan asked Samuel to suggest the emergency department so that she did not need to get involved again. Samuel insisted on her participation in hopes that it would be more

effective, and perhaps faster. After completing the elements of Mr. Walker's care that required his nursing and personal expertise, Samuel tried to pass the last part on to Julia.

*In the hallway, Samuel says aloud: "I wonder how much time we've spent with him." I offer to estimate it based on my notes: 1 hour and 5 minutes over the course of 1 hour 45 so far.*

*Back to charting, Samuel acknowledges the patient in the exam room across the hall, one of Dr. Wright's patients that he has not had time to see yet: "I haven't forgot," he says, "thank you for waiting."*

*"Things are getting fragmented," Samuel says to me, staring at his computer. He needs to leave before 5 today.*

As the end of the clinic grew closer, Samuel repeated his feeling that his work was "fragmented." The visit with Mr. Walker had been more time consuming than expected and did not follow the plan set out at the beginning. It was not just the pace or quantity of work but its fragmentation that was overwhelming. Meanwhile, Samuel was aware that others were expecting help from him. When he acknowledged the patient in room 10, he used a phrase frequently heard in the clinic: Thank you for waiting.

*Julia comes by and says, in an apologetic voice: "He [Mr. Walker] said, 'Does Samuel want to try the other arm?'" This means she wasn't able to get the blood.*

*Okay, Samuel says. He'll be there in a minute.*

*4:11. We go back to the lab and Samuel successfully draws full tubes of blood from Mr. Walker's other arm.*

*4:15. Samuel puts the sample in the fridge, saying "Okay, we got something done."*

*"So," he adds for my benefit, "The [lab] courier comes at 4:30... Wow, Shannon, this is perfect timing." He laughs relief.*

Samuel's comment that "we got something done" made light of a feeling that the day had not gone according to plan. It also downplayed the several tangible things he had done, including identifying an abrupt but subtle change, taking steps toward a workup, changing bandages, addressing "knocks," not to mention talking at length with a patient who needed it.<sup>74</sup> In both Samuel's movements and the clinic in general, one could feel the end of the session, and the week, approaching. Still, from the number of patients still there, clinic was far from over.

*As we walk by the room where Dr. Wright and Dr. Chan chart, Dr. Wright waves Samuel into the room. She's on hold, but she needs Samuel to stay there so she can tell him something. Dr. Wright speaks to the person on the phone: "I have 3 patients waiting." Still on hold, Dr. Wright explains to Samuel that they added to her schedule a hospital discharge patient who needs a procedure they can't do in clinic. She needs help working out an alternative plan.*

Dr. Wright was clearly stressed at having several patients still in clinic so close to the end of the day. She invoked their waiting on the phone in hopes of generating some urgency on the other end of the line. At the same time, I noticed that in her focus, Dr. Wright felt comfortable asking both nurses in clinic for help. The clinical hierarchy enabled her to ask Samuel to wait as she was being forced to on the phone. Both providers were relying on Samuel at once, and most of his clinic had been focused on Mr. Walker.

*As Samuel and his fellow RN, Camila, work on getting the recently-discharged patient an appointment at urgent care, Dr. Chan comes in and tells Samuel that [for Mr. Walker], "I should have a roll-in by Tuesday [that] we can steal." (A roll-in here is an appointment that opens on short notice.) She agrees with Samuel that Mr. Walker may be falling off the "self-care curve." Samuel repeats his impression that Mr. Walker's usual quirks seemed "amped up" this time...*

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<sup>74</sup> Davies (1994) observes that process time is not only difficult to measure. It can also make it difficult for the caretaker to recognize or account for what they have accomplished.



*We go back to the lab, where Mr. Walker is resting in the phlebotomy chair. Samuel tells him that, “after this long appointment,” he is okay to go home. Mr. Walker does not respond and Samuel says his name a few times. When Mr. Walker responds, Samuel asks him if he is dizzy. Mr. Walker says he can’t hear the question. Samuel asks the question twice more, getting closer to Mr. Walker’s ear. After the third asking, Mr. Walker shouts “NO!”*

*Mr. Walker stands and starts slowly zipping his layers. Samuel tells him that he has an appointment next Tuesday. Mr. Walker doesn’t feel he needs to come back so soon. Samuel reiterates their concern about his weight loss. Mr. Walker argues that this is a sign that he is healthy, adding an insult that Samuel does not react to or engage with. He reiterates the appointment for next week and wishes Mr. Walker to “get some rest.” Mr. Walker’s last word: “‘Get some rest.’ I’m an active person!” I can’t remember if Samuel said anything else as we walked towards the door leading back out into the waiting room.*

This last tense interaction with Mr. Walker seemed to reinforce the idea that he was not well. But, based on his preference, they needed to let him go home and return next week. In total, Mr. Walker had been in the clinic for over two hours. Samuel had not yet had a chance to help with Dr. Wright’s patients, other than the flu shot for Mr. D, and he needed to leave in less than half an hour.

*4:29. As Samuel holds the door open for Mr. Walker, he also says hi to the courier, who is here to pick up the labs. Samuel glances into the lab and calls out for the medical assistant in charge of packing samples. He quickly moves on to the med room, preparing another flu shot for the patient in room 10 whom he has not forgotten. He admits to me that he avoided helping to pack the labs, saying he needed to collect his own thoughts.*

*Back at his computer, Samuel comments that, “This is an example of how things can become fragmented. It’s worse when [other] people are waiting... the doctor might not feel enough support.”*

*He looks at his template, summarizing the afternoon for me. "Mr. Walker took my 2:30, my 3:30... almost to 4:30." He tells me that "it's hard to anticipate..." a "combination of the doctor's order and patient's tolerance."<sup>75</sup>*

*He reiterates unprompted that he feels "uneasy" with the idea of Mr. Walker being at home and "how he's thinking about things."*

In the busy clinic, I was not able to ask Samuel then what he meant by "fragmented." At the time, the word made sense. But what does fragmented mean here? It was as if clock time and the temporality expected by the clinic was being fragmented by process time. Fragmentation in this context referred to the way in which Mr. Walker's visit became more complicated than anticipated and could not be reconciled with Samuel's other commitments. His emphasis on the doctor feeling supported suggests that while he clearly prioritized patient care for Mr. Walker, Samuel felt he had neglected helping Dr. Wright and her patients. Even after Mr. Walker left, Samuel continued to think about him and worry about his wellbeing as he shifted his attention to remaining tasks.

*During this last stretch of the clinic, we go back and forth to various rooms and Samuel gives updates and vents to colleagues. He tells Camila (RN) and Kara (health worker) that he spent "an hour and a half" with Mr. Walker, adding: "Ask Shannon." Kara believes it, telling her own story about an interaction with Mr. Walker and saying, "I'll never forget that guy."*

The tone of this exchange, even in Kara's comment, was light. It seemed ambivalently affectionate. They were laughing at the apparent absurdity of spending an hour and a half with one patient in the context of a busy clinic. Yet, if perhaps not loving Mr. Walker, they

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<sup>75</sup> I interpret Samuel's reference to "doctor's order" as meaning the sequence of the doctor's schedule, not (only) their instructions. Samuel commented on the fact that despite their desire to save visits like this until after drop-in hours, there was no way to control when within the clinic session a complex patient like Mr. Walker would be scheduled. This is related to the practice of scheduling uniform appointments that I discussed in chapter 2.

were not being overtly critical of him either. In many clinical settings, complex and time-intensive patients risk garnering resentment and receiving a lower quality of care (Higashi et al. 2013). This often held true in this setting as well. However, I believe there is something unique about the primary care safety net, where many clinicians and staff desire to serve patients whose care is a challenge because of their complexity and vulnerability. I often witnessed a special kind of fondness in this setting for patients like Mr. Walker.

*Back in room 12, Samuel explains to me that while the nurses generally prioritize drop-in patients earlier in the clinic, "I accommodated [Mr. Walker] because I know him," and with someone else seeing him, "he would still be here." Samuel adds that there is no way to sort the "chronic patients" like Mr. Walker into particular slots on the schedule, so the distinction between drop-in and "tactical" time [for assisting with scheduled patients] that was written into the nursing schedule template remains somewhat wishful. Patients recently discharged from the hospital, for example, also have to be seen whenever they are scheduled "because of the acuity."*

By linking Mr. Walker to recently hospitalized patients who may also appear anywhere on the schedule, Samuel marks that Mr. Walker is not that unusual. His insistence on being attended to at his own pace, intensified this day by his illness, made him stand out. Nonetheless, the clinic sees many patients with a similar set of chronic, acute and acute-on-chronic concerns. This is what makes the persistence of current scheduling practices that are discordant with patients' needs striking to the anthropologist and fatiguing for clinicians.

Samuel's labor to care for Mr. Walker enabled Dr. Chan to see her other patients. Because of where Mr. Walker fell on his schedule and the time it took to address both his chronic wound care needs and his acute change in weight and behavior, Samuel had not been able to attend to other patients that he had agreed to see at the start of the session. While he charted, Dr. Wright, the other provider that Samuel was teamed up with and

expected to support along with Dr. Chan, appeared in the doorway. She asked Samuel about the status of him seeing her patients, other than doing Mr. D's flu shot. Samuel, who needed to leave, told her that he had just spoken to his fellow RN, Camila, about Dr. Wright's other patient and Camila was going to see her.

*Dr. Wright is visibly stressed. "I'm sorry," Samuel says, "I was busy with a chronic patient of Dr. Chan's."*

*Dr. Wright doesn't respond.*

*"It's okay," Samuel adds softly.*

*"It's 4:45 on a Friday, Samuel," she replies sharply, with something between a scoff and a sad laugh. The clinic staff goes home at 5.*

*When Dr. Wright leaves, I say I am sorry if I "drew heat" by being present and asking questions. I worry that Dr. Wright thinks Samuel was wasting time talking to me, even though he was working as he spoke and the day may have played out similarly in my absence.*

*Samuel's reply suggests that this is a more general pattern about his work: "You see, it's fires from all sides."*

Based on my approximate notes, Mr. Walker was in the clinic, from first sitting down in room 12 to leaving and not counting the scale shuffle for 2 hours and 11 minutes. Of that time, Samuel was directly involved in caring for him for at least 1 hour and 15 minutes. This is an underestimate because it does not incorporate some of the discussions about his care. At the same time, these totals show that Mr. Walker also spent considerable time waiting, a waiting made necessary by Samuel's obligation to other patients.

Fire was a common metaphor for the various urgent tasks that arose in the course of clinic. The urgency could stem from clinical acuity, patient or administrative expectations or prior delay. When time and staffing were inadequate to allow for thoughtful planning or

action, people described the work as “putting out fires,” suggesting that they were only able to minimize damage rather than make progress. Here, Samuel’s comment that “it’s fires from all sides” sounds like a summary of the absurdity of his task as an RN. Many days, he is able to negotiate his various obligations, but on days like this one, he struggles to provide good patient care and support his colleagues at the same time. In reflecting on the day, Samuel explained his focus on Mr. Walker as a reflection of his commitments and skills.

I learned that Samuel had a background in case management and that this was part of his reason for going into primary care and his professional identity as a nurse.

*Samuel: At the same time that I want to fall into a small little box of what my job is defined as and not really consider anything out of it so that I don't get pulled into it, I want to be pulled into it. I want to be a part of it. I want to understand; I want to be invested. And all [this] holistically (sic) approach to patient care, pushes against my own time restraints. And I am aware of these pushing and this slightly increased stress on my time management. I feel it's worth [it] because I believe the outcomes are better.*

Samuel describes his official role as oriented toward the primary care providers, providing coordination, follow-up and outreach to ultimately support their work. By contrast, his self-definition focuses on rapport and long-term continuity with particular patients. On the one hand, Samuel observes that his official role could act as a boundary-setting device, preventing his clinic from being derailed by patients like Mr. Walker. At the same time, it is clear that allowing himself to be “pulled in” fosters a sense of pride for Samuel in his unique ability to care for certain patients. He told me that he tries to prepare for this possibility of being pulled in by always using any downtime to address messages and other tasks so as not to get “behind.” That way, he can let such things wait on particularly busy days. He insists

that the outcomes for patients are better, reframing what might look like inefficiency in the context of clinic flow in terms of effectiveness for his patients.

I asked Samuel about Mr. Walker and how he balances the needs of patients like him with other demands on his time. He gave me an update:

*Samuel: Right. Some of these patients that are chronic... need – they will take more time, often with more constant check-ins, then they stabilize. That specific patient we followed that day [Mr. Walker] has gotten more stable. And if I can delegate some of these check-ins to home health nurses, work with them to help me – you know, I use as much as I can these [resources] that are available for a patient if they're willing to. And in this case, he has connected with a home health nurse. So that has helped, increasingly. Yeah... he's doing well.*

*S: Good. I'm glad.*

*Samuel laughs: He pushes buttons all the time. I never take anything personal...*

While I had in mind the time frame of a clinic session, Samuel's response focused on a longer term, the frequency of check-ins over time, which Mr. Walker's connection with home health nursing helped to relieve. I asked him to also speak to the flow of a given clinic:

*S: ... I remember that day, you were not able to see some of Dr. Wright's patients... I just wanted to ask you to tell me a bit about how you negotiate a patient with a lot of needs and all the other things that are expected of you in a clinic.*

*Samuel: One of the things that we've been doing is having a... meeting at the beginning of the day that – if it's – we call it like, "This is a red code type of day," where I am the Nurse of the Day. I may have more tactical [work] because I have a bunch of chronic care patients and I'm still responsible for the drop-ins; I may be supporting staff that have restrictions in their scope of practice and what they can do and I have to do it for them... So, we've been telling, like, having this little disclaimer in the beginning of our huddle, like, it may be a day that we'll just have to let it go, some of the things we're planning. There are things that... have to be done... Like, the doctor has ordered the labs. I have to do the labs...*

*If I [have] someone who is really complicated, all the things that are right in front of me may need to be addressed, and I may ask, "Would you be willing to take my drop-in?" So, I negotiate with my own peers. Like, we set out expectations, [but] the day may go kaput, like anything in life... I support [my peers] and I ask them for support. And I feel that it does help for the crazy days...*

Samuel emphasizes that some days are more hectic than others, and the degree of chaos may vary from person to person. Negotiating the multiple and often conflicting demands on clinical time requires teamwork and flexibility. While Samuel presents this process here matter-of-factly as acknowledgement and negotiation, the time pressures in the clinic often strained such collaboration and sharing of responsibilities. When Samuel had earlier described being in clinic as "fires from all sides," he conveyed a profound sense of the frustration that can arise from the need to care for several patients at the same time, which rarely follows the best-laid plans based on an imaginary timeline. Samuel and Emily's stories together illustrate the temporal conundrum of simultaneous obligation to particular patients and to colleagues and the flow of the clinic that defines all clinical roles.

Both Samuel and Emily had to let go of the normative timing of the clinic in order to care for the patient in front of them. For both, their prioritization of process time over clock time was a point of pride while also a source of stress. Samuel described things as getting "fragmented" or "disjointed." It is *things* he said were getting that way, not *time*, but his comment focused on the temporal dynamics of caring for Mr. Walker while knowing that others were waiting and relying on him. At the same time, he spoke of "actually doing some nursing" and acknowledged in a later conversation that he *wants* to be pulled in. Emily was confident in what was right for Mrs. Thomas but lamented that her experience of caring for patients like her did not seem understood by those concerned about her cycle time.

Samuel was ambivalent about keeping to idealized time schedules. As I spent the session with him and in later conversations, he sometimes told me how time-oriented he was, altering the visual appearance of his schedule to more accurately reflect his plans. Later in the same day or conversation, he would disavow the utility of scheduling in light of the variability and unpredictability of patient needs, seeing rigid notions of time as a barrier to care. I argue that the sense of fragmentation Samuel kept referring to was not caused by Mr. Walker, but by the disjuncture between process time and clock time, or between the temporality of caring for Mr. Walker and the need to attend to and coordinate with others.

Samuel described collective acceptance of the idea that “the day might go kaput.” The phrase refers to breakdown or malfunction, implying dysfunction when unpredictable or un-sortable patient needs throw a wrench in the flow of clinic time. Ideals like the clinic schedule template and its accompanying practices rhetorically contain the chaos of patient care. Yet, rather than dysfunction, the arrival of a complex patient with acute concerns who cannot be rushed is a regular occurrence. Clinic staff respond to these patients in a number of ways, ranging from frustration to a sort of ambivalent fondness for some of the most complicated patients like Mr. Walker.

Robin Higashi and her colleagues argue that within the hospital, “Time is the currency that is spent and saved by physicians” (2013, 15). This temporal moral economy values patients who give clinicians a sense of efficacy by allowing for quick interactions, rapidly improving or presenting with an interesting condition. Patients who do not meet these criteria, including the elderly and the chronically ill, have less capital. The cases presented in this chapter both exemplify and add to this analysis.



Emily and Samuel both take pride in the care they provide for patients like Mrs. Thomas and Mr. Walker. Thus, their care gives them a sense of purpose, one of the values in Higashi's moral economy. However, this puts them in a position of apologizing or defending their choices to others that rely on their help or monitor their performance. Within this temporal context, patients whose bodies, lives or personalities become a threat to flow can become a source of frustration, even without explicit judgement. At the same time, patients like Mr. Walker illustrate another possibility. Among those who choose to work in primary care and perhaps particularly in safety-net settings, some find precisely certain patients who are time-costly to be valuable because they are in need of "actual" care.

I asked one provider how her role has changed over her many years of experience in the same clinic. She responded:

*Yeah, for sure... I mean, my attitude has changed. I think that – I was just in a conversation about, you know, when we get really frustrated with patients 'cause they're not doing all the things that we'd like them to do. And so, you know, to take a step back and say, "Okay. What's that about?... How can I support their goals? And how can I help them figure out their goals? Who can help them figure out their goals?" So, I think to not be so driven by my agenda. Because ultimately – that only works for some people some of the time. And I guess I'm more interested in the people it doesn't work for most of the time. [laughing].*

We both laughed. I asked her how many of her patients fit that description.

*I think you collect them. I mean, it's interesting because my [new] medical assistant [who has worked with other providers] has said that. She's like, "You know, your patients... they don't come, they don't do what you tell them," ...and she's like, "Can I get a break from your panel for a little while?" ... And so, I think it's a function of many things. Like, I've been here for a longer time, so people are older and maybe sicker. And I do get that this – the way we have it set up doesn't work for everyone. So, I don't – but I don't want them to not be able to come, you*

*know... We're not set up right for them, but still, if they're trying to access something, there's some value in it for them.*

The uneasy coexistence of these two models of time – clock and process – structure the perception of patients in complex and sometimes contradictory ways. Such contradictions end up making some patients seem ‘non-congruent’ because they need more time and more care than the clinic is set up to allow. Clinicians’ and staff’s responses to these patients were varied and often ambivalent.

In his work on religion, Dumont (1982) distinguishes between hierarchy and stratification. Stratification in Dumont’s usage is like a pyramid, with a single top and flat base. Hierarchy, on the other hand, can be more complex, connecting multiple axes of value. One example is the “hierarchical dualism” of religious and stately authority, in which the priest and king are each superior and inferior to the other depending on the matter at hand (Boon 1999). This distinction may help to understand the perception of certain types of patients within the temporal economy of the clinic. One would deduce from the model of clock time that patients who require little time may be highly valued based on the logic of clinic flow. Yet, there is also a special kind of affection or value in this setting attached to the patients who are time-intensive but are felt to truly need the care (read: time) of the clinician. These patients perhaps exist near the top of a hierarchy based in process time and the desire to be “pulled in.”

Higashi (2013) and colleagues recognize patients who are interesting or give the clinician a sense of professional efficacy as valuable within the temporal moral economy of the hospital. I propose that in the context of the clinic, where clock time is perhaps more imposing and by the same token more fragile, this double hierarchy and the concept of

“process time” are useful for thinking about those patients who do not necessarily get better, nor are their conditions particularly interesting, but they are valued as exactly the type of patients that it is the clinic’s mission to serve. The salience of each part of this hierarchical dualism depends on context, including the personalities and ethical orientations of the persons giving and receiving care. While individual practitioners value the opportunity to be pulled in to the care of certain patients, this can become problematic for their colleagues. This shared nature of time in the clinic can intensify the normativity of flow and cycle time.

Temporal ideals embedded in schedule templates and norms about timeliness assume a patient whose needs can be adapted to the pace of the clinic. These ideals regularly confront scenarios in which this accommodation to clock time becomes impossible and clinic staff become immersed in process time. These encounters highlight the fragility of the temporal expectations of the clinic as clock time becomes fragmented by process. The distribution of labor across the clinical team allows providers like Dr. Chan to stay relatively close to her schedule by asking for Samuel’s assistance. Meanwhile, Samuel is simultaneously beholden to multiple colleagues and patients. In the next chapter, I analyze in greater detail these dynamics of clinical teamwork.

## Chapter 4. Protection: Labor, Value and Teamwork

One day, early in my research, I sat in a room where providers and MAs returned to chart between patient visits. Dr. Lee asked me: “Your research is about time in primary care, right?” Then, she spontaneously offered, with a serious expression and tone: “Time is our great enemy in primary care.” To elaborate, she referenced an article written “a decade ago” about preventative care, which argued that it would take “like 18 hours a day” if primary care providers did everything they were supposed to do.<sup>76</sup> “So you cut corners all day,” Dr. Lee said. I asked her how she deals with that. “A lot of not letting the perfect be the enemy of the good,” she responded.

The mandate of primary care is expansive. The feeling of “cutting corners” weighs heavily on the minds of many clinicians and staff (c.f. chapter 7). The notions of cutting corners and attempting to provide “good enough” rather than “perfect” care highlight that clinicians and staff are left to grapple with the finitude of clinic time that mounting expectations ignore.<sup>77</sup> In chapters 2 and 3, I described how clinicians and staff use delegation and time management techniques to maintain clinic “flow” while also providing

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<sup>76</sup> The article that Dr. Lee mentioned referenced the work of a research group that has published several estimates of the time requirements of nationally recommended preventive and chronic care. They estimate that it would take a primary care provider 10.6, 7.4 and 21.7 hours a day for chronic, preventive and comprehensive (including acute) care, respectively (Østbye et al. 2005; Yarnall et al. 2003). Their estimates were based on the recommended care related to the 10 most common chronic diseases for a patient panel of 2500. Ghorob and Bodenheimer (2012) drew on these studies, writing that it would take providers 18 hours a day to provide recommended preventive and chronic care – the figure that stuck for Dr. Lee. This overflowing demand is part of the driving force behind the adoption of team-based models of primary care. Interpreting these estimates in the context in which Dr. Lee invoked them is challenging, as the studies were based on national survey data and a panel size of 2,500, a frequently cited but hotly debated number (Raffoul et al. 2016). The “active” panel size for a full-time provider in the clinics in this study was 1,200, but their medical complexity and social vulnerability was considered significantly higher than average. Meanwhile, most providers were part time. For my purposes, parsing the validity and applicability of these studies is beside the point. I am interested in what Dr. Lee’s citation of the studies signals – that the work expected is felt to vastly exceed the time available.

<sup>77</sup> For a case study of one way in which the incremental increase in responsibility for primary care clinics operates, see chapter 6.

care to patients whose needs exceed the bureaucratic logics built into the clinic schedule. A sense of endlessness also characterizes aspects of the care coordination and documentation involved in realizing the goal of comprehensive and preventive care and meeting the administrative requirements of regulators and insurers. This contributes to a feeling that the time of the clinic and the labor time of its staff require protection.

Forms of work indirectly related to the patient-provider encounter were often moved outside of the frame of the patient visit or clinic session. They were distributed to other members of the care team and into the gaps between encounters, “administrative” (protected) time and overtime. These times and roles protected the encounter while requiring protection themselves. In this chapter, I revisit the management of clinic flow and overflow with a focus on clinical teamwork. I examine how institutional logics and interpersonal collaboration shape the distribution and forms of temporal protection for members of the primary care team.

Everyone, to a degree, is oriented or subject to the temporal needs of others (Sharma 2014). This is a fundamental feature of time as a social phenomenon. It is readily visible in team-based work and service to patients. Experiences of this mutual implication in social rhythms, however, are not uniform. The relationship between control over time, autonomy and status are complex, but the hierarchy of clinical roles is structured by the unique valuation of primary care providers’ time.

The work of clerical staff, medical assistants and nurses is essential to meeting the goals of providing quality care, yet clinical revenue remains largely based on *provider* visit volume. Teamwork involves many formal and informal forms of interpersonal care and assistance between colleagues. These personal relationships between team members are

embedded within a payment structure that only formally recognizes providers' labor time. The orientation and chronic care clinics run by nurses, for example, enable care for patients "enrolled [but] not yet seen" and in-depth patient education around hypertension and diabetes, but they are not billable. As one nurse manager observed, with some exceptions, nurses in healthcare are "a cost of doing business... rolled into your bed rate." In order to be recognized by payers, patient visits with a nurse have to be "flipped," meaning that a provider briefly glances at the patient and approves of the nurse's plan in writing.<sup>78</sup>

In addition to this critique of reimbursement, there were multiple other ways in which clinicians, staff and managers expressed notions of value institutionally attached to the labor times of team members. The lack of direct payment for nursing services gives nurses a certain autonomy (their schedule was not as subject to financial rationalization or monitored for productivity), but it also renders their work less visible (c.f. chapter 3, Bowker and Star 2000). The relative valuation of different roles manifests in a number of ways amidst and beyond the flow of clinic time. Value is not only understood in terms of salary or autonomy, but also in terms of protected time and opportunities for growth.

### **Temporal Interdependency and Protection**

A sense that time is out of control was reflected in Dr. Silva's sense of being a "prisoner" to cycle time (chapter 1) and Samuel's sense of fragmentation (chapter 3). In my fieldwork, I quickly found that a good way to make people laugh was to ask how much

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<sup>78</sup> Given providers' social status within clinic hierarchy and their location at the center of clinical organization, some staff were critical when they would refuse work such as seeing a patient briefly for a "flipped visit." Flipped visits, where the nurse assesses the patient first and the provider signs off, require comparatively little provider time for the financial payoff to the clinic network, but may happen amidst a hectic clinic and generate additional paperwork. By the same token, some clinic staff recognized the lack of time or temporal flexibility for providers that originated in that same central position, taking it as their role to offset this overload however they could.

control they had over their time. Degrees of “control” and its absence ranged from a provider being overwhelmed at the never-ending paperwork which spills outside the bounds of clinic time to a front desk clerk who has to ask someone to cover her post in order to use the restroom. While “protected time” in the clinic referred to specific blocks of time during which clinicians or staff could step out of the flow of the clinic, I use the concept of time protection in a broader sense to refer to the maintenance of one’s movement in normative time.

The question itself – how much control do you have? – is based on a model of time as a resource or space that can be managed or defended. This model is common in framings of temporal politics. The notion of time control, however, is complicated by the interdependencies which are so visible in the clinic. My analysis of the temporal dynamics of teamwork is inspired by a framework, developed by Sarah Sharma (2014), in which the focus is shifted away from control over time-as-space to study how we move in time and the ways in which some people’s movement is maintained or neglected by others. I use the concepts of time protection and time maintenance to convey relationships between time and power that are related to but not synonymous with control over time.

In Sharma’s “power-chronography,” the idea of being “out of time” is not about lacking free time but being outside of the temporal order of institutions. Staying or being kept “*in time*” means adapting to a normative temporal order. The maintenance of some *in time* is ensured by capital investments and the labor of others. In Sharma’s analysis, for example, business travelers and taxi drivers alike see themselves as out of time, but their experiences differ in the status associated with their unique temporalities and how their movement in time maintains or is maintained by the other. Sharma writes that we are all

required to “recalibrate into the temporal expectations demanded by various institutions, social relationships and labor arrangements” (2014, 138). What recalibration entails ranges from being pampered by others in first class to sleeping in one’s cab between fares. I draw on Sharma’s framework to understand the ways in which clinical teamwork maintains providers in time with the institutional norms of the clinic schedule through the labors of clinic staff. I also discuss how each member of the clinic team is maintained *in* or left out of other normative temporalities, including regular work hours and the progressive trajectory of a career.

### **Background: After Hours**

*A widely held presumption is that general practitioners have too much to do and too little time. Strangely, no research has asked the obvious follow-up questions: Have they no evenings? Have they no weekends?*

– Caverly, Hayward and Burke, *British Medical Journal*, 2018 <sup>79</sup>

As I asked experienced clinicians about overtime, I recognized that my thinking was shaped by my age and historical shifts in the practice of primary care over the past several decades. Having started medical school in 2012, I entered medical training at a time where burnout and work-life balance were frequent topics of conversation. Researchers and clinicians have identified shifts in expectations among younger providers, moving away from the historical image of the generalist always on call (Hoff 2009; Loxterkamp 2018). These shifts, including being more likely to work part-time, reflect reorganizations of medical labor, with more providers working as employees instead of owning their own practices and with

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<sup>79</sup> This is a satirical article entitled “Much to do with nothing: Microsimulation study on time management in primary care” (Caverly, Hayward, and Burke 2018). The authors encourage readers to read a “trigger warning” before proceeding.



increasing regulation of practice and extraction of data and labor enabled by the EHR (Waitzkin et al 2018).

The day I shadowed Dr. Reynolds, as the clinic was winding down, she told me about how she manages an overwhelming amount of documentation and paperwork:

*It is Friday, toward the end of clinic. Smiling at a text on her phone, Dr. Reynolds explains to me that she's been trying to get her partner to take their daughter to an event in the neighborhood today, and it sounds like they will go. "Did I just get time to write my notes?" she says. "I need an hour without feeling guilty."*

*She walks me through her strategies for addressing the "strict necessities" like prescriptions and referrals and keeping track of other tasks for later, when she will work from home on Sunday night... She says, "I'm lucky that I love what I do, but it doesn't seem sustainable [for] 15 years." In particular, she refers to paperwork and phone follow-up. "And you want to do it," she says, "to put yourself in [the patients' shoes]," but it is a lot.*

*We run into Dr. Moore upstairs and Dr. Reynolds tells her that she was just telling me about how she relies on the ability to work from home. Dr. Reynolds asks Dr. Moore, "What would you do without [off-site access to records]?"*

*Dr. Moore replies: "I would be doomed."*

Documentation and paperwork are often acknowledged as a major source of overwork and burnout for primary care providers (Erickson et al. 2017; Gawande 2018). Dr. Reynolds' comment about putting herself in the patients' shoes denotes that this paperwork can be an important part of patient care.<sup>80</sup> With the electronic record and remote access, clinicians who used to stay late at the clinic to finish their documentation now had the option to go home and be with family, finishing later. At the same time, the EHR has been linked to an

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<sup>80</sup> These tasks are also heavily shaped by billing and regulatory requirements but cannot be reduced to those purposes. One provider told me that part of the reason she spends so much time on paperwork is that there are many services available for her to apply for on behalf of patients.

increase in documentation requirements that leads to primary care providers spending hours of “pajama time” charting (S. Berg 2017; Arndt et al. 2017).<sup>81</sup>

None of the providers that I met worked clinically full time. This was in part because the job entailed significant work outside of the time they worked “on paper.” I asked everyone in the study how much, on average, they worked outside of their formal hours. For providers, estimates ranged from one to twelve hours a week. For physicians, this was not compensated as overtime, but it was work that providers did through lunch, after hours and from home.<sup>82</sup>

One provider told me that she does not keep track of her overtime. I asked why. “I mean, I think if I keep track of it, it might upset me,” she responded matter-of-factly. She also captured qualitative differences in forms of (excess) labor when she repeatedly told me that she was less concerned about the quantity of time she spent on her work than what she was doing with it:

*PCP: And then, I like to do what I like to do. I like to go see a patient at home. I like to go see a patient wherever. So, in that sense, even if it's my “free time” or my time off, it just makes me feel good. If I can do something that I like, I feel like [it is] nice for a patient and their family and all that kind of stuff.*

*S: Do you visit patients from [this clinic] at home?*

*PCP: Yeah!*

*S: Cool.*

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<sup>81</sup> Like many technologies that introduce new norms and temporalities into daily life, the EHR and off-site access to it appear here as both the culprit and the solution to the problem of documentation overload (c.f. Wajcman 2014).

<sup>82</sup> In this particular system, because of their job classification, nurse practitioners were technically entitled to overtime pay, but I was told that strong social norms meant that they often did not claim it.

*PCP: I just did last week... it just makes you feel so – ...it's not just time. Right? It's like what are you doing in your time? I think that's probably more frustrating for most people than... the actual time.*

This provider's observations draw attention to how responses to time-intensive tasks vary depending on autonomy and how much they can be related to or distanced from one's concept of patient care (c.f. Gawande 2018). I return to this theme below.

When I asked another provider how much she worked outside of her official hours, she asked me what the range was that I had heard from others. When I told her that it varied but that nearly everyone that I spoke with worked several additional hours per week, she seemed relieved. She confessed that she has lied to others, including her supervisor, about her overtime, under-representing the amount of time she works. When I asked her why, she said, "I don't want to look inefficient." I hesitated to make note of what she told me. "That's important," she said, "you can write that down." I asked if she felt like it would reflect on her rather than her workload and she agreed.

By contrast, another provider explained the extent of his work beyond paid time as a product of a mandate that exceeds the time available in the best of circumstances combined with the complexity of his patient population and organizational inefficiencies:

*I'm supposed to see patients 16 hours a week and do admin 4 hours a week, meaning that I have sort of a 25% admin overhead. But I just said that I work probably 10 or 12 hours over that. So, really, in this environment, I would need approximately a 50% overhead. So, for every clinical hour [that I] work, I would need an additional non-clinical [hour] to do everything that needs to get done. And that's what's needed for, you know, an experienced physician. I've been doing this for a really long time.*

This provider's reference to "this environment" emphasized that the amount of documentation and paperwork required was related to the density of medical and social needs among the clinic's patient population. The time it took was also related to the clinic's outdated technology (c.f. chapter 5), the resources available and the referral infrastructure. His insistence on his experience suggested that this was not a question of individual inefficiency. Rather, he located the problem in the organization of healthcare and the inequitable distribution of health and social resources.

Overtime still remains almost a given for primary care providers despite the fact that the turn to team-based care has had a profound impact on their work lives (IHI 2017). One doctor recounted that years ago, most providers in her clinic would regularly stay late – as late as midnight – and anything that needed to be done would be forwarded to the providers rather than addressed by the then-smaller number of other clinicians and staff. The transition to teamwork, in her view, involved "turnover" of staff who were not interested in a new format and an increase in the ratio of support staff to providers, supported by evidence in medical professional literature of the effectiveness of team-based models. Still, she and several others wished for more nursing staff. This is in part because teamwork has justified increasing the visit volume for each provider.<sup>83</sup>

In this chapter, I argue that the organization of teamwork in the clinic is oriented to protecting the time of the provider. This context makes clear that what I am referring to is

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<sup>83</sup> The literature on team-based care proposes that teams can increase both visit volume and panel size by removing inefficiencies (IHI 2017). This is an example of the persistent tendency in modern institutions for techniques and technologies that promise to lighten workload to result in shifting or intensification to match (c.f. Wajcman 2014, chapter 5). Team-based care draws on the less expensive labor time of clerical and medical assistants to increase revenue and access through provider visits.

the provider's time *as* the most expensive and primary source of revenue for the clinics. I do not mean that providers' personal time is protected. Each member of the team experiences vulnerability to the time demands of the clinic in different ways. These forms of protection and vulnerability reflect a traditional clinical hierarchy, but the detailed manifestations of time protection are more complex and extend beyond the protection of work hours.

### **Constant Influx**

The excesses of caring and administrative labor that form the focus of this chapter are essential to the ongoing operation of the clinic. They are nonetheless rendered invisible in certain conversations, research and policies. Like many time studies, the ones cited by Dr. Lee rely on a series of assumptions and interpretive choices that limit their practical interpretation. Still, they make a profound point about the incremental accrual of regulations and recommendations.<sup>84</sup> The panel size that they used in their calculations is arguably larger than is actually typical (Raffoul et al. 2016). On the other hand, the authors of the two original studies write:

The estimated times required to meet national guidelines also assumed a well-run, *fully staffed practice* with a functioning *informatics* system... We did not consider in the calculations the amount of time spent on *paperwork or contacting patients by telephone*. [Yarnall 2009, p. 2, emphasis added]

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<sup>84</sup> Time studies generate averages, washing out potentially significant differences, not only in patient need and clinic infrastructure but also in personalities, styles and skills. In the case of charting visit notes, some providers, like Dr. Lee, were often able to "chart as they go." Many, even with decades of experience, found this impossible, particularly if they also wanted to see patients as close to on time as possible with a front-loaded schedule. Many would chart certain elements, such as the physical exam or any orders and prescriptions, during or immediately after the visit because these required action in the moment or would be easily forgotten. Otherwise, they left a skeleton, (not unlike ethnographic jottings), to elaborate later. This deferral allowed them to write more detailed notes and to stay closer to on time in clinic. However, some lamented that this ultimately made the work take longer.

Considering the significant amount of time that clinicians and staff spend on computer and phone, this is a substantial exclusion. These studies and the papers that cite them focus on teamwork as a solution to this broad mandate (Bodenheimer et al. 2014; Altschuler et al. 2012). What constitutes adequate staffing ratios remains a topic for research and debate (Patel et al. 2013; Magill et al. 2015; Park et al. 2018). The clinics that I studied struggled chronically with understaffing relative to current staff-to-provider ratios, which several providers felt should be higher.<sup>85</sup>

While quantitative time studies and calculations like the ones referenced earlier draw attention to the amount of time required to meet current practice goals, counting minutes is limited as a method of analyzing time pressure given the multiple temporalities that contribute to the experience of feeling out of time. In other words, the ubiquitous sense among clinicians and staff alike that there is not enough time is not only a quantitative statement, but also a qualitative experience of tasks converging, out of sync or incessant.

Fieldnote, Afternoon Clinic:

*I ask, as I always do, how long after this session Dr. Peterson will spend on charting. Though she says 20 minutes, she points to her computer screen: She has 18 messages and 34 labs to review.*

*“We don’t have time set aside – we have time set to see patients,” she says, but have to “fit in” all this other stuff. She says that the time with patients feels manageable, but...*

*“All this other stuff?” I ask.*

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<sup>85</sup> In addition to ideas mentioned in earlier chapters, like scheduling fewer patients, variable appointment lengths and a better EHR, many clinicians suggested that the single most important change that could be made for their experience of time would be more staff – not just a full complement of the currently under-filled staffing ratios, but a higher ratio. This would not solve the challenges with communication and coordination that I describe in this chapter, but it would provide reinforcements in the struggle with clinical time.

*“That doesn’t feel so manageable,” Dr. Peterson continues... “I vaguely thought that’s what you were studying,” she says after a pause [referring to time experience], “and so when I was dictating the assessment and plan to [the scribe] AND filling out a form for [the social worker] AND writing a prescription and... That’s my experience of time.”*

*“Doing four things at once?” I ask.*

*“[My experience of time] is the constant influx of things to do.”*

Wajcman (2014) proposes three dimensions to attend to in understanding time experience at work: task volume, disorganization and density. Disorganization and density, respectively, refer to the difficulty of coordinating with others and juggling or multitasking. A complete study of time pressure, she argues, must account for these aspects together. Based on clinicians’ description of their work, I would add a fourth term – constancy – to Wajcman’s triad of volume, disorganization and density.

One of the roles of clinic staff in protecting clinician time was to minimize the density of mundane tasks and interruptions. Providers also did have some time “set aside” to manage care coordination tasks. This time for administrative forms of patient care was referred to as “admin,” or “protected” time.<sup>86</sup> When Dr. Peterson referred to not having time for “all this other stuff,” she was referring to the many tasks that exceed or cannot be saved for a later block of time. Protected time was generally concentrated in one or two sessions per week, separated from the rhythms of care coordination. This disjuncture between the flow of messages and requests and the available times to address them was a source of contention. At least one provider wished to get rid of admin time and instead schedule

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<sup>86</sup> Nurses and MAs also had protected time, though it was more variable. I return to that issue later in this chapter. This practice of scheduling administrative time is not universal. In many clinical settings, administrative work is incorporated into clinic time or overtime.

fewer patients each day, using the space between visits for the behind-the-scenes tasks that arose every day and seemed to multiply if put off. Many agreed that tasks deferred took longer. However, scheduling fewer patients per provider-day over more days was rendered impossible by a shortage of exam rooms. Further, many providers seemed grateful for the concentrated, (relatively) interruption-free hours to catch up on some of their work.

In professional literature, the term “protected time” appears often in reference to research and teaching, activities which may require “protection” from patient care and administrative duties, which otherwise tend to take precedence (e.g. D. S. Thompson et al. 2008; Rushmer et al. 2004; Denton et al. 2015). It has also been used in other fields to refer to personal or family time (Hochschild 2001). What is interesting about the use of “protected time” in the setting of the clinics I studied is that it is essentially time protected *from* patient care *for* patient care more broadly defined. Admin time removes one from the irregular and unpredictable environment of the clinic in order to focus on documentation, paperwork or outreach with fewer interruptions. The admin time guaranteed to providers is still inadequate to the task, as evidenced by provider overtime. The other principle way for providers to manage their workload is to rely on their team.

By contrast to providers’ part-time schedules and overtime, most nursing and clerical staff positions at the clinics were formally full time, working from 8 AM to 5 PM with one hour off for lunch.<sup>87</sup> In general, these hours were fairly strongly protected by the union that staff belonged to.<sup>88</sup> Still, nurses regularly worked for some time past the end of clinic. Much

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<sup>87</sup> I discuss job flexibility later in the chapter. Several staff would have preferred to work part-time but were constrained by the terms of each role and often by dependence on their full salary.

<sup>88</sup> Providers were also in a separate union, but it was rarely mentioned and seemed a less important factor in their status and experience of work in the clinic than it was for other clinic staff.



of this time was uncompensated. Nursing staff was eligible for overtime pay, but some clinics arranged for them to take “comp time” instead, coming in late or leaving early another day.<sup>89</sup> Nurses who worked after hours explained staying a half hour late as just part of providing care; or, they framed it as helping their future self by wrapping up tasks.

Like providers, nursing staff (MAs and RNs) were allocated a certain number of hours of admin or “panel management” time per week. This time was almost sacred to some, marked by physical separation from the clinic to a separate workspace (c.f. Zerubavel 1985). Admin time was, at least formally, supposed to be allocated in proportion to staff’s clinical and managerial duties. This did not always hold true. With rare exceptions, providers were guaranteed admin time in a fixed ratio to their clinical appointment. For every four hours of clinic, they received one hour of admin. Nurses and MAs ideally had some time each week, but this was subject to much more variation. In practice, admin time for nursing staff often became a cushion for clinic staffing. Clinic staff frequently cited this as a reason why they struggled to keep up on care coordination.

*S: When do you feel most burned out?*

*Emma (MA): Oh, god. When we don't have enough staff and there's not enough time to prepare. Like, when there's no panel management [time] or people are out sick and you just have to be pulled [away from admin time to other duties]. And, yeah, that's really when it's, like, the most draining. Because it's like... I don't feel prepared as is. And then it's like a crazy day and I haven't had any time. And just kinda having at least one time to prepare kind of helps because it's like,*

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<sup>89</sup> In my observations, it was uncommon for MAs or clerical staff to work significant overtime, though they would stay briefly to wrap something up. Some told me that they were not allowed to work overtime. The clinics did not have the budget to pay overtime. They sometimes made arrangements for someone to stay into lunch or after hours, making up for the time elsewhere. In some cases, the rigid work hours rules seemed to reflect back on the staff members in others’ assessments of their dedication to patient care. A rich question for further study would be: How can the flexibility necessitated by an unpredictable patient population be created while also protecting workers? How are labor protections understood in relationship to patient care?

*“Okay, well, you know, I had this time. I don't feel as far behind as I would if I didn't have that time.” So.*

Emma’s description subtly indicates that the ideal amount of preparation time will still leave her feeling behind, but not *as* far behind.

MAs and nurses experienced a similar discordance as providers described between the temporality of patient needs and spaced out blocks of protected time, but their protected time was also contingent on staffing. One staff member who helped coordinate prenatal care put it, “You don't get to wait: ‘Oh, I have an admin in 2 weeks.’ She [the pregnant patient] keeps going, she’s still moving along in her pregnancy and I can’t [wait].” This critique of the instability of admin time – which may not happen for two weeks – marked that staff admin time was never guaranteed in the same way that providers’ time was. Clinic managers sometimes adjusted expectations for outreach-related metric goals to this reality. Meanwhile, this did not eliminate the time-bound needs of patients. The ideal of doing as much of this outreach as possible during clinic was complicated by MAs’ obligations to be available to providers and to manage clinic flow.

In her study of medical training, Mizrahi (1986, 106) describes a discordance between the “structured responsibilities” and “situational circumstances” of medical residents that makes it such that “no time is the right time” for quality patient care, or spending time with patients.<sup>90</sup> In a sort of inversion, Mizrahi’s framework is useful for

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<sup>90</sup> For example, medical students have time but not skills. Interns are responsible for caring for patients but are too busy. Junior residents have more time than interns, but it is not their role to provide direct patient care and they cite protocol to justify keeping a distance as part of their consultant role. Similarly, senior residents’ structured role is that of an advisor or consultant and they consider it a violation of etiquette to develop a relationship with “someone else’s patient.” Mizrahi writes that the outpatient clinic is one place where structure and situation would seem to come together and provide an opportunity for relationship building, but the clinic is generally undervalued by residents because it takes them out of the hospital. In my research, these relationships were the most rewarding part of primary care. They are built over the longer term (chapter 7).

thinking about the responsibility to provide preventive and chronic care for populations with insufficient staffing and a clinical structure that is organized around brief individual patient visits. There is a disjuncture in time between population health goals, the administrative requirements of care coordination and the temporal organization of care. I elaborate on this disjuncture in this and the following chapter. “Admin” time is one effort to address part of this problem, but it is one that is contentious and partial, given short staffing and the tradeoffs of deferring work to a protected period.

Momentary understaffing was often cited as a reason why certain goals could not be met or why staff were being asked to work extra hard or forgo “protected” time. Meanwhile, these clinics were chronically understaffed.<sup>91</sup> Importantly, the implications of understaffing in different positions varied by role. For example, a shortage of providers would put a strain on the whole clinic but would also lead to a reduction in scheduled clinic visits. A shortage of MAs or nurses would require others in those roles to stretch such that the providers’ clinics, the source of revenue, could go on.

One clerical staff member described the effects of this pattern, “If you think of a whole body, you know, we’re probably missing the arm, the leg and you know, a head or an ear. We need all the body parts to function correctly, you know?” She said that this resulted in stressed out colleagues endlessly “passing the buck.” Although certainly a matter of degree – ranging from being short one to four MAs, for example – this chronic understaffing was frequently bracketed, rendered an exception even though it appeared to be the rule. In

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<sup>91</sup> One medical director insisted that their clinic was actually “overstaffed.” This unusual claim, though, was not based on the current realities of the clinic, but on the idea that with a dramatically different organization of care and with better technology, they would need fewer staff. In this perspective, staff are required to do work that compensates for current inefficiencies.

medical terms, it seemed more like an “acute on chronic” problem, or a momentary exacerbation of an ongoing pathology.

### **Growth: Career versus Workload**

Working typical hours and having time to complete one’s tasks are two aspirations to a normative temporality. Another temporality that is important in the clinic is the trajectory of a career characterized by personal growth. Early in my research, a nursing supervisor put the (rhetorical) question to me: “Do we value anyone’s work as much as we value the provider’s work?” Interestingly, in arguing that “we” do not, she pointed to operational differences in the way that providers’ and nurses time was protected for education, among other things. Once per quarter, all providers were simultaneously invited to a session of continuing education while nurses staffed the clinics. Pulling nurses out of clinic for required trainings and education, on the other hand, was an ongoing challenge. The network would hold the same training several times, pulling a subset of nurses out of clinic for each one so that someone remained at the clinic. “So, it’s kind of a double standard,” she said, “Because, like, who’s going to do the nurses’ work? The provider’s not going to do it.”<sup>92</sup>

While this supervisor was referring to internal trainings, a similar issue affected MAs’ pursuit of education outside of work. Several MAs were either taking nursing prerequisites at night or considering leaving work to go to nursing school. While providers almost all worked part time, at the time of my research, the staffing practices did not allow for part-

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<sup>92</sup> She also observed that providers had more authority to alter standardized protocols according to their own style. This theme came up often as a source of additional work for their nursing colleagues, remembering and adapting to different preferences. Of course, nurses and MAs have their own styles, but they are in a less powerful position to question protocol or insist on their own approach.

time positions for MAs or nurses. This meant that if a clinic authorized an MA to work part-time, they would remain effectively understaffed:

*Manager: I'm saying one thing and, you know, I'm talking [out of] both sides of my mouth when I say, "Yeah, we encourage you to pursue, you know, professional development. Go back to school if you want to become a nurse and let me know how I can support you." And yet when they come in and say, "Okay. I went back to school and I'm enrolled so I need to be off every this and this," it's like, "Uh, sorry I can't do that! I need you here full-time." Because we don't really have any provisions for any, you know, coverage during that time.*

Primary care providers' careers were understood in terms of their long training trajectory, followed by growth through practice and ongoing education. I asked one provider how long she could see herself in practice. She told me that she would work in primary care until she retired, explaining, "In medicine, the more we work, the smarter we get. Because, like, you've seen more, you know more, and so I'm always like, it's gonna be – it's, like, the one gig you can do forever. And I just started working in it... so I can do it for a while."

Meanwhile, clinical staff roles (MA, BA and some clerical) often seemed understood as one job from which staff would eventually move on. Within the roles themselves, there was little room for formally recognized growth.<sup>93</sup> There were formal educational events for MAs, but MAs and clinicians I spoke with observed that these events repeatedly focused on basic skills that MAs with years of practice had already mastered. One medical assistant lamented, "[You're] giving us more duties, but you're not giving us more education... We

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<sup>93</sup> This limited formal recognition was partly a product of the job classifications within the local system. This dynamic complicates the framing of intensifying labor in terms of "empowerment" (e.g. Bodenheimer et al. 2014). Recognition of the skills and abilities of staff is essential for team-based care (Solimeo et al. 2015). Here, I am questioning the way in which the term "empowerment" is sometimes used as a euphemism for charging staff with additional responsibilities despite their perceived overload and with little corresponding growth in skills, pay or professional status.

reach, like, a wall.” Several clinicians also spoke to me about this dynamic of increasing responsibility for medical assistants without a corresponding change in job title or pay.

### **Shepherds and Soldiers**

Teamwork involves the redistribution of tasks and forms of work oriented to “protecting” time for different purposes, including clinical care, administrative work and rest. Delegation and collaboration among team members help to maintain patients’ and providers’ movements in clinic time in ways that I have detailed in previous chapters. These include the management of flow (chapter 2) and assisting in the care of complex and time-intensive patients (chapter 3). One provider described her learning to rely on her team – even more than she might prefer – as a “survival tactic.”

Those in positions of direct contact with patients are commonly referred to in healthcare and other industries as “frontline staff.” The distribution of labor in the clinics I studied was discussed in language that evoked imagery of a military operation. While metaphors are often considered pragmatic or artistic tools, they speak to an underlying understanding that relates the described and metaphorical domain (Lakoff and Johnson 1980; Beckett 2003). Take Dr. Lee’s metaphor, “time is our great enemy,” and Samuel’s characterization of time as “fragmented” (chapter 3). Time is both an adversary and in need of protection and the clinic fights to save time from itself. This task requires camaraderie as well as a clear division of labor wherein temporal vulnerabilities and protections vary by one’s position.<sup>94</sup>

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<sup>94</sup> This military terminology has implications for how patients are understood. The threat against which staff protect each other might be burnout, but it is also implicitly patients’ expectations. In this chapter, I am focused primarily on the implications of pastoral and military imagery for understanding staff experience in team-based models.

Connections between the military, medicine and nursing are not merely metaphorical. Their histories are deeply intertwined and concepts like triage derive from battlefield practices (C. Adams 2018; Annas 1995). Militaristic metaphors permeated understandings of immunology in the 1990s and continue to do so alongside ecological and other metaphors (Martin 1994). What stands out in the uses of military metaphor is the sense of sacrifice that it implies in hopes of garnering recognition and resources.<sup>95</sup>

Nursing ethics scholar Mary Ellen Wurzbach (1999) argues that the military provided the primary moral metaphor for nurses at the turn of the 20<sup>th</sup> century, defining loyalty and obedience to supervisors and physicians as defining features of nursing. This military metaphor was later supplanted by metaphors emphasizing fiduciary duty to patients, personal integrity and obligation to the community. With the hard-won recognition of nursing as its own highly-skilled profession, hierarchy in the clinic became less overt but is still present. I wish to draw attention to how this hierarchy – independent of individual practitioners’ attitudes – is underwritten by the valuation of labor time.

Several years prior to this study, the health network had invited a consulting group to help remake clinic workflows. “Tactical nursing” was one of the catchphrases and organizational models that stuck from this period. The military metaphor embedded in this terminology is apparent in the definition of tactical, “of or relating to combat tactics,” which can also more generally refer to “small-scale actions serving a larger purpose” (Merriam-Webster 2019). In the clinic, tactical nursing referred to the flexible and strategic use of RN

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<sup>95</sup> In an older iteration of this type of framing, 19<sup>th</sup> century general practitioners in England attempted to assert their status within medicine through the imaginary of soldiers placing themselves in danger through regular exposure to disease (M. Brown 2010). Beckett (2003) describes a similar “language of siege” among British social workers.

skills and credentials to maintain providers' clinic flow and wrangle services for patients. The consultancy, Coleman Associates (2013), describes them:

Tactical nurses are the grease that keeps the wheels of the patient care team moving, allowing team members to see patients efficiently while ensuring that those patients receive the highest quality care possible... A tactical nurse is someone who can anticipate what's coming next and is appropriately reactive. The person filling this key position must be organized, flexible and adaptable, empathetic, fair, patient, positive, preemptive, open minded, humble, evaluative and invested – in short, someone who is clearly a team player.

Nurses in this setting clearly have a broad role definition and professional responsibility, charged with ensuring both efficiency and patient care, whatever that requires. Their position in this description is both “key” and objectified as “the grease.”<sup>96</sup>

In addition to their ‘tactical’ role seeing drop-in patients and assisting colleagues, some nurses also ran “orientation clinics,” offering intake visits for patients who had never been seen in the clinic before. Others held clinic sessions focused on specific chronic conditions like hypertension or diabetes. When clinics in the network tried to implement these types of scheduled nurse appointments, they continually faced obstacles due to staffing, multiple other responsibilities related to supporting providers and colleagues and low show rates. Whether holding their own clinic or performing “tactical” nursing, I regularly observed nurses staying into lunch or after closing to finish seeing patients or to support other staff members. As one nurse put it when I asked about their approach to drop-ins late in the clinic session, nurses “just take care of it.”

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<sup>96</sup> This subtext of objectification is echoed in the nurse manager's critical observation of how nursing pay is part of overhead, “rolled into the bed rate” in hospital care (See “Valuing the Team”).



This idea of “taking care of it” was echoed in Carol’s explanation of her role:

*Well, I’m a primary care nurse, registered nurse. And my role here is to help pretty much work with a team of providers and MAs to help in back office duties and trying – We do a lot of troubleshooting. Backup. If the MAs need, like, [some] kind of clinical assistance, we do a lot of troubleshooting for the providers or for our patients... Sometimes it's just almost like we're kind of [a] troubleshooter nurse, clinical/tactical, do a little bit of everything. But just trying to maintain and help the clinic flow. And our patient care and what we do. Respond to urgent and emergent situations.*

Troubleshooting is reactive. When I asked her to explain what “troubleshooting” meant, Carol gave the example of sorting out why a pharmacy did not have a patient’s prescription or finding an alternative medication because the one prescribed was not covered.

As the provider earlier in this chapter noted, time frustrations in primary care stem in part from the lack of meaning in the tasks that time is spent on. Much of the work made necessary by the fragmented organization of the healthcare system is deeply mundane and tedious (c.f. Satterwhite 2018). For providers, one way of addressing this problem is to ask other members of clinic staff to take on or facilitate these tasks.<sup>97</sup> Carol found it frustrating that, as a nurse, she spent so much time as a go-between between patients, providers and insurers:

*Carol: It's frustrating because it takes away from time that we could be focusing more on the patient and I know that's – the medication is an important part and stuff, but that part of it, you know, trying to figure out the insurance stuff and what's covered – I can put that time into probably more – spending more time with my patients, educating and talking to them about their health and those kinds of things. You know, more clinical things than just...talking about... how we're gonna fix this, you know, regarding their coverage and their medications.*

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<sup>97</sup> One of the critiques of the EHR is that sometimes built-in requirements force primary care providers to complete or authorize tasks that could be accomplished by someone else.

Here, the broad definition of her role as a nurse seemed to conflict with Carol's professional identity. Carol draws a recognizable boundary around patient care that excludes dealing with the insurance system, but it nonetheless becomes an everyday necessity. Carol believed that providers did not have time for such hassles either. Her complaint was aimed at the system that necessitates this kind of work. Meanwhile, interim solutions to this much bigger political problem rely on the redistribution of labor across the team.

Carol also spoke of being called away from one task to solve another issue. "If the patient comes in... late, and the provider cannot see them, we may be asked to check in with that patient, to [assess them and] let them know they will have to be, possibly, rescheduled," she explained, adding that if the patient does need something immediately, she will consult with a provider. They might also find out why a patient's specialist appointment has not been made. "Maybe the referral is not there," she said, "'Okay, oops, we apologize.' Try to smooth things over. Get it done." The role of the tactical nurse is thus to do whatever is needed and often involves frequent interruption (c.f. chapter 3).

I did not hear a similarly militaristic term for the medical assistant's role, but descriptions of their work carried a pastoral and protective tone. Emma's shepherding analogy (chapter 2) referred to more than movement from exam room to exam room. She went on to say:

*I feel like, you know, when a patient has 10 different things and we're trying to connect all of them, it can be a little hard, but I feel like we tend to go off of each other as well, just to make sure that, you know, I can get something done and she can get something done and we can make sure that it's going to flow correctly and not, like, all over the place. So, kind of like the shepherd. She's my sheep.*

MAAs were considered the primary “drivers” of healthcare maintenance, the term for cancer screenings and the monitoring of chronic conditions. Along with fellow health workers, they helped prepare for visits by reviewing patients’ chronic care needs and either speaking directly to patients about screenings or notifying providers of which tests or interventions a patient was eligible for. MAAs also helped obtain prior authorizations from insurance companies – a requirement for certain medications and medical equipment. Direct outreach to patients could happen in clinic by anticipating upcoming needs or through phone outreach. Sometimes, they would make room in providers’ schedules by identifying and rescheduling visits with patients whose imaging or lab studies had not been completed, a practice called “chart scrubbing.” All of these responsibilities were oriented to reducing the density of tasks for providers while maximizing the clinical utility of their labor time (Wajcman 2014).

Emma helps the provider that she works with keep track of all of the things a patient needs from a preventive and chronic care perspective and secures many of these things directly through the use of “standing orders” for things like vaccination and common tests. Her role as a “shepherd,” though, is not only to care for patients but to care for and protect her provider – including from excessive patient care demands. This includes asking the front desk not to register patients early or not to fill open slots in the schedule.

The physical separation between the front and back of the clinic often contributed to misunderstandings and tension between front office and nursing staff about the practice of blocking slots and how long things “should” take. Being in the front of the clinic meant, as clerical staff members said, “we take the heat out here,” where there is “nowhere to hide.” The

language that they used to describe their vulnerability to patients' frustrations evoke a sense in which the clinic must be protected from patients and clerical staff are out front and vulnerable.

Other medical anthropologists have studied clerical staff's unique vulnerabilities. These stem from their role administering patients' access to services and performing "emotional dirty work," or emotional labor specific to disruption or discord (Armin 2019; Solimeo et al. 2017). Front office staff play a key role in protecting colleagues and clinic time by managing patient expectations, apologizing for delays and creating a barrier between the front and back of the clinic. Eligibility workers and clerical staff have expertise in how to register and schedule patients and they are increasingly charged with implementing screening and data collection initiatives. Meanwhile, the principle trait upon which patients are asked to provide feedback about the front office staff is their customer service.

Each member of clinic staff feels subject to the temporal needs of others, but their orientations differ. The relationship between these roles was illustrated one day when a nurse had stayed at her desk into the lunch hour, helping to finish the morning clinic by discharging the last two patients. As she was charting around 12:30, a patient came in to give a urine sample. Formally, the clinic closes from 12 to 1 o'clock, but in this case the door stayed open and the front desk clerk was still at her desk. She asked the nurse for assistance. After the door closed, the nurse lamented that since the patient had seen her come into the clinic, they would know that clinicians were available and would require a response. She wished that the clerk had held a firmer line with this patient during lunch.

As another clinic debated a new system for formalizing the drop-in process, a nurse expressed anxiety about potentially "unlimited" need. Front desk staff expressed their discomfort with being put in a position of asking patients to go to urgent care or return

another time, as they were not licensed to assess them clinically and sometimes patients' stated complaints did not directly convey the immediacy of their need for help. Debate ensued about how nurses and clerical staff would prioritize triage and care for drop-in patients alongside "tactical" support for scheduled provider visits. The stakes were framed "in the name of" access to care or minimizing "missed opportunities." One of the nurses suggested that it would need to be made clear to providers that, "There will be days where we don't help them [providers] at all." She added that the provider responsible for seeing drop-ins would need to see patients with the nurses, including during lunch. She framed the issue of working through lunch as something they do, but, "We would like to stay functional throughout the day. People need to eat. People need to use the restroom..."

Both these interactions shared a premise that patients' expectations may become untenable given staff's need for rest and they *anticipated* this demand even in its absence. The nurse's indignation at being seen by the patient during lunch was not only about that one interaction. Enforcing the lunch hour was often justified to me in the name of future interactions: if you make an exception now, it will be expected later.<sup>98</sup>

The sacrificial language ("in the name of" access and missed opportunities) used in the debate about how to organize nursing time conveys the difficulty of reconciling often contradictory demands on clinical time as a limited resource. This resonates with the military metaphors embedded in tactical nursing and frontline staff. It also conveys dueling senses of vulnerability for front desk and nursing staff. In Rhodes' analysis of emergency psychiatry, she argues that clinic staff draw on situated knowledge, which is "specific,

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<sup>98</sup> This stance and the discretion with which it is taken can be problematic. My task here is to understand the affective reality that underlies it. The threats of being overwhelmed or of flexibility in the present increasing demand in the future affect the enforcement of temporal boundaries, whether or not the threats are realized (c.f. Massumi 2010).

partial, and visible only from where they [stand].” (L. A. Rhodes 1991, 174; c.f. Haraway 1988). Even with efforts to formalize moral-temporal protocols, the front office staff and the nurses would have to make decisions that might resist explanation or run counter to another colleague’s assessment.

### **Just trying to take care of people**

Many sociologists and anthropologists of work have examined the ways in which labor is moralized. Arlie Hochschild (2001) observes that what she calls the *management of values* prevents workers from availing themselves of worker protections and flexible employment practices even when they are available. Melissa Gregg (2018) observes that the labor politics that emerged out of industrial work, including limiting hours and resisting speed up are not easily translated to a context in which work is not recognized as laborious. In contrast to some providers’ concerns about MAs being overwhelmed by rapidly expanding responsibilities, others responded to their efforts at self-protection by questioning their commitment. This was generally not directly stated but conveyed through criticism of the union or phrases like “we’re just trying to take care of patients...”

During the study, MAs at two of the clinics called for break times during clinic, in accordance with labor laws. They did this through the Lean management model that had recently been implemented in the clinics. One nurse manager publicly praised the way in which the MAs themselves devised a system of coverage and took pride in this change as a great “morale booster.” However, the challenges created by the new breaks highlight the difficulty of drawing temporal boundaries in the context of highly interdependent care work.

One of the logistical challenges surrounding the breaks was that medical assistants covering for one another had split allegiances between their own team's clinic and the one they were covering. Someone would have to wait. "Should I room my own patients?" a provider asked rhetorically while recalling one such scenario. His tone implied that this was a preposterous idea. In frustration, he added "I'm sorry I'm seeing patients while you need to take your break."<sup>99</sup> He felt that the discussion of implementing breaks for MAs had quickly become adversarial. Defensively, he said, "We're just trying to take care of people."

Clinical teamwork configures timeliness and time management as forms of care and respect for both patients and colleagues. In light of this, the maintenance of role boundaries serves to contain the temporal load. Accustomed to relying on someone else to manage the flow of his clinic, the provider I quoted above resisted the idea of taking on an additional part of the visit in an already busy schedule. Interestingly, someone else had told me that the same provider often would deviate from his role by doing intakes when things got busy. Yet, he seemed bothered by the notion of another worker's break causing him to do the same. Meanwhile, the power dynamic embedded in the idea that he, as a provider, should not room his own patients was sidelined by his moral claim that this was a practical matter of "seeing patients."<sup>100</sup>

### **Protection as Care**

Although "protection" of time and colleagues from patient need is an uncomfortable formulation, it should be understood within a context where the workload exceeds and is

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<sup>99</sup> This quote is paraphrased.

<sup>100</sup> Several moments in this ethnography focus on points of conflict. I do not intend to overemphasize discord. Just as infrastructure becomes visible upon breakdown or accidents prompt reflection, tension and transitions highlight what is implicit in current, new or previous practices (c.f. Star 2010; Bear 2014b; Zerubavel 1985).

often out of sync with clinicians' time. The threat of potentially unlimited demands and endless interruptions set up a dynamic where people feel the need for boundaries and protections. In this setting, what sometimes appears as a lack or deferral of care for patients could also be understood as a form of care for colleagues.

Laura Bear (2014b, 74) writes that workmanship can include "a duty of care to fellow workers." She urges a refusal to "[reduce] the ethics and affects of work to serving the needs of capital or resisting it." The roles related to protecting and maximizing the utility of provider visits that I have outlined above reflect the system's financial and symbolic valuation of each team member's time. However, the forms of collaboration and protection that I describe here are not simply a matter of protecting provider productivity. Often, clinicians and staff would go out of their way to help others with certain patients, especially if they were more familiar with a particular patient's needs. Sometimes, this meant deviating from their other plans. The reasons they gave me for doing this included efficiency, continuity and respect for their colleagues. These forms of inter-reliance were, of course, not free of conflict, but the ability to rely on a teammate or colleagues clearly contributed to both patient care and staff wellbeing.

The forms of solidarity and mutual care that I witnessed among staff were not always immediately recognizable as work. These included small gestures like normalizing the strain of caring for certain patients or saying, "I appreciate you." They also included clinicians offering expert advice to colleagues and providers. Finally, staff acted as sounding boards for each other to process clinically and emotionally difficult cases.

One provider retold me a story that I had heard her mention in a staff meeting when asked for "recognitions" of colleagues. She told me it was "a very important story." She had



a patient who had a positive pregnancy test but due to complications of her past pregnancies, the patient wanted an ultrasound before any other prenatal care. The provider forgot to submit the referral for an ultrasound. The patient missed a prenatal appointment and when the nurse reached out to her, she said she was waiting for the ultrasound. When this provider's MA heard about it, she sent the provider an email on her day off, acknowledging that she was "off," but reminding her about the ultrasound. The provider submitted the referral right away, and the ultrasound revealed that the pregnancy was abnormal, requiring urgent treatment.

*PCP: I'm glad there was a system where she missed her appointment, and they called her and then she said, 'No, I'm not doing it until I get the ultrasound,' and then my medical assistant reminded me that I hadn't ordered the ultrasound, and then she got the diagnosis of molar pregnancy. Because had she waited longer, then it would've just kept, you know, growing inside of her, and [she might] get complications from that... I like the check-in systems, and I like that they – they're there to kind of make sure I did certain things, because it can't all fall on my plate.*

The way that this provider told me this story and also told the entire clinic staff during their monthly meeting was a form of care for the medical assistant she worked closely with, recognizing the importance of her work. Meanwhile, being able to rely on their system of checks was a source of comfort for the provider and an element of the work of clinic team members that might otherwise go unrecognized. Importantly, teamwork is not simply a matter of task shifting, but reliance. Even though – or even because – her day off was interrupted, she was grateful for the coverage provided by her nursing staff colleagues and the check-in systems that enabled her partner to catch something she missed.

A couple of months after she told me that “time is our great enemy in primary care,” Dr. Lee reiterated the sentiment and I asked her to explain it again. This time, the focus of her response shifted from the sheer mismatch between the task of primary care clinicians and their time toward the effects of this mismatch on interpersonal dynamics:

*We argued for hours about what our late policy would be. It’s all around time. Usually when people – when teams are falling apart, it’s because of time management. There’s all this tension around running late or not. You know, it’s all, it’s all time... So, yeah, I feel like, of all resources that we lack, time is probably the most pressing in my mind.*

Embedded in Dr. Lee’s second framing of time as an adversary was a common sentiment that naturalizes time scarcity: “It’s the scarcest resource that we have... And maybe that’s part of life,” she said, “...but I definitely feel it in the clinic.” This notion of time as a resource, clearly at stake throughout this analysis, is not universal, but this sense of time scarcity is broadly considered a part of contemporary life. It is exacerbated in the clinic by high demand and conflicting obligations. Dr. Lee’s tone of voice conveyed sadness as she went on to describe the strain that clinical time pressure put on her relationships with colleagues:

*S: Can you tell me a little bit more about the relational strain? Is that something you’re feeling in the clinic these days?*

*Dr. Lee: Yeah, I mean, Evelyn and I work together and have done so for a number of years. We have a very good – We don’t even have to say much, like a lot of our communication is nonverbal at this point. We know each other really well. But before I came to that place, or when other [MAs] are covering my clinic, I’ve had MAs covering Evelyn, you know, come early. They look like [they’re bracing], “Okay! I’m ready to work with you.” So, I know that the team feels pressure around me, around time. Like, “Dr. Lee doesn’t like to be waiting,” “Dr. Lee doesn’t...” I’m aware that whatever it is in me – many things, I’m sure – causes that kind of pressured sensation in the people around me. To some degree that I’m very ambivalent about, right? Because, it’s true, I don’t like to be kept waiting. I don’t like patients to be kept waiting. So, I’m glad that people are ready to go.*

*On the other hand, I don't want to stress out my coworkers! You know what I mean? Like, I want to be able to extend the same mercy and grace that that they extend to me...*

While many of my discussions with clinicians and staff about longevity of clinical relationships focused on relationships with patients (c.f. chapter 7), relationships with colleagues were clearly central to people's experience of their work. Teamlet relationships – between a provider and MA who consistently worked together like Evelyn and Dr. Lee – often became very close, finding a rhythm that worked and establishing clear verbal and nonverbal communication. These relationships were not always easy to establish but they were important. This was marked by the ways that people acknowledged the departure of a team member. One MA said, while working with a PCP whose longtime partner had left, “I'm not [her], but I'm definitely a hustler.” Speed and dedication on the part of a new teammate could only partially make up for long-term relationship.

The quality of workplace relationships is considered a central factor in burnout and its prevention. Accordingly, researchers have studied interventions that improve civility and teamwork as mechanisms for retaining healthcare workers (Maslach and Leiter 2017; Willard-Grace et al. 2014). Meanwhile, while professionalism and kindness are clearly essential to successful teamwork and staff satisfaction, Dr. Lee's reflection articulates that these traits cannot alone overcome the tensions embedded in the temporal structure of clinical care. Time pressure exacerbated by understaffing threatens interpersonal relationships. Her comment, “I don't like to be kept waiting,” rather than, “I don't like to wait,” suggests both her status and her dependency on others, the subject who would “keep” her waiting. Her reference to grace implies a recognition that her MA colleagues may be dealing with challenges of their own.

In this chapter, I have traced the distribution and dynamics of time protection in team-based clinical work. Social scientists who have studied work under capitalism argue that the ubiquitous sense of time scarcity that Dr. Lee references is a product of the commodification of labor, which renders time as something that should be controlled, its utility maximized (E. P. Thompson 1967; Harvey 1989). Her sense of time scarcity and the institutional imperative to maximize the utility of her time as a primary care provider makes demands of colleagues to keep up. Yet, Dr. Lee is aware of and concerned about the implications of this dynamic for her colleagues.

Discourses of efficiency in healthcare policy and in the clinic normalize the scarcity of resources, including time and staff. Combined with the moral imperative to attend to the suffering of vulnerable patients *and* to play one's part as a member of the team, this logic makes powerful demands upon clinicians and staff. As labor organizations for nurses and caregivers have argued for decades, the apparent tradeoff between worker wellbeing and patient care can be partially addressed through investments in higher staffing ratios (Duffy, Armenia, and Stacey 2015; National Nurses United 2017). For the purposes of this analysis, I have focused on the current arrangements of staffing that contribute to these tensions.

Each member of the team experiences forms of temporal protection and inclusion as well as vulnerability. These patterns are structured by the value attributed to their labor time but extend beyond that. The possibility of endurance for many in the clinic is created by forms of camaraderie and mutual protection. The sense of obligation to colleagues can lead clinicians and staff to extend beyond their formal roles or to draw boundaries around their obligations for fear of unlimited demand.

## Chapter 5. Compass and Clock: Metrics and Quality Improvement

Amidst the often chaotic day-to-day of patient care, clinics and health systems use quantification to keep track of care for their patient population. How many patients have received recommended cancer screenings or tests to monitor their diabetes? How soon are patients able to receive an appointment (see chapter 1)? Clinic staff produce an extraordinary amount of documentation for clinical care, quality improvement and reimbursement. In previous chapters, I have alluded to a number of care elements that are quantitatively tracked and worked upon over time (e.g. access, cycle time, patient experience, missed opportunities). In this chapter, I focus on the temporalities generated by the rapid expansion of quality measurement and reporting within the clinical context in which metrics are generated and interpreted (c.f. Minn 2016; Smith-Morris 2016).<sup>101</sup>

### Quantifying Health and Performance

The measurement of health and development of best practices have long been matters of concern in public health, medicine and nursing. Florence Nightingale, considered the founder of modern nursing, used statistics and visual charts to establish modern hygiene practices in the 19<sup>th</sup> century (McDonald 2001; Neuhauser 2003). Political-economic concern with health as a means of maintaining strong labor and military forces grew in the 18<sup>th</sup> and 19<sup>th</sup> centuries alongside industrialization and statistical techniques for evaluating, studying and managing health and disease (Foucault 1994). Ian Hacking (1990) and Theodore Porter

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<sup>101</sup> The metrics I describe in this chapter are most commonly derived from data captured in the electronic health record (EHR). They could be requested by external regulators or funders or used for internal assessment. Recognizing the many challenges of automatically capturing reliable metrics (c.f. C. P. Roth 2009), a team of analysts worked to validate the definition and data capture for each metric.

(1996) describe the role of statistics in enabling new forms of thought about social intervention.<sup>102</sup> These new forms of intervention upon the social body centered on improving the norm.

For much of the history of medicine in the United States, physicians were highly protective of their autonomy against external oversight or intrusion into their domain of expertise by public health (Starr 1982). In contemporary U.S. healthcare, quantification and monitoring are understood as essential to ensuring quality, safety and cost-effectiveness. Disagreement about the best means by which to improve population health and about the relationship of individual health to population-level measures continue to trouble the use of metrics in practice (Checkland, McDonald, and Harrison 2007; Mulligan 2010). For example, despite increasing awareness of the social determinants of health external to the clinic, much of quality improvement work focuses on processes internal to the clinic and payment models may or may not account for the influence of social factors on health (NASEM 2016). Population-level indicators are used as a proxy for the quality of care for individuals, in addition to quantified measures of patient experience. The proliferation of metrics for ensuring healthcare quality and value has a long history.

For decades, the U.S. healthcare system has been characterized by high costs without the outcomes to match the investment. Responses to this problem, at different moments and often simultaneously, have focused on quality, safety and cost (IOM 2001, 2015a). An intensified focus on cost efficiency accompanied the introduction of managed

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<sup>102</sup> In *The Birth of the Clinic*, Foucault ([1973] 1994) describes this process in medicine in particular. Once patients could be grouped by disease processes, elimination of disease came to be imaginable through a rigid and effective system of control based in part on statistical surveillance. From this moment, medicine also became preoccupied with normalization. The normal/pathological binary that is formed in this period deeply influenced medicine and all the human sciences (c.f. chapter 2-3).

care models in the late 20<sup>th</sup> century. In response, patients, providers and observers raised concerns that equity and quality of care were suffering amidst an overemphasis on cost containment (Chassin and Loeb 2011; Rylko-Bauer and Farmer 2002; Willging 2005). In response, national systems for quality monitoring and improvement have evolved. More recently, concerns that quality monitoring favored medical measures of success over patient preference have led to efforts to characterize the “patient experience” (Nicosia 2017; Checkland, McDonald, and Harrison 2007).

In the past half-century all of the following have been in vogue at one time or another: redesigning professional education; improving peer review of physician practice; reengineering systems of care; increasing competition among provider organizations; publicly reporting data on quality; rewarding good performance; punishing bad performance; applying continuous quality improvement or total quality management tools; and measuring and improving the culture of health care organizations to facilitate the adoption of safer systems of care. The answers to vexing quality and safety problems have often appeared clear, and victory has been declared over and over again. Unfortunately, although many small successes have been achieved, they have often been short lived. And they have not been enough to solve complex, persistent and deeply rooted quality and safety problems. [Chassin and Loeb 2011, 559]

Several of these approaches are currently at play in the clinics in this study and the broader U.S. healthcare system today. Despite valiant efforts in response to very real concerns, the pattern of short-lived success at a national level is mirrored in the local experiences of the clinics I observed.

Metrics pose care quality as a technical problem. The tempo of quality monitoring and incentives – focused on relatively short-term goals – encourages technical solutions. The logic of quality improvement makes demands upon time, inscribing clinical practice within a necessarily progressive narrative. This narrative is not new to medicine or public health, but the ubiquity of metrics and their consequences have raised both acclaim and

concern across professional and anthropological literatures. Concerns have been raised regarding narrow definitions of “quality” that may compel providers and organizations to prioritize measured metrics over other important aspects of care or to neglect “difficult” patients (Snyder and Neubauer 2007, Ryan and Press 2014, Commonwealth Fund 2015).<sup>103</sup> Anthropological critiques of metrics have focused on their (in)accuracy, a tendency for trends to be interpreted as signs of individual failure rather than social or structural concerns, and the ways in which enumeration erases complex social realities (V. Adams 2016; Biruk 2012; Pine 2011). Combined with other institutional pressures, efforts to improve metrics can foster new forms of triage and neglect (Fleming et al. 2017). These limitations may contribute to the cycles that Chassin and Loeb (2011) describe above.

Knowledge in the form of metrics is supposed to compel action and can be produced for multiple purposes. For example, reporting metrics for regulatory or payment requirements configures the metric as evidence of (prior) performance. For internal quality improvement, metrics are used to generate ideas about practice changes and then they are monitored as those changes are tested and implemented. Due in part to efforts to “align” or integrate metrics for multiple purposes, these uses are sometimes conflated, distinguished, or held together. For example, the number of mammograms that a group of patients has received can be read as an indication of the quality of work of the medical assistant or provider responsible for that panel, or as an indication of barriers to obtaining

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<sup>103</sup> In addition, researchers have suggested that pay for performance or value-based payment may disproportionately penalize safety-net hospitals, whose margins are generally much narrower than other hospitals (Paula Chatterjee et al. 2012; James 2012). On the other hand, others have documented that community health centers, despite budgetary constraints and narrow margins, perform as well or better on standard measures than their private counterparts (Goldman et al 2012). Despite ongoing debate, quality improvement and assurance as elements of formal oversight and incentive systems have persisted over time and the number of metrics keeps growing, sparking calls for simplification and streamlining across payers and regulators (IOM 2015a; Nunlist, Uiterwyk, and Nicoletti 2014).



mammograms that could be addressed at an organizational level. Metrics can function to punctuate the everyday flow of clinical work, generating a sense of urgency around chronic or abstract concerns subject to neglect amidst conflicting priorities (c.f. Ahmann 2018). They can also authorize a shift in focus once a target has been met. Each of these often-intertwined uses of metrics entails a distinct temporal relationship between measurement and change.

The elision of health, quality and performance underscores the challenge of understanding “metrics” as a singular concept. Metrics can be used internally to assess for lapses in care and externally to prove performance. In a volume on the use of metrics in global health, Vincanne Adams (2016) writes that “Metrics can be and often are useful. At the same time, however, it is important to understand how the use of metrics can also interrupt and derail efforts to improve health, no matter what scale we are talking about.” Like Adams’ work on global health, this is not an argument against accountability or assessment writ large. The safety net serves vulnerable patient populations and clinic staff and leadership agree it is important to assure that they receive just, high quality care. Yet, the relationship between numbers and just, quality care is not always obvious. It is important to pay attention to what the numbers generated represent. What does the act of working specifically to obtain good numbers in the safety net require? What do metrics mean for individual care as well as collective? What can the numbers obscure?

Staff and managers alike are simultaneously critical of the ways in which metrics fail to capture their efforts and insistent upon their utility for identifying areas where they could focus their efforts to improve care. The correlation between work “invested” in outreach or other initiatives and the change in the numbers varies widely. Another form of work that

can disappear into the metrics is the production of the data itself. As data are supposed to *capture* the work of care, the work of gathering, interpreting and responding to data has an ambiguous status as labor. In my research, there was both frequent emphasis on the importance of proper data entry and a sense that the time that this documentation work required in aggregate was underrecognized.

The flurry of numbers at issue in this chapter has been enabled and intensified by the widespread adoption of electronic health records (EHRs). EHRs have enabled new forms of research and coordination. EHR technology has been also been implicated in increased “administrative burden” for primary care clinicians and staff (Arndt et al. 2017; Sinsky et al. 2016, c.f. chapter 4). Thus, before returning to the uses of metrics and the way they structure clinical time, I introduce the EHR as it was presented to me.

### **The EHR: General and Specific**

There is a wide and growing range of writings in the professional, policy and social scientific literatures on the promises and perils of Health Information Technology (HIT), including the EHR. Adrienne Pine (2011) writes that HIT gained broad support after the Institute of Medicine’s (2000b) “To Err is Human” report. Pine argues that this report located the source of medical error in individual choices and weaknesses rather than systemic issues like understaffing. She describes how HIT enables health systems to increase patient loads per worker through scripting and automation. It also individualizes accountability by serving as an “audit trail” for medical errors (A. S. O’Malley et al. 2015; Pine 2011). This framework for HIT takes the time scarcity created by the organization of the clinic for granted and proposes increased protocolization of care as the solution.

Hunt et al (2017, 403) summarize many articles across professional and social scientific literatures when they write that, “EHRs are structured to prioritize the interests of a myriad of political and corporate stakeholders, resulting in a complex, multi-layered and cumbersome health records system, largely not directly relevant to clinical care” (c.f. Olayiwola et al. 2016; C. P. Roth et al. 2009). They lament the disappearance of the individual patient’s narrative through digitization as structured data fields force choices and exclude context shared in the visit. While they acknowledge that the EHR is also valued and embraced by users for certain reasons (namely facilitation of communication), the EHR remains, in Hunt and colleagues’ analysis, a tool of surveillance.

A study of clinicians’ experiences with EHR-derived performance data in safety-net settings found that care was full of contingencies that are documented as free-text if at all and thus not captured automatically through the EHR (Bunce et al. 2017). Clinicians felt that performance metrics do not account for patients’ barriers to recommended treatment or their creative ways of obtaining treatment that may not be recorded in a structured way. Meanwhile, the same providers did see potential for improvement *if* performance feedback included data specific to individual patients and the clinic had dedicated staff and time to act on the information.

Clinical data captured in the EHR and other systems can only ever represent an “approximation of the complexities of everyday practices that refuse to be simplified” (Pine 2011, 268). This has implications both for patient care directly and for clinic finances when payment is attached to the data captured by these “approximate” systems. Social scientific critiques of the uses of the EHR and the prescriptive protocols embedded in the process of documenting care have warned that these technologies obscure the complexity and social

nature of medical decision making (e.g. M. Berg 1997; Willging 2005). Further, the timeline and scope of factors that metrics measure structure time in a way that favors quick fixes rather than deeper organizational or political change (Biehl 2013). This temporal structure can rationalize the incremental intensification of labor for clinic staff (c.f. chapter 6).

The network of clinics in which I conducted fieldwork implemented the use of EHR in 2011. For clinicians and staff, computers presented both opportunities and challenges. In principle, they could facilitate data tracking, offer useful prompts and help clinical teams coordinate their work within the clinic and with outside specialists. However, the EHR was more often discussed as a hindrance. One person, early in my research, told me: “If your paper doesn’t end up including a significant section on eCW [the EHR], I will be *shocked*.” Another provider, when asked what would most improve her experience of time in her work, stated simply, “I would get rid of electronic medical records.” The omnipresence of this technology made it fundamental to the structuring and experience of time in the clinic.

## Clicks

*S: Do you feel like that has changed? The documentation and correspondence over your career in primary care?*

*Sarah: Uh... I don't know. Maybe? ... I mean yes? But, I mean, we used to do paper charts. And you still had, like, the overwhelming amount [sic] of things to get through, it was just a different delivery system. I think in – the electronic medical record has created more... clicks that you have to click to get through each task. Um, so where in the past you could just pick up a chart and kind of leaf through it, now you have to, like, go to this page, go to that page, open this other, you know, page...*

“Clicks” are ubiquitous in discussions of electronic documentation. Clicks are tiny, each one may barely be measurable in time. Yet, the volume of clicks required to document

care is enormous (Hill, Sears, and Melanson 2013; Levinson, Price, and Saini 2017). Later in our conversation, Sarah (quoted above) told me, “It takes probably 12 different – probably 20 different clicks to refer somebody to physical therapy. Where you have to enter twenty. different. little. things in little boxes.”

Providers told me that moving between multiple digital fields takes more focus than jotting a note or checking a box on paper. This led many clinicians to leave documentation work that previously happened within the visit for later, when it takes longer. Of course, the electronic record enables many forms of communication and collaboration that were not feasible with paper charts, including the visibility of patient records to multiple clinicians and across multiple clinics. This same visibility makes the EHR a tool for work surveillance. Clicks standardize data, making it easier to track for multiple ends. Clicks are of variable consequence in terms of the information they convey. Some make subtle distinctions of real or questionable clinical significance. They are oriented toward structuring the data for billing purposes and so that, at least hypothetically, they can be mined for scalable information – trends, patterns, population-level statistics. Overall, electronic documentation was a necessary part of patient care, but elements of it were questioned by some as disconnected or even distracting from patient care.

To illustrate what people meant by “clicks,” a behavioral assistant (BA), Hannah, showed me the process for charting that someone accepted smoking cessation counseling. Offering smoking cessation is one of many recommended practices that are required or incentivized by funders and enforced by many EHRs through templates and automatic reminders (c.f Checkland, McDonald, and Harrison 2007). Hannah demonstrated:

1. Open a “telephone encounter” (TE) in the EHR. TEs are used to document and communicate about elements of care other than a scheduled visit with a nurse or doctor.
2. In the “message” box of the TE, type “quitting smoking” so that others, such as those at the call center, can find it.
3. In the same screen, click the button for “virtual visit,” which creates a progress note.
4. Select “screening and risk assessment,” which pulls up a set of questions, including the type of screening. Select “tobacco use.”
5. Merge the template for a “behavioral assistant note,” which includes several more drop-down lists.
8. Select “smoking cessation” from a drop-down menu for the “referral reason.”
9. Another drop down is for “service provided.” Also select “smoking cessation” here.

I laughed at the redundancy. Hannah said that these were “required fields” for the people who track smoking cessation. “We have to do that. If we don’t, it won’t count.”

In the case that she was documenting, the patient had not yet been ready to quit smoking at the time of their conversation because of a medical issue. Hannah charted this in the “planned quit date” box and then wrote a few sentences of free text explaining what they talked about and the plan going forward. This part, she commented, “helps you remember if the patient [comes] back.” Done with one record, she told me that after she does five of these notes, she feels like (with a sigh), “I’m tired of clicking. I need to go see a patient.”

“The funny thing,” Hannah told me, about this tedious documentation process was that when a group of BAs asked to use this structured information for their own planning, they were told that the information could not be pulled at an individual level. They were

also told that their own estimates were inaccurate, a claim based on the same data. The BAs had wanted to use the data to determine a reasonable number of smoking cessation conversations to aim for each week in order to avoid the annual rush to increase their numbers at the end of the fiscal year. When they suggested their own goal, they were told it should be higher based on what they had been doing.

The dominant discourse about metrics is that the knowledge represented by data will inform and “drive” improvement. Quantitative improvement may be driven by the imperative to increase the numbers, but it sometimes appears that the data cannot inform that process in a way that recognizes and accommodates current workloads. In this case, data that the BAs generated was used to monitor and encourage productivity, but it could not be used to inform a reasonable pace. The way in which, according to Hannah’s account, data was used to track productivity but could not be accessed by those who produced the data to inform their own practice calls into question how improvement is “driven” by data. Cases like this and efforts to clean up the data at the end of reporting periods illustrate that work is often driven *towards* producing evidence of care that has already occurred.

Often a “click” or set of clicks may not be useful to the person making it, but it may be to someone else. Structured data is not only for monitoring productivity. This type of data can also be useful for coordination across clinical contexts. The lists that Hannah used to identify patients who may benefit from smoking cessation counseling could be generated because an MA clicked that they smoked. Prior to the EHR, such a task would have required chart review or the keeping of a specific registry by hand.

Meanwhile, data were often invalid (or understood as such), undermining their authority among staff, but still requiring a significant amount of time and work to re-

produce. The stakes, in terms of regulatory and financial consequences, held despite widespread understanding of the data as provisional and possibly wrong. Sometimes, the inaccuracies stemmed from automated data collection that could not account for variation. At other times, they were due to glitches in the software that “pulled” data from the electronic health record and compiled it into rates and registries. This could mean extra work to identify patients in need of outreach. These challenges regarding the reliability of the data added to frustration among staff whose work was not fully captured.

I spent hours helping one clinic clean up their automatically generated registry of patients with diabetes who had not had a recommended eye exam in the previous year. Many patients who had in fact been examined were not counted as such. One of the reasons this happened was that the ophthalmologist’s office scanned handwritten notes into the record rather than entering the data in the structured field from which the registry was generated. The unstructured data in the image file would not be automatically accounted for. This left the MA or the anthropologist to hand-review those images and alter the date of the patient’s last eye exam in the registry. A manager explained that MAs often spend outreach time checking multiple sources, because if they make an appointment for a patient with ophthalmology that is too soon after their last exam, the patient loses time and trust by going to the appointment and being told they are not eligible. At the point in the reporting cycle during which I worked to clean up the data, however, the stakes were focused on the metric, pushing the clinic over the cutoff for performance-based funding and, hopefully, allowing the work that went into that number to feel recognized.

The case of the eye exam data illustrates the complexity and temporal stakes of realizing population health through electronic records and outreach. The policy



(incentivizing clinics to ensure that all patients with diabetes have an annual eye exam), technique (automated data collection to monitor screening) and technology (EHR) each come with their own temporal assumptions. For example, there are estimates of population risk that inform the screening campaign. The assumption that the data is already available as a by-product of patient care obscures the additional labor time required to check the data prior to outreach or reporting. Multiple consequences are intertwined in the metric, including patients' future vision and income for the clinic (often, again, articulated as the future ability to offer care). Each of these invokes future risk to structure current practice.

### ***Half the System***

Sarah and Hannah's observations that the EHR involves endless clicking sounds familiar to anyone working in clinical settings. The EHR is often experienced as cumbersome, stealing time and attention from patient care. The editor of a special issue on the EHR in the *Journal of the American Board of Family Medicine* observed that it is nearly impossible to walk down the hall of any clinic without hearing complaints about the EHR (Krist 2015). My purpose here is not to add to the litany, but to draw out local specificities of this theme. As a common idiom of complaint, the EHR embodies the tensions between clinical, public health and fiscal commitments. This technology is also tied to the instability of funding and to a disjuncture in tempo between clinical practice demands and slower political and infrastructural change. In the setting of these public primary care clinics, I realized that complaints about the computers and their EHR software shared concerns with critiques of EHR as a technology in general. At the same time, they were also about this specific setting and a feeling of being hindered and behind the times.

Anthropological studies of the EHR tend to take the technology as a general entity with universal intents and effects (e.g. Pine 2011; Hunt et al. 2017). In my research, many observations that my interlocutors made were not about electronic medical records in general, but *their* medical record and broader IT infrastructure.<sup>104</sup> Dr. Lee compared the subjective experience of using their records system to other clinics with better technology through the experience of a friend:

*Dr. Lee turns to me and says there must be a “whole corpus of literature” on the EHR and burnout. I ask her if she’s saying that she thinks they are connected, and she says of the EHR: “It’s a source of endless frustration.” She tells me that a friend of hers who used to work at [these] clinics and then went to work for Kaiser said at some point that she actually cried, “remembering what we have to deal with here.”*

While much of the literature focused on the impact of HIT on providers, nurses and patients, the system is utilized by and effects all members of clinic staff. Madison, an eligibility worker with many years of experience, simultaneously worked and narrated an orientation to her job for me. The clinic’s registration and EHR software figured prominently.

*On the registration screen, some patients need information updated, others just need to be “cleared out” [with a number of key strokes that finish their registration]. “It’s just extra work,” she says, which she attributes to the [public healthcare delivery] system not buying the full software package.*

*Later, Madison observes, with a deadpan delivery: “This system was supposed to decrease paperwork.” She pauses. “So, I’ll just leave that.”*

*From her perspective, there’s still a lot of paper, but now it needs to be scanned. [Also, billing codes are manually entered in this system from separate paper forms.] [The EHR software], she says, has “increased work for me.”*

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<sup>104</sup> One notable exception that at least two providers pointed out was their referral system. It was still cumbersome but reliable.

*I ask: Has this system made your life easier in any way?*

*Madison: "No."*

*She monitors the schedule because of issues with the registration software, where patients who need to be registered [don't] "always come up on the board." Again, she attributes that to the [network] only buying "half the system," so "getting half-system work."*

Madison attributed many of the hassles of the EHR not simply to electronic records but to a short-sighted underinvestment in particular software. This sentiment was echoed by others, such as when someone explained: "We had to go with eCW because it was the lowest bid." Some speculated that it cost more in the long run (c.f. Gawande 2018).

## **Epic Future**

In 2018, the network announced that it was finally going to overhaul its EHR system, upgrading computers and moving to a different, more expensive, EHR vendor called Epic. During my fieldwork, there was much excitement about this prospect, coupled with skepticism about how soon it would actually happen. An email sent to staff struck a distinctly utopian tone. The message led with a countdown clock to the "go-live" date for the new EHR system. The email subject line was "Our Future will be Epic," a play on the name of the soon-to-be implemented health record system. Below the countdown clock was written: "We are embarking on a transformation that will improve patient care, finances and efficiency and bring [our department] *into the modern era* of health care" (emphasis added).

Anthropologists have analyzed the ways in which categorizing people and events as modern or non-modern reflects and reinforces existing norms and power structures (Fabian 1983; Davis 2012). In narratives of the promise of the new EHR, the current system and, by

association, the clinics and healthcare providers that used them are implicitly placed in the past and, therefore, inferior to others. The new technology promises to “bring [them] into the modern era of healthcare.” In this modern era, patient care is explicitly linked to finance and efficiency, which promise to improve in tandem.

Some who had used Epic before had far more tempered optimism, recognizing that certain common features of the EHR would continue to cause frustration, while other things, like record sharing with other hospitals using the same system, would improve. Epic, which automates many tasks, can generate a lot of “repetitive BS,” as one provider put it. At the same time, providers wished for certain automations and reminders unavailable in eCW.<sup>105</sup> Speaking about keeping up with patients’ screening needs, Dr. Huynh told me:

*Dr. Huynh: Hopefully with Epic, if it’s due it will just shoot into your orders and you just click okay, right... So, now – it kind of sucks, right? Because something that a computer can do, we have to allocate a staff person to do. So, you know, hopefully, maybe we can get that. I don’t know.*

*S: I feel like I’ve heard the phrase, “Hopefully with Epic...” a lot of times this year.*

*Dr. Huynh: I know. Everybody’s like, “That’s not the Epic we’re gonna get.”*

*S: Oh really?*

*Dr. Huynh: Apparently you can get all these different bells and whistles and so, if you don’t buy that bell and whistle... But... I mean, that’s what’s hard, right. Like, there are just a lot of inequities in medicine [She lets out a sad laugh that edges into a sigh.] Like, the patients that don’t really necessarily need that, but they get it because that’s, like, a paying system and it’s got a lot more money. The patients who maybe need it the most don’t get it. Right? So, they come here five times and not get it because everybody’s so preoccupied with all your (sic) other stuff, right?*

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<sup>105</sup> Some wishes – such as for automated reminders – make sense in the context of time pressure and a wide range of tasks to remember. Meanwhile, accounts of EHR implementation elsewhere suggest that they may later cause another type of frustration (e.g. Checkland, McDonald, and Harrison 2007; Gawande 2018).

*S: Right, yeah.*

*Dr. Huynh: And they [the clinic] can't reach you because you [the patient] don't have a phone. And, you know.*

I heard in Dr. Huynh's comments a theme that has been widely discussed in the professional literature about healthcare for the underserved. There is a risk with performance-based payment of a cycle wherein safety-net clinics and hospitals that are already financially stressed miss "quality" incentive targets, further narrowing their margins or increasing their dependence on other unstable forms of funding, which in turn render achieving improvements harder (Paula Chatterjee et al. 2012; Friedberg et al. 2010; NASEM 2016). Many explained their tempered hopes for the new EHR in terms of the health system lacking the funds for the full package. Dr. Huynh corrected me, though, when I summarized this point of view. She asserted that this county and its clinics have quite a lot of resources for a local system, "Which is part of why it's fun to work here, right, there's a lot of resources here... but it's also – there's not the political will to do it differently..." As part of the larger county bureaucracy, the health network was embedded in a system very slow to change and subject to policies sometimes poorly adapted to the provision of healthcare.

Both explanations may contain elements of truth. And maybe the version of Epic that will be implemented will have more "bells and whistles" than expected. What matters for the purposes of this analysis is the temporal overtones in discussions of the transition. On a webpage concerning the change, quotes about nurses' hopes for the new system were compiled. One nurse manager commented: "I feel like using an integrated EHR like Epic will help our department jump into the 21st Century with technology. I can't wait!" During my fieldwork, others made related observations about the particular frustration of living near a

center of massive tech development and working on slow, clunky and fragmented software. The system seemed both out of time and place.

In *Pressed for Time*, Judy Wajcman (2014) argues that the relationship between specific technologies and contemporary temporalities are far more varied than narratives of technological progress and generalized speed-up suggest. Wajcman is interested in the time-pressure paradox, in which technology hastens many processes, yet people still feel short on time. She draws on feminist time studies, which documented how domestic technologies aimed at saving time (e.g. the washing machine), instead raised social expectations (e.g. for cleanliness). She argues that the coevolution of social norms and technologies contributes to a cycle in which standards change in response to the technology available, undermining their time-saving potential. There is no inherent link between technology and temporal acceleration, but technology can naturalize norms that promote the filling or fragmentation of time.

Surveying the literature on health information technology and listening to providers and staff in the clinics I studied, it becomes clear that the EHR facilitates many practices that used to be time-intensive in other ways. At the same time, the layered interests and standards that have become embedded in the technology lead them to feel like more of a barrier than an aid. The degree to which structured (i.e. mineable) data is prioritized and small distinctions of low clinical but high regulatory or payment-related utility are embedded in these systems exemplify the way in which cultural and organizational norms and technology evolve together. This coevolution happens on a scale much bigger than this clinic network, with implications for their use of a specific version of the EHR.

Wajcman also observes that speed, technologically-induced or otherwise, is not equally distributed. Control over the use of information technology and its effects on the pace of life vary across axes of power. In the case of the EHR, expectations for the ready capture of standardized financial, regulatory and population health data have both spurred and intensified with the development of HIT in general. Technical infrastructure varies between different clinical systems. Clinics like the ones I studied, serving low-income and uninsured patients, may use inferior technology due to cost. Within this context, clinician and staff optimism about Epic was tied to an idea of having “caught up.” At the same time, the promise of the new software was tempered by past experience and recognition of the generalized disjunctures between clinical work, data collection and incentives, even with the most “modern” EHR. The EHR promises to save time and improve care by integrating clinical work and quality monitoring. In practice, it has facilitated previously impossible forms of population management and generated new forms of labor that become time consuming in the face of technical barriers and ongoing expansion of the sheer number of measured practices (c.f. Østbye et al. 2005, chapter 4).

### **“Healthcare has to pay for itself”**

A common sentiment among staff and providers was that money clearly mattered for the health system, but they preferred to think of their task in terms of patient care and let “the brass” worry about the money. Working in the public sector, many providers felt insulated from some of the financial emphasis one might find in private practice. “I think it's a really good place to practice the medicine that I like, which is not focusing just on the money and the numbers,” one provider said, “But, sometimes you have the message that it

is about the money... which is fine to be pragmatic about it and not naïve, but, you know, it's nice to still think that that's not the focus.”

Meanwhile, there was a narrative I heard from clinician-managers that, until a couple of years before I arrived, there had been little explicit discussion of the budget at the clinic level. Then, with changes to the administrative organization of the network, situated within a broader turn toward “value-based payment,” emphasis on finances, and particularly on maximizing the revenue from incentives, became a major focus. Linking billing to the ability to pay for additional staff and services, one supervisor put it, “If you care about patient care, you need to care about financial sustainability.” By not doing so, “you’re making your own job harder.”

At a management meeting, a clinic manager stated matter-of-factly that we were in an era where “healthcare has to pay for itself.” In addition to changes in Medicaid and broader health payment structures wrought in part by the Affordable Care Act, there was always the possibility of budget cuts or a “bad budget year” in which funding from the county would not fully buffer the public community clinics if their revenue was inadequate.<sup>106</sup> Members of leadership insisted on their commitment to relying less on local government funding. Generating maximum revenue internally included meeting value-based payment measures.

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<sup>106</sup> The concrete consequences of missing performance goals were rarely specified in the meetings I attended. Instead, fiscal stewardship was framed as essential to the ongoing operation of the clinics. I asked members of leadership about the potential real-life consequences of missed measures. They explained that while the local government’s general fund supports these public clinics, local politicians often question the size of this investment and could impose a hiring freeze or reduce their contribution to the public health budget. In order to insulate against this uncertainty and maintain the highest level of staffing and programming that they could, they aimed to be as financially self-sufficient as possible.



Fleming *et al* (2019) describe the growing entanglement of economic and justice-oriented claims in the provision of social services, where provision for basic needs is figured as a cost-saving measure. Progressive practitioners and organizations make claims to economic efficiency to garner resources, even if they are personally critical of this fiscal logic. The pursuit of metrics makes a similar, inverse translation, mobilizing justice claims about economic decisions. The pursuit of financial incentives can be understood as ensuring the future ability to care, whether or not one believes that the particular metrics or incentives themselves promote or hinder good care.

These complicated entanglements are fostered by a socially structured sense of scarcity as inevitable and a model of healthcare in which care must produce value in addition to being a moral good (Kertesz et al. 2016; Farmer 2012). The argument here is not that incentive-based funding is fundamentally corrupting, but that the temporalities that it imposes on care and improvement work limit the possibilities for progress in health and equity. An anticipatory, risk-oriented approach to improving care and the short-term punctuation of time in the use of metrics generates a sense of endlessly pursuing disparate goals. Those who work in the clinic hold some of these goals as both essential to just healthcare practice and requiring deeper social change to make their pursuit sustainable. Claims that link economic efficiency and care are quite real, but they are real within a context and logic of scarcity, which does not have to be the basis of healthcare financing.

Blending financial and moral value, the health network that the clinics I studied belong to organizes their metrics under headings called “True North” values, or “a precise, concise and universal set of ideals which, when taken together, provide a compass that describes the ideal or state of perfection that [a] business should be continually striving

towards.”<sup>107</sup> Realization of these values is aspirational, but they are operationalized as concrete quantitative goals, some with financial and regulatory consequences attached. In this operationalization, universality must be reconciled with precision as general moral goods are translated into measures. The striving is to be continual but is punctuated by reporting deadlines. The image of a compass suggests that striving toward this set of universal values goes in a singular direction. In practice, they were often experienced as pulling in different directions. This divergence could be between interpretations of a given metric or between multiple metrics that draw on a limited pool of staff’s labor time.

The True North universals at the time of my research were: Safety, Quality, Care Experience, People [Staff] Development, Financial Sustainability, and Equity. These are “concepts that are nearly impossible to argue against” (Nicosia 2017, 8). Each value is linked to a small set of indicator or “driver” metrics. For example, the metric that was tracked regularly for Financial Sustainability was the percentage of visit notes that were “locked” or finalized with a diagnostic code within 5 business days.<sup>108</sup> The metrics associated with each universal value give the “illusion of precision,” even when the relationship between measure and value are unclear (Nicosia 2017).<sup>109</sup> Trends in the metrics did not explain their causation, leaving this up to interpretation. While those who gather and use the data acknowledge that they are provisional and contingent, they have consequences for the organization and recognition of care (c.f. Biruk 2012).

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<sup>107</sup> Variations on this phrasing were used in internal presentations within the local government.

<sup>108</sup> There were two reasons given for this time limit: As a matter of safety, locked notes were more visible to other providers whom a patient may see following the visit. Financially, the amount that the network could bill the insurance plan declined if notes were delayed.

<sup>109</sup> This observation is not to discount the precision of the metrics themselves relative to the specific outcomes they measured. Many people worked hard to validate the data relative to the assumptions built into the metrics’ models. What this analysis questions are the relationships between the measures, the values and care itself for which they serve as proxies. Many users of the metrics are well aware of this gap.

In this section, I interrogate how improvement is operationalized and its implications for clinical time. I begin with metrics as they are tied to regulation and financing before taking a broader view of their uses within the clinic. By tracing the temporal assumptions in the use of metrics and the experiences of those who use metrics in practice, I draw out contradictions that are obscured by universal value claims. I argue that the simultaneous moral and pragmatic consequences invoked in relationship to *each* metric make it appear impossible or undesirable to systematically prioritize certain measures over others. This puts clinicians and management in a position of reconciling contradictory aims with the limitations of clinic time in practice.

### **Driving toward Deadlines**

The “True North” measures, which were reported monthly at staff and management meetings, were just one small subset of measures for which the network was “accountable.” Others were linked to the local health plan’s “Performance Improvement Program” (PIP) and PRIME, a Medicaid pay-for-performance program, among others. At one meeting, a lead administrator estimated that there were over 80 metrics they were concurrently tracking. They attempted to “align” metrics that would satisfy multiple programs and introduced the “scorecard” model in an attempt to help clinics focus. “It’s okay if you’re not working on everything at the same time. That’s crazy-making,” the administrator said. But, she continued, there needs to be priority setting, with champions or owners “and a timeline.” The following presentation, which came toward the end of my fieldwork and the end of the fiscal year, illustrated the language and many recurring themes surrounding clinical metrics:

## Fieldnote, Population Health Standardization Meeting

*Two administrators, Dr. Lin and Daniel, stand near the screen in front of a small cluster of tables where data analysts and clinic managers sit. They are going to talk about, “Marginal/At Risk Metrics.”*

*“You’ve heard about this but I’m gonna show you the data,” Dr. Lin says. For each measure, there is a table of clinics listed alongside their current rates and goals. On this “scorecard” presented on the screen, the current rates are in colored boxes (red, yellow and green) for those clinics that “chose it [the particular metric] as a driver.” Green means that they are at or exceeding the goal required by the metric. The other (non-driver or “watch”) metrics are noted in gray.*

*For depression screening, Dr. Lin observes, “We are moving the needle on this, but this is so that we can sort of squeak by, so we can’t let up on it for the next eight weeks.”*

*She reiterates this “scorecard” strategy again: “[We’re] trying to do this so that clinics don’t have to think about every single metric but set a goal and focus on [drivers].”*

*Daniel presents the data about hypertension control for Black and African American patients, a measure being used to monitor and improve health equity. A couple of clinics are exactly at goal – “Don’t take your foot off the gas,” he says, “because one patient and you’re back in the yellow.”*

*“One patient,” a data analyst murmurs with a shudder in her voice...*

*...Dr. Lin comments that they have not figured out how to “message” or visualize that some watch metrics are decreasing... She says we will “have conversations about how to stabilize” so that we don’t “lose all the hard work.”*

*Next, Daniel presents a slide showing of a scorecard for the whole network and multiple metrics.<sup>110</sup>*

*“A lot of red still and this is accurate,” he says. “[We] need a push to get more green before the end of the fiscal year.”*

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<sup>110</sup> The “scorecard” is a selected list of metrics from among the many that the health network is accountable for. The priority (i.e. “driver”) metrics are intended to be related to several others and to reflect the primary concerns and capacity of each clinic or the network as a whole. Next to each metric is a box with the current value for each measure. If the metric is “below goal,” the box is turned red. If marginal, it is yellow, and if it is firmly above goal, it is green. This visualization technique is supposed to give one a quick idea of the state of quality improvement for a clinic or network. For an example, see Lowder 2016.

Talk of metrics and incentives is riddled with metaphor. Drivers. Scorecards. Dashboards. Needle. The analogy to driving suggests movement, speed and direction. Metrics as evidence of quality *improvement* are supposed to follow a forward and upward trajectory. Status of metrics is often marked with the red/yellow/green scheme of traffic lights. “Don’t take your foot off the gas,” Daniel admonishes, or you’ll miss the light. Of course, green also stands in for money. When Daniel said they need to “get more green,” he did not pause for effect. The double entendre seemed unintentional. To me, it was a striking nod to the increasingly explicit link between care quality and finance.

From a fiscal perspective, meeting metrics on a fixed time frame was what made a difference. Pressure was intensified toward the end of the fiscal year, as metrics that missed the mark before no longer had time to catch up. In this moment of the annual reporting cycle, the metrics themselves were “at risk” of missing the goal (c.f. Nicosia 2017). “At risk” suggests a particular future orientation – they currently are not at goal and are at risk of not improving. Or, they are just barely there and at risk of dropping – going “back in the yellow” (c.f. V. Adams, Murphy, and Clarke 2009). The timeline here – eight weeks until the end of the year – lent urgency to quality improvement efforts and encouragement in the form of an end in sight.

The framing, in terms “not letting up” and keeping one’s foot on the gas for the next eight weeks raises questions about the purpose and sustainability of their efforts. Focus on certain “drivers,” required to “move the needle,” tended to shift attention and resources away from other initiatives, making gains difficult to sustain. If the goal is continuous improvement, then it would seem one cannot let up after eight weeks either. In practice,

because of the number of competing priorities at play, one might have to. This contributes to the trouble with “how to stabilize” that Dr. Lin refers to.

The cyclical feeling of watching metrics rise and fall was a common feature of the temporality of improvement efforts at the clinic level. Time could become an imposing presence on a timeline. The network leadership worked hard to distill the massive number of metrics required by a number of agencies into a relatively more manageable number and involve clinic management in prioritizing their “drivers.” Time also appeared strangely absent in that the temporality of sustainable change, limitations of labor time and the opportunity costs associated with contradictory goals would be deferred except for the narrowing of priorities to the drivers on the scorecard. The public secret of time as a limiting factor was not based on individual ignorance of these contradictions (M. T. Taussig 1999; Geissler 2013). Rather, my argument is that the logic of continuous, incentivized improvement *requires* bracketing these other temporal matters of concern.

For measures that are perennially a focus of regulation and improvement, seasonal patterns were sometimes obscured by the *tempo of measurement*. The response to appointment access numbers exemplified common themes in the discourse around metrics. The goal for access, measured by the third next available appointment (TNAA; see chapter 1) was an absolute threshold of 14 days or a relative improvement of 7 days over the previous reporting period. As of late June, the average was 34. There was a memo and much concern. Over the previous couple of years, TNAA had been decreasing, but in the last quarter it had popped back up. TNAA improvement (reduction) is required for regulations.

“There’s not much more low-hanging fruit,” a network administrator stated as she presented the access stats at a monthly management meeting. “Low hanging fruit” referred

to easy fixes. Checking on the numbers every month was meant to keep it from slipping, but it also encouraged thinking in terms of things that could change the outcome within a month. Even when the focus of discussion shifted to an annual cycle, emphasis – at least at the clinic level – remained on tactics in the present to remedy the mismatch between demand and supply. Central leadership suggested several such tactics, including reminder calls, delaying special projects to focus on access and asking staff and providers to use admin time to “scrub their schedules” for patients who could receive care in a format other than a provider visit, such as a phone call or an appointment with a nurse.

In response to the administrator’s observations about the current TNAA trend and lack of simple solutions, one administrative operations supervisor with decades of experience raised her hand. She observed that, “Every summer this happens, and usually by September, October, our TNAA improves. Just putting that out there.” The presenter responded that that was true, but insisted they still needed to improve.

The TNAA metric held steady at 34 for two more months. The third time that the same number was presented to a meeting of managers, the room was silent. There was a bit of a murmur, though, when the presenter added that the previous August, it had been 43. Another member of the administration added that they had had a record-setting number of new patient appointments during the preceding month. She insisted, “We’re going to keep chipping away at access.” Rather than the maintenance of a consistent delay being understood as a success, it appeared as a stagnation. New patient appointments, another form of patients accessing care, helped to explain the depletion of appointment slots. At stake here was the time frame for comparison. Zooming out to compare August to August

isolated the values from seasonal changes and helped offer encouragement by reinstating a progressive trajectory.

In September, TNAA decreased slightly, but remained far from the goal. “Don’t let these numbers discourage you,” admonished the presenting administrator. “Access” shifted to “these numbers.” In February, the sentiment was repeated as TNAA slowly dropped: “This is hard number to move.” The tone shifted from admonition to an encouragement to persist. Finally, in April, the administrator announced something “super exciting. We continue to be the 20s.” She started to thank those at goal and caught herself, saying thank you to “all of you, actually, because even if you’re not at...” She trailed off before saying “goal,” but another administrator nodded, making a hand gesture imitating the downward trend.

To focus too closely on the numbers as metrics and their demand for progress would produce an over-determined narrative relative to how they are actually used. In the beginning of this series of exchanges, it seemed difficult to historicize the numbers. The operations team shifted their emphasis over time in an effort to maintain a sense of urgency on principle (Patients are waiting!) while avoiding discouragement.

## **Sustaining**

*“Once you do well, you move on to new challenges.”*

*“Once it goes down, they’ll say get that back up again.”*

Improvement implies forward progress. In this case, it is supposed to be continuous or constant. Maintenance work is itself an “ongoing, frequently artful and often fraught accomplishment” (Jackson 2017, 174), yet what emerged from my observations of discussions around metrics was that the temporal logic of continuous improvement often



renders maintenance as failure rather than accomplishment. At the same time, managers worry over their inability to sustain prior gains. Within the logic of continuous improvement, the goalposts always move. Risk is ever-present. Improvement implies sustaining prior outcomes *and* advancing, even though sustainment itself is often elusive. The ethos of constant improvement risks rendering stability as inadequate.<sup>111</sup>

One of the ways that managers and clinicians managed this gap between the aspiration to constant improvement and the challenges of maintenance was by articulating both long and short timelines that maintained a sense of progress. An upward trajectory was sometimes rhetorically maintained when there were lapses. A central management team member said about their “care experience score” one month, “We went down a little bit, but we’ll be up again.” Often the sentiment that I observed in clinic was oriented toward the opposite possibility. Sustaining change was a challenge given shifting priorities. This led people to describe initiatives as “going in waves” or to address new emphases as “the flavor of the month.” These descriptions were accompanied by a sense of fatigue and some clinic staff expressed cynicism about the frequency of new initiatives. In a fascinating formulation, one administrator suggested that a key role of clinic management was to help staff “get grounded to the priorities, however often they might change.”

When I asked a medical assistant, Liz, to describe how she balances the needs of individual patients with that of her larger patient population, she said:

*Sometimes we’ll have a patient that has, you know, like you said, multiple things they need and we have to spend a lot of time with them, and then the next*

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<sup>111</sup> Meanwhile, primary care itself is arguably a form of maintenance and repair work. (Recall that preventive and chronic care practices are labelled “healthcare maintenance”). Primary care practice requires similar work upon time in the absence of cure, taking a longer view than the structure of incentives or clinic schedules necessarily emphasize (see chapter 7, c.f. Gawande 2017).

*patient doesn't have so many issues, so we address what they need, but, I don't do the foot exam [or] the eye exam [recommended for diabetic patients], because they don't need it. It's just a measure to be met.*

*So, I don't – but it's like, maybe if I did do the foot exam, I would've found something that the doctor didn't see– that [the patient] didn't tell us about. But because we had this other patient, and then these other patients... [we didn't] get to it. Or what if I did do the eye exam and it turns out... something's going wrong with your vision? And it's just, like, all that stuff got skipped for you, because we have to constantly keep going.*

The orientation cultivated in screening and metrics is anticipatory (V. Adams, Murphy, and Clarke 2009). An uncertain yet seemingly inevitable future demands action in the present. That future can be the future illnesses of patients, as in the case of screening, or the future existence and infrastructure of the health network. Value-based payment and related regulatory and incentive schemes rely on this affective state of anticipation to drive practice. Meanwhile, this intense future orientation coexists with a presentism enforced by dense clinic schedules. Pursuit of quality and of good numbers in both population health and patient satisfaction operate on disparate scales and temporal horizons. The first is oriented to a large scale and long term while the latter is often understood as based on the interactions and delays in a particular clinic session.

The presence of risk-based anticipation in clinical work, monitored and reinforced by metrics, is exemplified by Liz's question, "what if?" Liz's ambivalence about the importance of screening in the context of a busy clinic points to the coexistence of multiple time horizons, each of which make different ethical demands on her time – the flow of the clinic session, in which they are behind; the patient's disease course and the pressure within reporting regimes to meet or exceed metrics within a quarterly or annual reporting period. In framing the recommended screening tests for diabetic neuropathy as "just a measure to

be met,” Liz implicitly distinguished between the population-level focus of metrics and the individual risk to this patient. In the next sentence, she starts to question the distinction. By design, they are not easy to fully disentangle.

In their study of an expansion of performance-based payment in the National Health Service, Checkland and her colleagues (2007) found that providers insisted on their ability to maintain their understanding of and focus on patients as individuals while also following incentive-backed guidelines. Nurses expressed more concern about the potential irrelevance of population health measures to patients’ reasons for seeking care in a given encounter. They worried about a “crowding out” of other ways of knowing about patients through the structuring of practice by the EHR.<sup>112</sup> Checkland and her colleagues make a clear and concise critique of the potential effects of population-based metrics as captured by the EHR and tied to incentives. However, they reinforce a distinction between the measures and individual care that is incomplete in practice. The notion that these population health indicators matter for individual patients and that missing them may constitute neglect is absent from their analysis. The latter framing was motivation for those I spoke with who remained committed to the use of metrics to guide their practice.

## **Punctuation**

Chloe Ahmann (2018, 160) writes that temporal punctuation “formulates speed as moral when compared with the violence of deferral or the treacherous patience of incrementality.” Whether used internally for monitoring or externally for reporting and

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<sup>112</sup> At the time of their writing, Checkland et al (2007) awaited a new contract which would “counter” the potential misuse of quality indicators with measures of patient satisfaction and appointment access. As I have discussed, this fix *by* metrics to the risks of other metrics has been subject to critiques of its own, such as Nicosia’s (2017) analysis of efficiency and patient experience and Pine’s (2011) account of scripting techniques aimed at influencing “patient experience” scores amidst the standardization and acceleration of care.

incentive programs, measurement and the pursuit of temporally anchored goals serves to punctuate time, drawing attention to matters that risk being deferred in the name of other priorities or simply falling out of attention. Depending on the tone of this attention and the options for responding, the punctuation can feel empowering and exhausting.

Tracking population health metrics can generate a sense of urgency around chronic and preventative care practices that tend to be deferred in the face of patients' acute needs and clinical time pressure. The use of metrics in this way can also involve punctuation in a different sense. They can be used to pause the often-harried flow of individual care and take stock of what may or may not be working and what has been missed. Structuring a schedule according to which there is time to review and respond to the metrics could enable reflection and intervention independent of external timelines. In other words, practices of marking out time to reinforce population health efforts, which varied by clinic and moment, broke with many of the other discussions in this chapter. They made explicit that metric-related tasks take time that is often unavailable in the rush of clinic.

As one provider, Sarah, put it, focusing on population health is as an opportunity to "see from above rather than swimming up from the bottom." It allows one to look at patients "as a population versus one patient at a time, which doesn't work, because somebody won't come in or they do but you're focused on their pneumonia and don't do their labs." Sarah's use of metrics here is less oriented to the punctuated time of regulation and more to a concern for equitable care across her patient population and over time. The data helped her identify labs and other chronic care needs that could get lost in the face of other acute concerns.

Key to making metrics work in this other temporality, one that looks back and acts on things that were missed for individual patients, requires time for both review and intervention. I discussed efforts to “protect” time for outreach and other less visible work in chapter 4, but here I describe one clinic’s model for allocating time to act upon both internal and external metrics for population health. A team of provider, nurse and medical assistant had their schedule blocked for one half-day per month to focus on a specific condition and set of best practice indicators. “It’s so nice,” one provider told a colleague as she was on her way to her office for one such session. She turned towards me and added, “Instead of just giv[ing] us the numbers and [saying], ‘you’re not at goal.’”<sup>113</sup>

The conditions that the clinic focused on each month included some that were tied to reporting and some that were purely internal. A meeting during which providers decided what to follow and how illuminated key temporal distinctions between these two uses. The group of providers debated the age cutoff for several metrics.<sup>114</sup> When debating whether a certain measure should be tracked until 85 or younger, one provider argued that it might be good to “overcapture” (i.e. to set a high cutoff). “This is internal, right?” she asked. The implication was that because it is not an external performance measure, providers could

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<sup>113</sup> One question for any metric was who was supposed to “drive” it. “Ownership” is considered key to realizing quality improvement projects, yet as one manager observed, with increasing integration of team-based work, “the issue of attribution” becomes more complicated. Metrics were therefore ideally “messed” as a tool for improvement rather than a judgement of past individual effort. In practice, the two were far less clearly distinguished. Many people told me how frustrating it was to be told “You are not at goal,” for things they felt they had little opportunity or power to alter. The ubiquity of this particular phrase marked that individual responsibility still often shapes approaches to metrics.

<sup>114</sup> During this discussion, there were a few uncomfortable jokes about what would happen to older patients, since those who build the metric and outreach reports have to enter an upper limit in the search parameter. Someone joked that they should be referred to the geriatrician, “[who] will take them off everything anyway.” The exchange highlighted how many of the “best practices” are focused on tests and medications, some of which may not be proven appropriate for older patients. At the same time, it points to the general question of how much these systems shape care for individual patients. As they become embedded, these decisions could shape and naturalize ideas of who warrants certain forms of care (c.f. Bowker and Star 2000).

cast a wide net and then decide what to actually do for individual patients. Relatedly, someone suggested using a narrower age range for “dashboards” that track performance and another, broader search for the outreach list. The idea behind the “dashboard” would be to spur us to action,” the clinic director said. The grid of measures would serve as a “warning system,” triggering a response when values dropped below a certain threshold. In this incarnation, the metrics were used to *maintain* acceptable rates. In contrast to the pace of externally reported metrics with changing targets and priorities, this approach emphasized the vigilance and time required for maintenance as well as improvement.

Metrics are generally reported as a percentage of the eligible patient population who have received a certain service or experienced a certain outcome. A set of questions about who belongs in the denominator of this fraction is inherent in discussions of performance metrics. Many guidelines, such as mammograms or pneumonia vaccines, apply to particular age ranges. What is of interest for my analysis is a set of decisions about who falls under the clinics’ responsibility based on their care-seeking and access histories. For example, current Medi-Cal quality reporting guidelines include patients “enrolled [but] not yet seen” in the population for which clinics are responsible, in addition to their “active panel” of patients who had visits within the previous 24 months. Formally, patients are considered to have left the clinic after two years without being seen. Some people in this study considered one and a half years a more appropriate point for removal from their patient list. There were many reasons why a patient may not be seen in 18 to 24 months, including barriers to care-seeking, lack of perceived need or because they obtained care elsewhere. “Cleaning” patient panels removed patients who may not engage in care from the denominator, improving metric percentages. This process, which involved a significant amount of vigilance

and administrative work, was also framed in terms of patient care. It could save wasted outreach time and, one administrator argued, improve patient experience by preventing obnoxious phone calls to patients who have left the clinic. These technical decisions encompass rather profound questions about the responsibilities of patients and of the clinic. If primary care providers are responsible for the health of their population, what is the proper temporal frame for that population? When should a patient's absence from clinic be understood as an active choice and when does it signal a need for outreach? When are they "lost to follow-up?"

Much of the work of preventive and chronic care was done through "in-reach," reviewing schedules to identify patients in need of certain tests and connecting with them when they came in for a visit. Because in-reach risked missing those who did not come in, clinicians and staff, primarily MAs, also conducted outreach by phone and through letters (c.f. chapter 4). When mammogram or FIT test (colon cancer screening) rates were understood as the MA's responsibility and found to be lacking, several MAs responded by asking about the patients' responsibility to respond to their recommendations and outreach. The distancing that happens during data collection erases context both at the clinic level and in patients' lives (e.g. that they have more pressing things going on). Is the ethical response, then, to leave them be or to further insist on outreach as a form of support/coercion (c.f. Checkland, McDonald, and Harrison 2007; Brodwin 2013)? Although this question remains open, time pressure associated with reporting led to forms of triage based on patient "engagement" (c.f. Fleming et al. 2017).<sup>115</sup>

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<sup>115</sup> This question is partially present in debates about the proper balance of process and outcome measures, which I address below. However, the stakes of the question go beyond the measures themselves.

One formalized way of containing the potentially endless work of reaching patients outside the clinic was the “three tries” rule. Clinic staff were considered to have done their job if they called someone three times but did not reach them. While this did not change their screening rates, it allowed them to move on to other members of the population. Depending on the message, they might follow up with a letter.<sup>116</sup> People also described using their own forms of prioritization based on patient “engagement,” operationalized according to the time elapsed since their last visit, their tendency to miss appointments or a qualitative assessment by those who know them and their circumstances.

Metrics take panel, clinic or population-level rates as a proxy for individual care. Focusing on the aggregate obscures who might be excluded from improvement efforts. The same metrics combined with individually-focused data like outreach lists can both mitigate and enable this process. They allow clinicians to identify patients whose care for a certain condition was unknowingly neglected and, if under pressure to meet a deadline or in the name of efficiency, they can be filtered through logics of “engagement” as a form of deservingness (Willen and Cook 2016).

### **Multipurpose Data**

There is much ambivalence and ambiguity around the multiple uses of data, for managers, analysts and healthcare workers alike. They can secure resources for the clinics,

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<sup>116</sup> Many made exceptions to this rule in cases where they felt particularly invested in a patient or the issue about which they were trying to reach them. In that case, they acknowledged they were “supposed” to stop after three tries but felt compelled not to. A chronic care nurse told me about her desire to follow up on a patient she had stayed late with in clinic the previous week: “[She is] not my patient, so technically I shouldn’t waste – ‘waste’ my time” [on her],” she said, adding large air quotes to “waste.” She added that she would keep this patient on her list for one week to call and check on her. Again, she said that she felt like they should do this for all patients. “If I don’t, she will end up with an infection and amputation and then she’ll be on my list of high utilizers, but why not get them before that?”



motivate resource allocation to positive goals, and accurate records can help avoid repetitive work or wasted time for patients. Yet the same data can become problematic as a form of evaluation, individualizing accountability for complex problems and requiring the reallocation of resources to meeting numerical targets with or without improvements in care. The difficulty of linking metrics to both labor and outcomes has long been a subject for debate. This debate has centered around the relative or contextual utility of process and outcome measures (Mendelson et al. 2017; Gross 2012). At issue is the fact that “outcome measures may seem to represent the ‘gold standard’ in measuring quality, but an outcome is the result of numerous factors, many beyond providers’ control” (AHRQ 2011).

One possible response would be to take a broader view of the actors and interventions that could be involved in changing outcomes, but this does not solve the problem of using metrics to assess performance. Major government and non-profit entities involved in monitoring and improving healthcare quality have settled on recommending a mix of process, outcome and structural measures (AHRQ 2011; IHI n.d.b.). One of the things that close attention to measures in practice shows is that whether something is a “process” or “outcome” depends on perspective. Formally, for example, the number of patients who receive a screening test is a process measure, and changes in morbidity or mortality would be an outcome. However, to the person whose outreach efforts have come up against patients’ barriers to desiring or actually obtaining a mammogram, the procedure seems like an outcome in itself, its completion something largely outside of her control. In this case, over-emphasis on metrics risks unlinking the number from the care it represents, rendering it “just a measure to be met.” On the other hand, some metrics were considered to

represent such important moral goods that they served an important function regardless of their quantitative effects.

### **Case Study: Hypertension Equity**

The questions regarding the relationship between measures, the desired outcome and the timeline necessary to achieve change that have run throughout this chapter clearly came together in the effort to measure improvement in health equity. In 2015, the Department of Public Health created an initiative focused on improving the health of black and African American members of the community. The health equity initiatives related to this effort recognized that the African American population of the county was steadily declining and that those who remained faced significant obstacles to health and healthcare. As one speaker from the initiative put it, this region is progressive but has, “some of the most racist outcomes in the state.” One working group within the broader initiative worked with the Primary Care division of the public healthcare delivery network to focus on eliminating the disparity in hypertension control between their black patients and their general patient population, which was persistently about 8%.

Funding to support some of this effort came from the Center for Disease Control’s Million Hearts program and the project was “aligned” with the network’s commitments to other funders. One administrator put it: “It’s not just because it’s the right thing to do, that’s the most important thing, but it’s also our metric.” One nurse who served on the hypertension equity workgroup told me about how, during an exercise to identify causes of the elevated rates of uncontrolled hypertension in African American patients, they identified factors like inability to afford medication or lack of transportation to the clinic. Then, they

narrowed their focus to food pharmacies and “education,” interventions that seemed feasible and fit within the purview of the clinic. They created a toolkit so that MAs could “coach” patients on monitoring their blood pressure at home. Some clinics also established RN-led hypertension clinics focused on black and African American patients. “Food pharmacies” were regularly scheduled events where healthy food from the food bank was offered to patients in conjunction with blood pressure checks, health coaching and, in some cases, medication adjustments. A grant promised to support the food pharmacy program for a number of years at a subset of clinics that one presenter referred to as “equity sites.” I understood this to mean those clinics with the largest disparities (therefore the focus of equity initiatives). One clinician asked me with a crinkled brow – “Aren’t we all equity sites?”

The metrics monitoring hypertension equity had two components: the process metric of repeating blood pressure measurements if the first was over the threshold, and the outcome measure of hypertension control (i.e. appropriate blood pressure). As part of this quality improvement project, clinics presented providers with individualized data about the gap between black patients and all patients within their own patient panels. Nurse managers received reports weekly that tracked repeat BP measurement, including “how this best practice is showing up for our black and African American patients.” Over the course of my research, both measures improved for patients overall, but the gap persisted or, in some cases, widened. At one point, the rate of rechecks was 4% lower for black patients compared to overall. This statistic gave one administrator, a white woman, pause. During a meeting, she expressed sadness at this unsurprising pattern and observed that it might be tempting to question the data rather than grapple with the implicit biases that could explain the gap. In this case, the use of a process measure (rechecks) alongside outcomes (blood

pressure control) served to focus on at least one element of blood pressure management that was within the clinic's control.

During another meeting of clinic managers, the room erupted in applause when one clinic announced that thirteen of their African American patients now had their blood pressure controlled. This was cause for celebration, even though the gap between their black patients and general population had not decreased. In another conversation, Ariana described her clinic's efforts to improve hypertension equity as one of their QI successes despite missing the goal:

*I feel like we're going to go through cycles of, like, how things get reported and what's important or not, but, like, I'm okay that we didn't meet our equity goal because we are, as clinic we're so much more aware of what equality is, or what equity is. Or like, what systemic racism is... Had we met the goal and not learned those... I'm way happ[ier] – you know? So... yes, we're going to move toward that [goal]. It's important. This is a motivator, but it's not like the end – end all be all. You know? ...If we can get this, we'll eventually get there... But it's like – you have to be conscious of that because you totally get caught up on the numbers.*

Perhaps because the social, economic and political factors contributing to racialized inequity in hypertension control were readily recognizable, addressing the inequity was understood as a process that might take time. This could be read as a justification, deferral or as normalization of institutional racism. Based on the discussions that I witnessed and had with many clinicians and administrators about this initiative, the metrics were also serving a purpose beyond reporting. They were keeping attention on something too often ignored. In the meantime, time and resources were invested in projects to support patients and educate staff. Ariana and others noted qualitative changes in staff's awareness and

understanding of the problem while recognizing the necessity of ongoing work toward actually closing the gap.

### **Timing Data and Change**

Primary care has always had a focus on prevention and chronic care. EHR data, the turn to “evidence-based medicine” and incentive structures have both enabled and encouraged an increasing focus on population health within clinical practice. This is perhaps especially true in a publicly-funded context concerned with both justice and cost-effectiveness. This raises questions about the temporal organization of care, historically and currently organized around the care of individuals. In other words, the effort to improve and account for population health *through* individual care (as opposed to food and housing reforms, for instance) requires a number of assumptions about the relationship between population health and individual care. For example, this model assumes a correlation between clinical effort and improvements in outcomes. Ideally, with a deadline and motivation, these changes can be brought about for the whole population. These assumptions and the structure of payment based upon them generate timelines for improvement that often feel unsustainable. With limited time to pursue multiple population health goals, staff engage in formal and informal forms of triage and selective neglect, persist in chasing metric targets or redefine the goal.

The cases and examples outlined in this chapter illustrate the complex temporal relationships between data, quality and progress. I have traced temporal dynamics that each require further ethnographic attention. Data can be mobilized to demand or to prevent change to systems and practices of care. They can be interpreted as showing change

attributable to practice or outside of the clinic's control. Sometimes, the data appears to be generated for data's sake, like when numbers are collected after the fact or made sense of in terms of already given ideas about patterns. Given this variation, what sense do we make of the ways in which incentives do and do not drive care to resemble the simplistic model embedded in the measures? What are the implications of reacting when a measure drops below a threshold versus pursuing a goal? When is work driven *by* knowledge gained from data or driven *towards* proving achievement and how does that shape one's response? The equity initiative was driven by data on health disparities and motivated important learning for clinic staff but failed to show quantified improvement in outcomes. Other measures did the opposite, demonstrating improvement without a profound change in care. As public services and funding become increasingly organized around "data-driven" improvement, it is important to study the varied forms that that driving takes.

## Chapter 6. Case Study: Behavioral Health Vital Signs

I first heard of Behavioral Health Vital Signs at a meeting for clinic managers. The health network needed to significantly improve their documented rate of annual depression screening before a reporting deadline for a pay-for-performance incentive. Behavioral Health Vital Signs was the name given to a screening tool being implemented partially in pursuit of this goal. In this case study, I analyze how multiple, incommensurate temporal and ethical concerns converged in the implementation of this screening tool. The urgency to collect screening data was imposed by incentive schemes in the absence of what some clinicians felt would be an adequate capacity to respond to positive screens. This raised conflicting moral claims about the function and implications of universal screening and its relationship to individual patient care. In this chapter, I argue that the divergent temporal structure of obligations to the population and to the collective and individual patients seeking care in a given clinic session underlies the implicit ethical conflict that was raised by this project. This tension is relevant to many primary care initiatives as this clinical field becomes increasingly oriented toward and accountable for population health. A number of temporal framings allow debates about universal screening to leave the ethical quandaries it poses implicit and unresolved.

This case also illustrates elements of how labor intensification in primary care takes place and why it is difficult to challenge. In the second half of the chapter, I describe how the implementation of this screening tool was situated within a broader context of concurrent initiatives and understaffing. This context was largely bracketed during discussions of screening logistics and the importance of screening for patient care.

This project recalls many of the themes in previous chapters, including the temporalities of clinic flow, metrics and teamwork. The ever-broadening primary care mandate, the effects of which I have traced, stems in part from legitimate and pressing concerns about patient suffering. Without substantial investment in staffing or resources that would increase care capacity, incremental responses leave clinicians, staff and managers to adjust to new workloads and reconcile contradictory obligations in their efforts to realize abstract goals of care and accountability (c.f. Vohnsen 2017).

To meet their depression screening metric, clinics were offered two strategies: 1) continue doing standard depression screening with two questions (a questionnaire called the PHQ-2) followed by a longer questionnaire (PHQ-9) if the PHQ-2 was positive, or 2) implement a new screening tool, called Behavioral Health Vital Signs (BHVS) with technical support from central management. The BHVS screening form contained a combination of well-established screening questions for depression, substance use and intimate partner violence. This would allow the clinics to identify common mental health concerns all at once. If clinics implemented the BHVS form, they would be on their way to succeeding in the future when the completion of all three screenings (depression, substance use and intimate partner violence) would be tracked.<sup>117</sup>

My aim here is not to assess the appropriateness of this intervention, but to trace the temporal frameworks implicit in the debate that surrounded this screening initiative. The analogy to “Vital Signs” reinforced that it was essential to collect this information for all patients and to respond as necessary. The use of this metaphor recalls efforts to establish

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<sup>117</sup> Appropriate responses to disclosure of depression, alcohol or other substance use and intimate partner violence may be quite different and contingent on the immediacy of danger to the patient. For the purposes of this case study, I focus primarily on depression screening because that was the focus of discussion in the early period of BHVS implementation that I observed.



“Pain as the 5<sup>th</sup> Vital Sign,” which was in part a response to racialized inequities in pain treatment (Knight et al. 2017). This language establishes screening as a moral necessity.<sup>118</sup> In this particular moment, it was also a fiscal imperative.

At one management meeting, the leadership team of a clinic that piloted the BHVS form presented their efforts. Speaking to a room full of clinic managers and network administrators seated at round tables, they started with a background slide entitled: “Financial Sustainability: Keeping this place open for the sake of our patients.” After also speaking about billing forms and unlocked visit notes – other factors that affect reimbursement, they framed adopting this mental health screening tool in terms of ensuring both financial sustainability and care quality. A clinician-administrator from the healthcare delivery network leadership outlined why this mattered: It aligned with many metrics. The goal would be both to identify cases and follow through (thus connecting screening to care outcomes). As the last reason BHVS was important, she noted, “There’s a lot of money... [This is] one of the ways to make sure there is an infusion of infrastructure.”

The promise of an *infusion of infrastructure* was both grandiose and vague, but it served to reinforce a potential link between screening and better care, even if the two were out of sync.<sup>119</sup> The recommendation by the U.S. Preventive Services Task Force (USPSTF) to implement universal screening for depression remains somewhat controversial based on a

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<sup>118</sup> A recent study of an intervention called “Alcohol as a Vital Sign” noted disparities in screening for depression among men and patients of color who report unhealthy alcohol use. The authors of that study warn of inequitable treatment through lack of screening (Hirschtritt et al. 2018; c.f. Wallace, Ann 2015).

<sup>119</sup> Timmermans and Buchbinder ask how the potential of a technology like newborn screening remains or even grows in policy despite a wide range of “unexpected” consequences in the clinic. They argue that advocates, scientists and policy makers alike reinvigorate the potentiality of the technology when it fails to meet expectations. In the process of reasserting the already-implemented technology’s potential, they render contradictory experiences invisible. “Imbuing a medical technology with potential requires broadening and deepening the technology’s ability to act in the world, often in a way that is *both underspecified and grand*” (Timmermans and Buchbinder 2013, S34, emphasis added).

distinction between the efficacy of screening and the efficacy of intervention.<sup>120</sup> While interventions have shown benefit for patients with depression, the benefit of screening is more complicated. This is due to differences between patients actively seeking care for depression and those identified through screening and because screening may become unlinked from treatment given barriers to care or clinical incapacity to respond. Payment structures and limited organizational resources hinder implementation of coordinated care for patients who screen positive (Price-Haywood et al. 2016). The current recommendation states that “screening [should] be implemented with adequate systems in place,” including the staff and infrastructure to ensure diagnosis and treatment (USPSTF 2016).<sup>121</sup>

The presenting clinic’s medical director observed that depression, substance use and IPV screening represents, “Information that we don’t know, or we do know but aren’t documenting in a way that can be captured.” This comment emphasized the importance of structured data entry for the reliability of metrics derived from the EHR. Much time, then, was devoted to discussing the data entry process. The nurse manager from the pilot clinic reported that, after revising the paper form to match the format of data entry in the EHR, they did time studies and determined that it took 30 seconds for an MA to enter the data.

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<sup>120</sup> Universal screening for depression is considered a highly cost-effective intervention in light of lost productivity and high healthcare costs related to depression (Jiao et al. 2017). The USPSTF, which reviews and makes recommendations regarding evidence-based screening practices, currently recommends screening adults for depression and unhealthy alcohol use (USPSTF 2016, 2018b). They also recommend screening women of reproductive age for intimate partner violence (USPSTF 2018a). In all three cases, the USPSTF recommendations are based on existing research. The task force cites the adequacy of current screening tools for identifying patients and the adequacy of certain interventions that *could* follow upon identification. However, they acknowledge insufficient evidence for a direct effect of screening on morbidity and mortality. The effect is mediated by access to effective treatments. There have been no studies of the potential harms of screening independent of intervention. Interestingly, the Canadian counterpart to the USPSTF does not recommend universal screening for depression in primary care, citing opportunity costs (Mojtabai 2017).

<sup>121</sup> A 2009 systematic review of the evidence conducted on behalf of the USPSTF did not support screening when the responding clinician could provide feedback to the patient about their answers but not offer programs to support follow-up care (O’Connor et al 2009). While primary care may be a point of identification and access to mental health care, studies have found that time limitations and gaps in the “treatment cascade” often limit the realization of effective depression care (Baik et al. 2005; Pence, O’Donnell, and Gaynes 2012).

This comment seemed aimed at preempting questions about the impact of this initiative on clinic flow. The clinic had administered the form to nearly 500 patients in six weeks. The medical director admitted that they had been concerned about their capacity to care for patients identified as suffering by the screener. He reassured his fellow managers that the number who did screen positive in their pilot study roughly followed prior epidemiological estimates.<sup>122</sup>

As the presentation wound down, a lead administrator for the network reminded clinic managers that 1.4 million dollars were at stake. This money, she promised, would “[keep] us from making hard budget decisions.” The behavioral health administrator repeated: “We need your help, so please step up. We need those numbers.”<sup>123</sup>

#### Fieldnote, Population Health Standardization and Metric Validation Meeting

*Standing next to a projector screen, a behavioral health clinician-administrator outlines how the data from the screening tools should be entered in the electronic record and how to document if a patient declines so that they are removed from the metric denominator. She reminds everyone of the money at stake. As a network, they need to screen ~1,400 more patients to meet the metric goal, which means adding 350 per month to their numerator.*

*A manager from one of the clinics asks a question. She says they really want to do this and feel like they can administer the screening, but they feel limited in their capacity to get the data entered in real time. However, they have volunteers. She asks if it is possible to develop a way to add the data in batches later. The administrator responds that there is a way to do this with the initial screener*

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<sup>122</sup> By epidemiological estimates, I refer to the “20%” of patients frequently referenced in discussions that I observed about BHVS. I was not able to determine of the source of this particular estimate. In individual studies, the rate of positive screens varies widely by population and setting (Yano et al. 2012; Schaeffer and Jolles 2019; Ali et al. 2006).

<sup>123</sup> “Hard budget decisions” is the counterpart to the “infusion of infrastructure.” Both are vague expressions of potential – positive or negative – used to reinforce claims about this intervention. As discussed in chapters 5 and 7, potentiality is a powerful temporal concept in healthcare and permeates organizational narratives as well as medical ones (c.f. K.-S. Taussig et al 2013).

*(PHQ-2), but the challenge to batching data entry is that, if someone screens positive, a PHQ-9 needs to happen the same day. (The PHQ-9, a more in-depth screening questionnaire for depression, serves as same-day follow-up for a positive 2-question screen, which is also part of the depression screening metric).*

*In the discussion that follows, a behavioral health clinician asks about skipping the PHQ-2 and just giving people the PHQ-9. She also expresses concern about capacity to care for folks who screen positive.*

*The administrator says that she hears her concern about the “20%” [that may screen positive]. However, she explains that since they are looking at the “health of the population,” they expect many people to screen negative, in which case the PHQ-9 is extra. She does not comment on the capacity issue.*

*One of the behavioral health staff asks a manager from the clinic that piloted the new form about their experience. They emphasize entering the data in real time and repeat that they determined that it takes 30 seconds. Another doctor adds that “from a provider perspective,” it’s nice to have the answers already in the note. Someone counters that clinically, the provider would still see the paper form. The question does not get resolved.*

In this interaction, multiple temporal frames run up against each other: the reporting deadline, the associated future promise of infrastructure or its absence, and present clinic understaffing. The discussion also implicitly evokes competing potentials, in the sense described by Karen-Sue Taussig and colleagues (2013) as both possibility (recognizing suffering, better care infrastructure) and threat (overwhelming clinic capacity). The insistence that “it takes 30 seconds,” invoked a rigid and universal time in the form of an average. It did not address the way that data entry and patient care concerns varied across clinical contexts. The persistent focus on the screening form as a means to collect population health data distanced it from its use in clinical care and deferred concerns about what comes after screening. Yet, the importance of screening for individual care was central to the moral claims made about the need to screen. Financial concerns tied to the future ability to care for a population of patients at risk existed in tension with the anticipated

temporal consequences of the urgent demand that knowledge of a particular patient's suffering would make upon clinicians already struggling to keep up.

The effort to roll out the BHVS form came within weeks of the implementation of a questionnaire about patient sexual orientation and gender identity (SOGI), also distributed in the front of the clinic by clerical staff. The SOGI data entry in the clinic I observed during this period was done in batches by the clerical staff during downtime. Both interventions raised questions about the infrastructure for an appropriate response to the data collected. The timing of implementation was tied to financial incentives and both were presented with an urgency that generated a sense of catching up to a deadline rather than moving forward intentionally. Indeed, in a later management meeting, a quality improvement expert for the network acknowledged that several clinic managers wanted to hear about the depression screening initiative earlier. She explained that the central team, responding to a multitude of tracking requirements, had been trying to balance shielding the clinics from too many things at once and had erred on the side of not giving enough warning (c.f. chapter 5).

Staff and providers at one clinic I observed tested the BHVS form with a couple of PCP-MA teamlets before rolling it out to the full clinic. Prior to the full roll-out, members of the clinic network's central management team and a behavioral health clinician from another clinic joined the clinic's monthly staff meeting. In the conversation that ensued, managers and clinic staff alike seemed to feel that refusal was not an option. However, they set about negotiating the speed and structure of implementation:

*Dr. Avery, behavioral health clinician from another clinic comes to give a presentation at the clinic staff meeting. In explaining the workflow that was developed at the pilot site for this questionnaire, he says that the front desk was felt to be in the best position to identify patients who were due for the screening.*

*Those who have not had it in the preceding 10 months should be screened. The central office recommends using a particular page of the EHR to keep track of these forms, based again on the pilot. This does not fit with this clinic's usual protocol for forms, and a brief debate breaks out.*

*Dr. Young, a clinician-administrator, interjects to say that "the central [administrative] team" knows that this is important for patients. They also know that it "feels like more work" and will work on streamlining it...*

*Alexa, who works at the front desk, raises her hand and says that she feels like this "will take priority over [managing clinic] flow" because "patients have a lot of questions" and they've been getting push back about other forms. The medical director, Dr. Newton, acknowledges her concern and that there's been "a huge increase in forms in the past 4 months." Part of the challenge, Dr. Newton says, is that "when you start out, everyone is due."*

*Dr. Newton also acknowledges that providers are going to have questions about what to do with the positives. She explains that Dr. Avery will be at the next provider meeting to discuss that, suggesting that providers hold on to those questions for now.<sup>124</sup>*

*Somewhere in the midst of this discussion, Dr. Murphy asks to borrow my pen. A medical assistant asks what to do in terms of data entry when a patient declines the screener. Then, Dr. Murphy raises his hand, and when acknowledged by Dr. Avery, begins, "A number of concerns." He consults notes scribbled in the upper-right corner of his handout.*

*Dr. Murphy observes that "the flow" [of clinic and of forms] is already hard. (Occasionally a provider would find out about an important issue from a questionnaire at the very end of a visit or even after the patient had left the clinic.) The completion of the BHVS form and communication about it will also complicate flow. It is great to identify these patients, he acknowledges, but he is "concerned" about behavioral health.<sup>125</sup> He feels that it is already hard to connect patients to behavioral health during clinic because the behavioral health clinicians' schedules are often full far in advance and this will increase the burden*

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<sup>124</sup> I was unable to attend this subsequent meeting. I can only speak to the discussion of the screener with the full staff. It is notable even in this discussion that the question of what to do with the positives was considered a matter of concern specific to providers and separable from the logistics of screening.

<sup>125</sup> Each of the clinics had one to two behavioral health clinicians located in the clinic, to whom they could refer patients for short-term therapy. Ideally, providers could conduct "warm handoffs," in which a therapist meets with a patient briefly during the same visit to the clinic in which a need is identified. Here, Dr. Murphy is explaining that this is challenging to realize in practice.

*on them. If those clinicians are unavailable, it will fall to the providers, as some urgent issues will need to be addressed in the same day. "All that together," he says, "it's going to be a challenge." Dr. Murphy's tone suggests that he objects, but he does not explicitly challenge the initiative, which seems inevitable.*

*Dr. Avery describes implementation at his clinic, where they rolled BHVS out in stages, starting with a couple patients per provider per session, increasing up to all patients over the course of a few weeks.*

*Dr. Young chimes in, anticipating MAs' concern about this adding work. She says that another clinic "did time studies" and that once they optimized the format of the form, it took 45 seconds to enter the data in the chart. She says that they've found that "reassuring." Still, this is separate, she says with a nod towards Dr. Murphy, from "the positives..."*

*Dr. Newton, who has been testing this form out with a couple of teamlets in the clinic, reiterates that these are "real concerns [that] we will need to address." Her plan is to start with two patients per provider per session. She does not specify how quickly this will be scaled up.*

*Responding to concerns about screening patients when they may not have the capacity to care for those identified as suffering, Dr. Young informs the staff that the network is in the process of hiring someone who will work on "availability and access" and "flow" for behavioral health. She says that, in fact, the network is "more resourced than many community clinics" when it comes to behavioral health support. "That said," she continues, there is still a shortage of services. Dr. Young frames this initiative as one step, making a "registry" that would allow for outreach and other forms of support apart from the care of a primary care provider or behavioral health clinician. "The first step is screening" to assess demand.*

The questions that Alexa and Dr. Murphy raised were based in part on recent experiences with other forms that collected patients' personal information in an effort to both tailor their individual care and collect population-level data. I kept thinking that people had told me of a previous, similar effort to screen for depression where there had not been attention to follow-up. In this instance, "follow-up" was institutionally defined and tracked, though one of the ways to do so was with further screening. The prior experience with

depression screening was not discussed in the exchanges I witnessed regarding BHVS. A future-oriented temporality of care and improvement, combined with the urgency of meeting the reporting timeline, foreclosed the possibility of challenging the project itself. This foreclosure stemmed, I argue, from two sources: The power structure of the health network, backed by the weight of incentives and, importantly, the ethical importance of identifying patients who may be experiencing depression. Who would say that they cannot or do not want to know if patients are suffering?

Staff and providers cared about aiding patients with depression, some but questioned the logistics as well as the relationship between screening and care.<sup>126</sup> In the conversation above, it is both acknowledged and dismissed that there may be a gap between the ethics of individual care and population-oriented screening. Given the risk of derailing clinic flow or causing harm by asking patients about their mental health without the capacity to offer an adequate response, I wondered why the screening was needed to estimate need. If the demand for care is already estimated (20%), why did it need to be assessed again *before* systems could be built up to meet at least that many patients' needs in a timely way? Ultimately, it was because depression *screening* was the incentive-backed "quality" measure. As I introduced earlier in this chapter, the equation of *screening*, *diagnosis* and *care* for depression is central to current recommendations and debates about universal screening. Dr. Young's allusion to a registry tenuously connects the collection of

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<sup>126</sup> This debate could be thought of in terms of role boundaries. Alexa attempted to define her role as checking patients in and managing clinic flow. She felt like she was being asked to focus on forms instead. While Dr. Newton acknowledged her concern, there was no easy answer. Dr. Murphy raised the threat of discovering a need for services that exceeds capacity. When this happens, his ability to rely on support from behavioral health and the role distinction between PCP and behavioral health clinician would be blurred by the urgency of patients' needs. I found boundary-making inadequate as an analytic in part because what stands out in these exchanges is the apparent inability of staff and managers to meaningfully challenge the imperative to implement this screening at this moment in time.



data from particular patients in the present to a possibility of better care in the future. Still, the debate brought out conflicting ideas about the ethical implications of identification and the temporal demand that knowledge of suffering makes on the person who asked.

The delay between screening and response may be acceptable at a population level, where this information is used for planning. A similar delay may not be okay in the clinic, at the moment in which the questions are asked. As Dr. Murphy's comments in the meeting implicitly suggested, disclosure sometimes necessitates responding with urgency to ensure the safety of patients experiencing violence or considering self-harm. In a conversation independent of this particular initiative, one provider mentioned intimate partner violence in how he thinks about triage and time allocation in the clinic:

*If a patient presents with domestic violence, they're gonna get as much time as they need unless somebody else doesn't have a pulse... I'm not being facetious. Unless you're doing CPR, domestic violence is more important than anything else because domestic violence is going to kill that patient. Whereas, diabetes, hypertension – unless you're in shock – that person [experiencing IPV] gets what they need, right? Even if that means that everybody else waits or my colleagues have to see the patients or patients don't get seen and have to get rescheduled, whatever. Doesn't matter.*

This stark expression of the urgent threat posed by intimate partner violence reinforces the importance of screening. It also makes clear the effects that a disclosure during screening may have on the rest of the clinic. Even in less acutely urgent scenarios, responding to the disclosures solicited by the BHVS form takes time. Given that providers are “always-already-late” (Fleming 2015; c.f. chapter 2), that possibility is cause for anxiety.<sup>127</sup> This tension is

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<sup>127</sup> These concerns are common. While researchers emphasize patients' desire for empathic listening and counseling (e.g. Keller et al. 2016), another study found that some primary care providers fear opening “Pandora's Box” by discussing depression in primary care because it could “set them irrecoverably behind in their clinic schedules” (Keeley et al. 2014, 1).

bracketed in the abstract discussions of screening as population health assessment, where the focus is on the time it takes to administer the questionnaire and log the data.

One day, before this screening initiative had been introduced, a medical assistant told me that that morning, the provider had to break difficult news to three different patients, including a diagnosis of cancer to a patient who was a health professional. Her comment to me was unprompted but she thought I might be interested. Then she added, “You’re just looking at workflows, so maybe it’s not relevant...” I told her that actually it was and that I imagine that time feels very different in that kind of appointment. She said that at least one of those appointments lasted 40 minutes or so. Thankfully, two of them were towards the end of the clinic, so they were able to take time because no one was waiting.

It is interesting that this medical assistant separated breaking bad news from her idea of workflows. In Laura Bear’s (2014) study of shipping pilots subject to intensifying temporal demands, she observes that accidents are informative because they prompt explicit reflection. Yet, they are a regular occurrence. Similarly, despite the prevalence of trauma amongst their patients and the fact that that breaking bad news is a regular part of clinical work, emotional encounters in which the aim of staying on schedule is suspended were often rhetorically placed outside the norm, like an accident. “What to do with the positives” was repeatedly placed outside the scope of discussion about the imperative to screen the patient population for depression.

Clinicians I spoke with were already well aware that many of their patients were suffering in ways they remained largely ignorant of. They may or may not screen positive for depression, but many patients wished to talk to their providers about their life experiences

in ways that the clinic schedule did not allow. When I asked one provider what she would do with “enough time” with patients, she explained:

*PCP: ... There [are] many things that we end up brushing over because we don't have time to do it.... And so, I think what we could do with more time would be... we would maybe be able to explore some of those things that are not as urgent-feeling. I think the other thing that we see a lot in our patient population is a lot of downstream effects of chronic trauma and most of us don't really get into that piece about their trauma history because we know that it's going to take more than – Well, you don't even have 20 minutes to talk about something like that, 'cause you're doing a Pap and you're talking about their knee pain and you're going over their lab results...*

Later, I asked her about how she balances the needs of more talkative patients with others on her schedule, she returned to patients going through something difficult.

*... I feel like I'm always cutting patients short on... what they actually want to tell me. Which doesn't always feel great... And there are times where I'll just sit and listen to patients and I know that it's going to blow my schedule. And it's going to blow the schedule of everyone around me... But, yeah, so, I feel like I'm constantly cutting people off or handing them off to someone else to listen to them. So, [I say] “Okay, that sounds really hard. Let me go get my counselor and then they can sit in here and talk to you.” And that's one of the things that we've – our team-based care does. But, often – sometimes – they're like, “Oh, no, no, no. I'm fine.” And then the patient will just stop and then they actually won't share anymore. So that opportunity has then passed.*

This provider's reflection articulates an awareness of the burden of trauma in the community and her inability to listen in the way that such experiences merit. She does let some conversations “blow her schedule,” particularly when patients disclose profoundly traumatic experiences. To some degree, cutting patients off feels necessary even as it is alienating. She also suggests that even when a behavioral health clinician is available,

suggesting that patients speak with them instead of with her can sometimes make patients withdraw.

It was not only histories of trauma but current stressors that manifested in patients seeking care.<sup>128</sup> In the midst of telling me about the patterns she saw among patients dropping in, one nurse told me:

*RN: You see more people dropping in, more urgent issues, honestly, when people are – maybe their funds are running low, like towards the end of the month, mid-month, you know... They'll have issues but then it's compounded by, you know, the stress of finances and makes people feel worse... I think it's exacerbating their conditions. Or, just, like, not even financial [stress] but I think just environmental. You know, [this neighborhood], especially for our patients of color, it's a very stressful place to live if... you're in an underserved population. And we had someone that came in, she wanted to see the nurse, but she didn't want to talk to me about it, but she was, you know... feeling mentally stressed and started crying. And then... I found out from a social worker [that] it was because she had no money to pay her rent.*

*S: Oh wow, okay.*

*RN: She dropped in for that, you know. To be triaged for that.*

*S: Hm. How do you feel like – I mean, do you feel like the clinic has the resources to support the patient population that you serve?*

*RN: Um... not really, to be honest... because, like I said, a lot of our patients have so much mental stress and mental health issues that they're dealing with that... a lot of times when you get down to it, I have people who... [you'll] see them for blood pressure but when you talk to them, they can't focus on their blood pressure because they're homeless and they have no money and, you know, they may be in an abusive relationship, and so, like, it's hard for them to focus on their health when they have all these other issues.*

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<sup>128</sup> These narratives of trauma and current stressors are interlinked as they both stem from the structural vulnerability of this patient population (c.f. Philippe Bourgois et al. 2017). In a recent study of trauma discourse in complex care management, Ariana Thompson-Lastad and her colleagues (2017) argue that “trauma” is a clinically legible way of discussing structural violence.

*And I think that's been a struggle for the clinic, to try to – or just in general healthcare – to try to meet those needs for people and not think of them as two separate things. But yeah, I think that's a struggle in general for public health. Getting the resources. I mean, I think we do have a lot more resources than maybe some other [counties] but it's a struggle.*

Research has shown that clinicians' perceived ability to address patients' social needs is linked to burnout and its prevention (Olayiwola et al. 2018). This nurse articulates an integral relationship between her patients' social, mental and physical wellbeing. Her solution is not to narrow her focus to the physical but her ability to support her patients is limited by the clinic's scope and resources.

At odds with the ethical imperative to screen patients for depression was the potential that this screening would reveal an overwhelming need *before* the hypothetical "infusion of infrastructure." The content and timing of this infusion were unclear, but implicitly about providing mental health services for patients and relieving strain on clinics. The experience of patients who would screen positive was bracketed by use of phrases like "the 20%" and "the positives."<sup>129</sup> Meanwhile, the identification of suffering itself demands a response in the individual encounter. Then, the need for a response from the PCP might, as Dr. Murphy worried, delay or preclude other forms of care during that clinic.

This is another example of the shepherd's paradox (Foucault 2007). The clinic is charged with attending to individual patients, the collective of patients present that day, and the population. As incentives are tied to the future ability to provide clinical care, this population also includes future potential patients who might benefit from the infrastructure

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<sup>129</sup> Carr (2009) and Geissler (2013) describe the importance of language, and sometimes strange linguistic conventions, in resolving ethical contradictions that continue to exist in practice.

financed by the metric-based payment. While quality care for each individual patient entails identifying and responding to their full range of concerns and suffering, including mental health, doing so potentially exceeds the time available in the provider's schedule and the support resources they can offer. This threatens to compromise care for others. Underlying this conversation was an uncomfortable and unspoken suggestion that it may be necessary to remain ignorant of some suffering in order to keep providing care within the current structure of services. This public secret ran through each of the conversations I witnessed about this screening initiative.<sup>130</sup>

The central management, themselves constrained by the incentive system and committed to the health of the patient population, variously and sometimes simultaneously acknowledged, downplayed and sidestepped these concerns. Dr. Young's comment that it "feels like more work" throws into question the validity of staff contestation by rendering the observation that it *is* more work as subjective. The "reassuring" observation that entering this data only takes 30 or 45 seconds answers other anticipated concerns but does not address those that were raised.

Implicitly at stake in the discussions surrounding BHVS were the relationship between population and individual risk and care and the potential harm in posing the questions without adequate response. Providers' comments anticipated that the urgency of caring for patients with mental health concerns, while profoundly important, would require

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<sup>130</sup> Michael Taussig defines a "public secret" as "That which is generally known but cannot be spoken" (1999, 50). Part of social life, he observes, is "knowing what not to know" (6). In an analysis of knowledge production in global health, which relies on the erasure of forms of difference and inequality fundamental to transnational research, Geissler (2013) draws on Taussig's concept to describe "unknowing" as an active process rather than a matter of ignorance. He suggests that unknowing can be intended as peace-keeping or as face-saving. It is reinforced by the apparent futility of addressing the widely known "secret" problems. Unknowing is a matter of feasibility. The effects of unknowing can be ambivalent, but Geissler primarily worries that it forecloses or depletes the ethical impulse to address the problems that one has to not see.

them to potentially abandon or delay care for other patients on their schedule. However, the ethical importance attached to screening deferred reckoning with this tradeoff.

In the implementation of this screening tool, a set of decisions that speaks to much more becomes mostly a debate about a few particular aspects of time: the timeline for reporting to get the funding, the time it takes to enter the data, and whether or not providers have time at the right time to care for the patients who screen positive.<sup>131</sup> Running through this debate are also the unspoken temporalities of fatigue and anxiety on the part of clinic staff in the face of patients' chronic exposures to trauma or the acute threat of violence. This case study highlights a preoccupation with time in the form of the timeline and process measurement alongside an avoidance of reckoning with the limits and contradictions of care time across temporal horizons and for individual, collective, and population. These remain public secrets and must be navigated in practice.

### **“The one more thing”**

In addition to the ethical questions raised about screening, the implementation of this questionnaire itself also posed practical concerns for clinic staff. As Alexa's comments in the meeting above suggest, these arose from the context of other recent changes and were felt to conflict with other parts of staff roles. After the meeting about BHVS data entry, I spoke with Ariana, a manager. At the time, her clinic was short-staffed by several MAs. Despite understanding others' concerns about ensuring follow-up in the same day through real-time data entry, she expressed that this was problematic for a staff already stretched

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<sup>131</sup> There were other meetings about this initiative that I did not participate in where some of these concerns may have been more explicitly discussed. Still, the public secret of the tensions inherent in screening under time pressure was visible here and speaks to more than this particular initiative.

thin. Even though they say it takes 30 seconds, “and to me, that’s not a lot of time,” Ariana explained to me, it is one more thing to do. “It’s not the 30 seconds,” she repeated, “it’s the one more thing.” The *one more thing* here referenced the sense that medical assistants were being asked to do too much, even if the additional time required for each task was small.

In an article entitled: *It’s exhausting to create an event out of nothing: Slow Violence and the Manipulation of Time*,” Chloe Ahmann (2018, 155) defines incrementality as “a gradual buildup that sometimes coalesces into something (an event, a reform, disease).”<sup>132</sup> Incrementality as a model of time can enable slow and steady progress toward a desired outcome. It can also, in being piecemeal, bring about dramatic changes while disarming recognition or protest. In this section, I draw on Ahmann to think about the accrual of initiatives and tasks over time. I am particularly interested in the ways in which context is bracketed to enable this slow intensification of work. The accrual of each new task fails to register as a significant event or problem as it is quickly renormalized following moments of demoralization or resistance. This case provides an illustration of the ways that incrementality comes about in the context of primary care amidst contradictory ethical imperatives and out-of-sync investments.

I heard another manager wonder aloud how they were going to get their clinic’s medical assistants, who were collectively protective of their time and role boundaries, to administer this survey. The manager appealed to their job description, saying “medical assistants administer screening tests.” This response to anticipated resistance and the “30

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<sup>132</sup> Ahmann (2018) studies the tactical uses of incrementality and temporal punctuation by activists fighting the slow, uneventful violence of pollution. I do not think that the temporal structuring of implementation here is as intentional, yet it bears a resemblance.



seconds” response are examples of how invoking and bracketing time’s limits can function to silence concerns about incremental demands. 30 seconds is based in clock time, regardless of context. That time being deemed a small amount precludes any contestation about the nature, value or consequences of the task that takes 30 seconds. “Medical assistants administer screening tests,” brackets the question of whether MAs have time or feel they have time altogether. Both logics can enable roles to expand incrementally until or beyond the point that staff feel overwhelmed.

Medical assistants and clerical staff in the primary care clinics that I studied have experienced an expansion of their responsibilities over the past several years (c.f. chapter 4). It sounded sometimes like a slow, if fundamental, shift. Other times, like this one, new initiatives seemed to stack up quickly. Both the SOGI and BHVS data collection initiatives aimed to collect important information in hopes of better serving patients. Both were also implemented quickly, out of sync with the organizational infrastructure to support an ideal response. In the debates and discussions that surrounded this push to increase (documented) depression screening, the basis of competing claims shifted between present and future, measured time per task (30 seconds), capacity and expertise or job description. These claims often seemed to speak past each other.

As described in chapter 4, when teamwork is defined in a way that is organized around shifting administrative work away from providers and administrative work increases, nursing and clerical staff workloads become a space expected to accommodate some of the excess. Understanding this context helps to make sense of how “one more thing” that “takes 30 seconds” can be experienced as too much. The BHVS implementation did not occur in isolation from other initiatives. The following field note is from a meeting where clinic staff

were presented with the results of a survey about staff experience. The survey included measures of burnout along with a number of other domains such as “team culture.”

*The staff are crowded into the clinic conference room, facing a screen where a presenter, Erin, shares slides related to their survey results. Among other questions, she presents the mean scores for the exhaustion, cynicism and team culture domains – all averages of a few questions on the survey.<sup>133</sup>*

*All these measures are worse this year. There are fairly dramatic increases in cynicism and exhaustion for both primary care providers and nursing staff, suggesting that some are experiencing burnout.<sup>134</sup>*

*Erin ends her presentation by saying that, “We know clinics are works in progress,” and so she wants to acknowledge that this clinic has historically been known for its team culture (despite the drop this year).*

*We number off and break up into 6 groups. I tack myself onto a group that includes people in a range of roles, including a provider, nurse, medical assistant and clerk. It is facilitated by Erin.*

*Early on in the discussion, Erin asks whether they think the shift in scores this year is about turnover. The doctor in the group says yes, but also there were elements of a “hopelessness that makes it feel like it won’t get better.” This comment expressed a sense that there are deeper and longer running issues at play, despite the fact that it is easy to pin it on turnover.*

In Erin’s presentation and the discussion that followed, several people tried to place the current feeling of demoralization in the clinic in broader historical context. There were several potential readings of the situation. One circumscribed the phenomenon as an aberration this year, perhaps due to worse-than-usual understaffing exacerbated by a long

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<sup>133</sup> The staff experience survey included questions from the Maslach Burnout Inventory, a well-established tool for assessing occupational burnout in service professions. It measures three domains: emotional exhaustion, depersonalization (often also called cynicism) and personal accomplishment or efficacy. High scores on the exhaustion and cynicism scales are considered indicative of burnout (Maslach and Jackson 1981). For an explanation of how “team culture,” or perceptions of the quality of work-related and social interactions among the clinical team is operationalized, see: Willard-Grace et al. 2014.

<sup>134</sup> In this version of the survey, front desk and behavioral health responses were combined to ensure anonymity, making it impossible to interpret trends for clerical staff.

hiring process and resulting lag between staff leaving and the hiring of their replacements.<sup>135</sup> Erin's comment on the clinic's reputation as a positive, team-oriented place seemed intended to encourage staff and reassert the possibility of returning to that state. However, another historicization of this moment, opened up by the discussion here, is that, without correction, they might be at the beginning of a trend. The group went on to discuss how shifts in the organization and expectations of clinical work over time might explain the current increase in turnover and burnout.

The doctor in the group observed that the call center had been scheduling patients in any open slot, including with people other than their PCP.<sup>136</sup> As a result, an open slot is "not a catch-up slot anymore. It's a you-have-a-new-hospital-discharge-patient-that-you've-never-met." This example implied an extremely complicated visit, the polar opposite of "catching up." While this PCP recognized the importance of access, the practice of scheduling patients into any open slot posed a problem both for the care of that patient – who would not be seen by someone who knows them – and for the tenability of the provider's schedule. Again, a moral good (follow-up after hospitalization) is linked to a fiscal imperative (cost-effectiveness and incentives) and made necessary for both reasons,

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<sup>135</sup> Subject to county policies for the hiring of public servants, the process for hiring new staff took several months. This bureaucratic time was out of sync with the needs of the clinics, leaving them understaffed each time someone quit or took a new position.

<sup>136</sup> The centralized call center was a welcome addition for members of staff who used to receive very high call volumes. Meanwhile, it also enforced a greater degree of standardization across clinics. The call center had its own goals. They focused on offering fast responses to patient requests, both literally in the duration of calls and by offering the closest available appointment. One of many priorities was to ensure a primary care visit within a certain amount of time after a patient was discharged from the hospital, in order to avoid patients being readmitted and ensure ongoing outpatient care. Post-hospital discharge follow-up was an actively tracked metric. At the clinic level, teams tried to balance maintaining continuity with the same provider and reaching out to patients soon through nurse visits or phone calls. The doctor in this exchange acknowledged that the call center practice of booking with someone other than the patients' PCP "probably improved access for some patients." Erin clarified what "improved" meant: they got seen faster. It seemed clear to everyone in this discussion that this was coming at a cost to clinic staff and possibly to care. This observation evokes the tension between wait times and continuity that I discuss in chapter 1 and the desire for protection from this type of "add-on" appointment (chapter 4).

regardless of capacity. The centralization of some appointment scheduling through the call center imposed a particular resolution to the conflict between priorities including access, continuity and timely clinic flow.

Next, the nurse in the group raised a more general pattern that seemed to resonate for others, as evidenced by nods and the animated discussion that followed. The nurse described a pattern of tasks continually being “added,” but only “1 in 1,000” being “taken out.” Conversation turned to this being most intense for the MAs – hence the spike in their scores. Erin asked the MA in the group for her thoughts and she responded, “Absolutely.” She felt like everyone, whatever her role, was doing more and then all of this fed back to the MAs “because we work with everybody.” The nurse agreed, restating that the “MAs are the role that more and more is added with nothing taken out” over the past eight years. The mention of eight years seemed significant, as it implicitly referenced the year that EHRs were implemented in this clinic, a step toward increasingly team-based care. The provider and nurse both acknowledged that because of their role, MAs were less able to speak up and protect themselves (c.f chapter 4).

Concern about MA burnout was not evenly distributed across the clinics I studied, members of each clinic or moments in time.<sup>137</sup> This conversation, though, highlights the experience of incrementally expanding demands for both primary care providers and MAs as coordinators and managers of clinic flow and healthcare maintenance. It suggests that as expectations for primary care expand, a process enabled by technology and enforced by

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<sup>137</sup> This is not to say that certain MAs at each clinic did not feel a similar intensification of their work combined with limited opportunities for job advancement. Each clinic had unique dynamics around the MA role, including how involved MAs were in decisions about process improvements and the strictness of role boundary maintenance.

regulation and financing, all members of clinic staff are feeling stretched thin. Turnover exacerbates this by leaving those who remain with more to do. It also depletes morale by interrupting relationships.

A major contributor to the concern about provider burnout is the expense associated with loss of revenue when physicians and nurse practitioners cut back clinical hours or leave practice, as well as the cost of recruiting replacements (Shanafelt, Goh, and Sinsky 2017). Within the market logic of healthcare, it is possible that the strain on support staff will be downplayed in the absence of a similarly strong business case for addressing it. This does not mean that individual colleagues, managers or network leadership are not concerned. Meanwhile, conversations like the ones I describe in this section raise concern about the personal costs of staff burnout, with or without a statistical association with turnover.<sup>138</sup> Clinics do not necessarily or directly lose revenue from staff shortages, but it is a major cause of fatigue and a barrier to meeting quality goals.

### **Integration and Incrementality**

Several months later, in an interview, Ariana reflected on the push to implement BHVS screening as a particularly difficult moment in her clinic's previous year. After telling me about their successes in quality improvement, she said:

*I think one area that we didn't do so well, that was a lot of work and I think that was like really overwhelming for people was with our Behavioral Health Vital Signs. Really important work, [but] it was very much about the numbers. And we*

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<sup>138</sup> A recent study examining the correlation between burnout and turnover in primary care clinics found that burnout was predictive of leaving the clinic for clinicians but not for staff (Willard-Grace et al. 2019). Meanwhile, both groups demonstrated high rates of both burnout and turnover. The authors suggest that the lack of correlation for staff may be attributable to factors like career growth and cost of living concerns leading staff who are not necessarily experiencing burnout to leave.

*were really short staffed at the time. I think – when it rolled out here specifically, it was just like the worst of our staffing. You know, we were like – we had 3 permanent staff left, medical assistants, out of 7. We had one float that wasn't here all the time. And we were trying to do it for – you know, roll out this whole new thing. So that felt – I felt really bad.*

*I didn't feel like I had a choice because it was – this is what we had to do. And I think we tried as much as we could to, like, ease it in as slow as possible. But still, it felt like it was another thing and I think that was really demoralizing for the staff. It was not – the timing was terrible. I think if I had a little bit more say or if I felt like I had more control over rolling that out, I would have wanted to wait, probably. Also, if we would have waited, we probably would have met the metric as a system. So, it's like – that was 2 million dollars, was it worth what we went through? It was a call we made and decided to go for it and tried to do it as slow as possible but start. And we met our goal. Exceeded our goal, actually.*

*S: You did meet your goal for Behavioral Health Vital Signs?*

*Ariana: We did. So, as a system and as a clinic. So, we were trying to make 44%. We got to 45.7 or something. Yeah, so we did really well. And toward the end of it, we were more fully staffed. It was way better, and people were, like, fine about it, but at the beginning you just feel, like, one more thing. It felt so big even though, you know, it's a survey. But I think it's just – it's less about the thing and more like the time when it happens, right? It's like, how does it feel? What else is going on? How well staffed are we? How supported do they feel?*

*S: Yeah, totally. Are you still doing it?*

*Ariana: Yes, so it'll become – the metric's going to change. So, it was more the depression screening, which is one of the questions on Vital Signs. Now it's going to switch to the actual [BHVS] form. So, some people may have gotten depression screening but not done the form yet. They haven't told us our new goal, but I think now it's fine. Like, it's kind of integrated already, we're way [better] staffed. We're going to have more providers. We're going to be okay. It's just – it just happened at the time it came out, for us to do it, it was just not ideal.*

Ariana's reflection highlights the contingency of temporal experience at the clinic level, in this case based on the severity of understaffing. She also emphasized that it was not the work of screening for mental health concerns that she questioned. The reason that this

initiative could have been refused in the moment was because it seemed that the *timing* of this initiative was explicitly about the metrics. The patient need would be equally present and urgent later when the clinic had greater capacity. Perhaps at this moment in time, her clinic could have waited while others met the metric for the network as a whole.

In Ariana's reflection on BHVS, her focus is less on patients and whether or not they may be experiencing unrecognized depression. Instead, she is focused on staff at a time of acute demoralization. If, as in the notion of patient- *versus* provider-centered care, staff and patients are seen as engaged in a zero-sum game, then critique of these demands appears to be a shift away from care for patients. I argue that what is at stake is a conflict of time frames and related scales from individual need to population screening. The data collection was based on particular patients in the present, but oriented to characterizing the population in order to secure resources for a population of patients – perhaps the same ones, maybe different – in the future. This gap is part of what allows Ariana to distinguish chasing the numbers from patient care despite ambiguities that equate them.

What also interests me in Ariana's comments is her characterization of the initiative a few months later. "At the beginning you just feel, like, one more thing... [but] it's kind of integrated already." Added tasks get absorbed and normalized over time. In this case, the clinic's staffing shortage had also eased. Further, normalization is partly a function of the rhythm of screening. As Dr. Newton observed earlier, "when you start out, everyone is due." After a critical mass of patients have been screened, the density of patients eligible for the annual screening during each clinic session does decrease. Still, the need to keep track of this screening task remains and becomes the baseline for the next initiative.

Incrementality is exemplified in the frequent addition of these arguably important tasks. Each task is small on its own, precluding their recognition as problematic, particularly when the “task” such as data entry is rhetorically separated from its other consequences.<sup>139</sup> Over time, the accrual of these tasks becomes exhausting.<sup>140</sup> Ariana referred to this as “another thing,” the addition of which was demoralizing for staff. The stress of implementation is always temporary but there is always something to implement.

The tone of moral and pragmatic urgency surrounding each intervention precludes reckoning with time in three forms: the accrual of tasks over time, the limits of clinic staff’s labor time and the opportunity costs involved in attending to one patient’s multiple conditions and to multiple patients at once. Questioning new tasks in the clinic is complicated by the fact that the labor of the clinic is to care for vulnerable patients and that many population-oriented practices are not separate from what is considered good patient care. In other words, ideally, patients *should* be asked about their mental health and have services provided to them. I did not meet anyone who disagreed with this ideal. Yet this aspiration cannot be separated from clinic capacity for screening and intervention.

The tensions and contradictions between metric and flow imperatives, combined with unstable staffing and changing requirements make for morally fraught negotiations. The temporality of incentives rather than preemptive investment operates on a logic that more can be done with less provided the right motivation (c.f. chapter 5). Combined with

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<sup>139</sup> Most of my discussion of the potential identification of additional and potentially urgent need has focused on patients and providers, but this also affects other staff. While medical assistants may only be formally responsible for entering the data, those data represent that one of their patients may be in distress and the provider’s choice to make a referral or stay and respond to the screening results affects their work as well.

<sup>140</sup> Østbye and colleagues, authors of the original study that Dr. Lee cited as proof of the impossible mandate of primary care (chapter 4), make this observation and call for guidelines to take into account the time required for their realization: “The guidelines may be reasonable when considered one by one, but they can be impossibly burdensome in aggregate” (Østbye et al. 2005, 213).



the ethical weight of the desire to identify and respond to patients' suffering, this makes new initiatives difficult or impossible to refuse. Meanwhile, the perception that the clinic and its staff do not have the capacity to respond without compromising care for others carries a moral weight of its own. The expanding number of screenings and interventions within the same structure of care intensify both the work and the unspoken contradictions of the shepherd's paradox.

## Chapter 7. Care Over Time

*PCP: I feel most fulfilled – it's the relational connection that's most fulfilling to me. Which is probably why people are crazy enough to go into primary care. It's also satisfying to diagnose stuff, or fix stuff, or to see people get better, but frankly, that can't be a primary motivation for an internist, because by and large, people don't get better. And everybody dies. [Said with a grin:] Mortality is 100%. So, you really have to be nuts if that was your primary motivation. So, for me, it's really the relational connection and continuity over time that's most satisfying.*

In my research, the benefits of being able to offer *care over time* often followed quickly on laments about time scarcity in the short term. After Dr. Lee told me that time was her enemy in primary care, she added that it was also a friend (c.f. chapter 4). Echoing this, another provider put it: “It’s a double-edged sword. A gift and a curse.” These idioms were attempts to capture different temporal registers – time as a scarce resource in the present and time’s extension into past and future as the foundation of fulfilling relationships, knowledge and care. In interviews, I would open with questions about what drew people to work in primary care and end on questions about fulfillment, burnout and the future they imagined for themselves in this line of work. The answers to these questions centered on interpersonal relationships and forces that protected and threatened them. These are the themes I explore in this chapter.

In previous chapters, I have alluded to burnout as central to contemporary anxieties about primary care as a field and something experienced by many members of clinic staff.<sup>141</sup> Meanwhile, a number of providers and staff refused the label of burnout. They

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<sup>141</sup> See the introduction for a discussion of the concern about primary care provider burnout, chapter 4 for an elaboration of staff burnout and chapter 6 for a description of how burnout is commonly measured. The reasons that people described feeling burned out were often related to excessive workloads and bureaucratic obstacles. These affected all members of clinic staff. People also often located their feeling of burnout in tense interactions or moments when they felt like they disappointed or failed a patient.

distinguished their fatigue or discouragement from burnout in part because they had not lost their ability to find joy in their work.<sup>142</sup> In this chapter, I seek to reconcile these two realities. I examine the relationships between temporality and trust in the clinic. I describe an ability to tack between scales and temporal registers to characterize the means by which I witnessed clinicians and staff maintaining a sense of potential for *care over time* amidst the constraints and contradictions in clinic time that I have described.

### **Remember?**

In the introduction, you met Caleb, the young boy who insisted on using Dr. Peterson's stethoscope. Caleb was the fourth patient we saw in clinic that afternoon. The visit before his was with a woman there for her first prenatal appointment. I mentioned that while we were with Caleb, another of Dr. Peterson's patients, Damien, was waiting. Damien had diabetes and chronic pain that was excruciating on that particular day. His visit was to follow up after he went to the hospital for an infection following a therapeutic joint injection for pain.

He told Dr. Peterson about being refused the pain medicine he felt he needed at the hospital. They discussed his tendency to develop painful infections after treatments and the fact that Dr. Peterson was concerned about both his pain and the risk of opioid dependency. They would work on reducing his pain medication next month, when the infection cleared. They talked about how they might need to do something about his diabetes soon, too, but it

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<sup>142</sup> Some argue that asking people to self-identify as burned out will hide some cases, as people are not always aware of changes in their own orientation to work, or they may not identify with the term (Knox et al. 2018). Further, burnout experience was intended to be understood as a spectrum, not a binary diagnosis that one does or does not have (Maslach and Jackson 1981). Adopting colloquial use of the term, I asked people *when* they felt burned out to identify what they saw as the cause of feelings of exhaustion or cynicism.

was a challenge to find an insulin dose that worked for him. Woven between updates and plans were reminiscences about past infections and hypoglycemic episodes.

“Remember?” each asked the other.

Damien was a patient of Dr. Peterson’s for nearly two decades. Trust in their ongoing relationship meant that there would be time to make things better, to figure out his insulin and pain management regimens. Patients like Damien, with multiple health concerns and frequent hospitalizations, were common in the safety-net clinics I studied, and so were histories of mistreatment by healthcare providers and the health system. These realities structured the profound sense of the (un)ethical surrounding clinical time scarcity in the safety net. Damien and Dr. Peterson’s question to each other, “Remember that?” referenced their long-term relationship and served to highlight Damien’s unique traits that each felt had to inform his care. We were only in the room with Damien for 15 minutes, but within that time, both Damien and Dr. Peterson drew on the past and anticipated future goals.

“Remember?” was one way of indexing long-term relationships. Continuity also manifested often in the form of a gentle nagging grounded in familiarity. Care over time enabled the observation of trends and a knowledge of each patient’s individual “baseline.”

*PCP: I think [building relationships] is probably what physicians like the best, and then – I mean, my sense is that's what patients like, but also probably what gives patients that primary care mortality benefit, right? [She laughs]*

*If somebody knows you and can kind of help you through the medical system, that's probably why you do better if you have a primary care [provider]... Like, you know, if it's my job to say, “Oh my god!” – if I can interpret your elevated liver enzymes in the context of your life and your history, and when you had it before and all that – that nobody else can do because it's all just a 15-minute visit wherever you go, [even to] a specialist, right? – you probably do a little bit better than if it's just “Oh, yeah, take some steroids for your elevated liver enzymes.”*

*S: Because you have more context.*

*PCP: And more time, right? That relationship over time.*

Continuity of care has been shown to improve care quality and value according to metrics like lower cost, reduced hospitalizations, and better health outcomes (Bazemore et al. 2018; Pereira Gray et al. 2018). Continuity is one of the classically defining features of primary care (Starfield, Shi, and Macinko 2005). Some argue that it has fundamental moral value, a “deep well” of benefits independent of its cost-effectiveness (Stange 2018). Provider reflections on continuity in the literature narrate the joys and complexities of long-term relationship, which sometimes serves as a reminder of one’s own fallibility as well as a source of fulfillment (Loxterkamp 1991). A sense that continuity is being lost to new arrangements of care premised on productivity has raised calls for a renewal of dedication to continuity as a source of both patient and provider wellbeing (Frey 2018; Hall 2016).

The time pressures of a given session can overtake the prioritization of continuity or be refused. In one visit I witnessed, Dr. Bennett worked to re-establish a relationship with a patient who had fallen out with his provider over a positive urine toxicology screen which the patient stated was a lie. The visit lasted half an hour. It was at the end of the session and extended into lunch. When we left the room, Dr. Bennett turned to me and said: “So, you saw that,” referring to her patient’s distrust. “You knew that was coming,” I said. Yes, she replied, but “you saw how it changed over the visit. That’s about the time. It’s all about the time.” In this commentary, Dr. Bennett asserted an important relationship between time in the present visit and continuity. She argued that short visits threatened the trust that was essential in building, maintaining or repairing long-term therapeutic relationship, especially with patients who felt judged and mistreated in healthcare and other institutional settings.

The trust and knowledge that underlie the benefits of continuity are not simply a product of interaction over time. They take work to cultivate and maintain in each encounter. This work makes demands of patients as well as providers. I witnessed one encounter in which a younger provider was taking over the care of a patient whose primary care provider of ten years had retired. After she acknowledged that she had fumbled a few things and that they were “still getting to know each other,” her patient reminded her that he and his old PCP had a system. “You’re trying to fill some big shoes,” he said. “In more ways than one,” the new PCP agreed. Later, the patient seemed to try to take the edge of their tense interaction. “We’re communicating now,” he said, “We all good?” He extended his hand for a handshake. In this delicate exchange, the patient had to walk a line of expressing his needs and frustration concisely while keeping the peace to ensure his own access to care in the future.

If this trust can be cultivated, then it opens up the possibility of care over time, which can relieve some of the strain imposed by short visits. Continuity of care in this particular sense is a feature of primary care that distinguishes it from hospital medicine. Dr. Silva explained it as a (relative) luxury of the clinic, in contrast to the luxury of concentrated resources and time in the hospital:

*Dr. Silva: I've learned... if they're complex, they're coming back to me... If they have a million complaints on the first visit, I'm going to try to listen to a lot of it, and then I explain to them, like, "We're kind of restrained, and I wish I could spend more time talking about all these things. I can't even fix a lot of these things on the first visit, so let's focus today on this and then I'm going to see you in like 2, 3 weeks." You know. I've learned, like, by doing that with certain patients, it helps us. And so, that's sort of something – the luxury that I have as a primary care provider that I don't have in the inpatient world, you know? Like, I feel like in the inpatient world, the patient was mine for three, four days. And I can think about them overnight, come back, and be like, "Oh, let's do this, this*

*and this." Because I thought about, maybe this is happening. Or we have all these people contributing to the one patient at the same time. Consultants putting [in] their notes, us reading their notes, and doing all these workups. So, that was a luxury in the hospital. But I always lost that opportunity in primary care – especially as a resident in primary care, because we were only in clinic very little. But now, as a full primary care provider, I have the luxury to say, "You're going to come see me in three weeks"... And so, if they come like I'm asking them to come, it's a luxury I have that will compensate – [She expresses something between a laugh and a sigh] – for the 15 minutes we get every time.*

The point here is not that the 15-minute appointment slot is adequate or made acceptable by the presence of continuity. As Dr. Bennett observed, short visits in the present threaten the trust upon which continuity is based. However, under conditions in which alternatives to the 15-minute slot seem remote, continuity becomes particularly valuable by offering the ability to address concerns over time. By extending the space of potential action, people sometimes make a way to offer care and find fulfillment.

Within the temporal frame of a clinic session, staff and providers negotiate their present and future obligations to individual patients and the rest of their panel. They tack between different temporal horizons to negotiate often contradictory imperatives. They might recommend a longer follow-up time when "access" to visits is tight or try to do as much as possible in a given visit to avoid rescheduling a patient (c.f. chapter 1). This intensifies the demands on time within the clinic session but is linked to the possibilities for care in the future. Clinicians weigh the clinical urgency of patient concerns and, in the interest of staying on time for others, negotiate with patients to deal with some things "next time." This is form of deferral, potentially experienced by patients as a refusal of care. At the same time, in the context of clinical tempos based on structurally-imposed time scarcity, I

understand commitment to relational continuity as an antidote to scarcity in the short term by shifting focus to longer relationships and the possibility of care over time.<sup>143</sup>

In addition to extending the space for action, continuity was often explained to me as efficient based on the knowledge it provided of patients' needs and behaviors. Dr. Silva's off-hand qualification in her reflection about patients coming back – "if they come" – always haunts the choice to defer things to next time. Long-term staff continuity directly affected the clinic session by enabling judgments about scheduling and flow. One provider told me that Chloe, the medical assistant with whom she had worked for many years, was very skilled at knowing which patients would likely attend their appointments or come back for a fasting lab test and which needed to get as much care as possible in the visit because they may not return. The doctor wavered on whether this skill of predicting patients' abilities to attend a clinic visit could be transferable or scalable. She wished someone could help Chloe figure out her own implicit logic such that others might learn from it. Yet, her comments insisted on the practical nature of this ability, embedded in Chloe's years of working with the same panel of patients. This practical skill could perpetuate stereotypes or make it difficult to overcome judgements of past behavior. This type of implicit knowledge spread across the team could also be a source of knowledge continuity as providers and staff came and left. This provider's wish that it could be scaled raises the question of how much the relationality that this knowledge is based on can be institutionalized.<sup>144</sup>

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<sup>143</sup> I emphasize *commitment* to continuity here as a counterpoint to what Petryna (2013) describes as the "impermanence of obligation" in fragmented health systems in which patients are dependent on research studies for access to treatment.

<sup>144</sup> Thanks to Melina Salvador for articulating this question.



Ava (RN) told me about the way in which she experienced continuity as time saving in the long run:

*Ava: The more familiar the patient is with you and you with them, you actually sometimes don't need that much time. You know, that's what I've found.*

*S: Why is that?*

*Ava: Um, I think because they're able, just comfortable, they're able to just tell me what they need straight out... I maybe know their personalities a little bit, so I can – Again, they can let me know, just – I don't know how to explain it. I just actually have felt like they're a little bit more aware, maybe, of my time and I am of theirs.*

For Ava, it is both her knowledge of the patients and their understanding of her working conditions that develop over time. She went on to give an example:

*Like, I have one guy who, he does call a lot... he has a lot more needs than some of the other patients, right? I used – to be honest – I used to call him and, like, dread it. Like, because I knew I'd be on the phone for like 30 minutes, 30, 40 minutes... Now, I've realized, when I call him, I call him at a certain time when I know, like, I have more time and, you know, he tells me what he needs. But I feel like he feels like he's being heard more, now. Because he knows me, he trusts [that] what he tells me, I'm gonna be able to get it done for him, relay it to the provider. So, he's not... he is not needing as much time as he used to. Yeah, I don't know how to explain it, but I feel like when patients have that continuity, like, with our teams, they know who they can check – they know who they can go to, or if there's an issue... he'll call me, I'll take care of it. I'll be like, "Hey, I'm gonna take care of it for you." Then, he's not on the phone like, "Are you sure it's gonna get done?" He's like, "Okay," and that's it. And I know the best times to call him.*

When I asked Ava when she felt most fulfilled in her work, part of her response was when she is able to make patients feel heard. Her observation that patients must learn who they can go to within the clinic through continuity with a *team* articulates a type of continuity different from the ideal of a one-to-one relationship between patient and provider.

Familiarity and trust established between patients and teams influenced the flow of a day and also MAs' or nurses' abilities to engage patients in self-care and preventive practices.

In addition to gaining trust that facilitated getting to the point, providers did not need to spend as much time reviewing charts on patients they knew. They critiqued the call center's practice of booking patients with providers other than their PCP. Clinic staff developed strategies aimed at ensuring continuity for patients making short-notice appointments, even though this could complicate clinic flow and lead to long waits in the waiting room (c.f. chapter 2). The relationship between continuity and other clinical times and tempos, though, could be quite complex and variable.

*S: Do you feel like having a longer-term relationship with patients changes the way you spend time with them?*

*Dr. Lam: Absolutely.*

*S: How so?*

*Dr. Lam: I think in a couple of different ways. I have some patients that, as I've gotten to know them, they are in and out. I have other patients that, as I've gotten to know them, [it] seems more like they want to update me on everything that's going on in their life in the last 3 months since last time I saw them. So, it probably balances out. I think that over time many of the patients reveal more as they get to know you and trust you. And so, while you think, okay, well after I get to know people, after like a year, it should be easier, but not always. I think a lot of times what I see is that they're feeling more comfortable and so they're actually telling you more about their health...*

The quality of relationships, which clinicians and patients care about immensely, is mediated by time and the temporal pace of engagements in the short and long term. Dr. Lam's observation raises a tension in the setting of a clinic visit between the efficacy of relationship – patients disclose more – and efficiency from the perspective of visit volume

and timeliness. The disclosures made as patients gain trust and feel more comfortable are ostensibly a good thing. Within the frame of the schedule, they are also potentially a liability (c.f. chapter 6). Dr. Lam makes a distinction between clinically useful information revealed as patients open up and “updating [her] on everything that’s going on in their life.” Variations on the latter figured in frequent refrains from providers as both fun and potentially running on too long, in which case it was useful to have a time limit.

Because of this contingency, schedule rearrangements and other strategies aimed at maintaining continuity and conserving appointments were not always enacted based on the pressures of a given clinic session. Consider the following two contrasting exchanges:

*Sarah, a nurse practitioner, has a patient added to her schedule. Looking at the added patients’ chart, she sees that she has a recent cancer diagnosis and saw her primary care provider, Dr. Wilson, less than a week ago. Dr. Wilson is in with another patient, so Sarah works on other tasks while we wait.*

*A medical assistant calls out to Sarah, pointing toward Dr. Wilson and saying, “Catch him before he runs away.”*

*Sarah crosses the room and waits until Dr. Wilson looks up from his computer, then explains that his patient is on her schedule. As soon as he hears the patient’s name, he says, “Put her on mine. Put her on mine... That’s insane. She shouldn’t be on your schedule. Put her on mine.”*

*On the way back to her desk, Sarah tells me, “We try to have the patient’s primary care provider see them. We try to take care of our own patients as much as possible.”*

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*Another day, I am shadowing Dr. Wilson. Dr. Peterson comes to his room and tells him, “A patient has been added to my schedule as last of the day that’s yours.”*

*Dr. Wilson asks who it is, then emphatically declines to see her. He explains: “If I go in there, I’ll be in there for two hours. If you go in there and it’s just a sore throat, you’ll be in there 10 minutes.” Dr. Peterson says that’s fine, she just wanted to check. “Sometimes I want to see my own patients,” she says, “sometimes I don’t.”*

*As Dr. Peterson leaves, Dr. Wilson says to me: "Saying no is good."*

In both of these moments, Dr. Wilson was asked to see one of his own patients unexpectedly, something that would disrupt the flow of his scheduled appointments or make his time in clinic run long. In the case where his patient was dealing with a new and serious diagnosis, Dr. Wilson insisted on seeing his patient and the effect of adding her to his schedule was not mentioned. Meanwhile, with another patient deemed time-consuming, he reframed non-continuity as a time saving mechanism, distinguishing the care needed for an acute problem (sore throat, which can be managed by anyone) from all the patients' chronic concerns. This implied that the clinical utility of the additional time this visit would take was not enough to prioritize continuity in the moment. Dr. Peterson normalized this type of strategy with her acknowledgement, "Sometimes I want to see my own patients, sometimes I don't."

This tension between the benefits and potential costs of continuity ran both ways and on multiple scales. A deep knowledge of patients and awareness of their needs can be the foundation of good patient care, fulfilling relationships and identity at work. At the same time that these relationships are essential, some feel their investment in these caring attachments requires moderation in the face of systemic insufficiency.<sup>145</sup>

*S: [Can] you tell me what first comes to mind when I ask you to describe your experience of time in practicing primary care?*

*Alice (PCP): Enjoyable. [She laughs softly]. Responsible. [She pauses, thinking]. Yeah.*

*S: Okay, can you tell me a little bit more about each of those words?*

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<sup>145</sup> For a critique of this idea and in-depth study of the concept of compassion fatigue, see: Austin et al 2013.

*Alice: Enjoyable means I like a lot of my patients, although there are some patients that I don't feel [are] always likeable. [She laughs]... So, working for those patients [is] enjoyable. And, responsible meaning that I carry my responsibilities 24 hours a day, 7 days a week, non-stop... Especially people who are very sick, then yeah, I kind of think about them, even at home. Kind of bring those to my home or even to my vacation.*

I asked her why she worked part-time. Alice told me: "Because it's a lot of work. A lot of work. And I – I mean, emotionally. Also – not just only time-wise. Emotionally, it's just a lot."

This is not only true for providers, but for all clinic staff. One medical assistant, Nathan, told me that:

*Having the kind of relationship with the patients that I have and that I have cultivated with them is probably bigger than the official role that I have [as an MA]. Because walking through the community and engaging with people and connecting with them is larger than what my responsibilities are. Right? And I'm doing that outside of them. Because this is a part of my personality.*

Later, when I asked him how things had changed over his career as a medical assistant, he told me:

*Nathan: [When] I first got here, I was really plugged in. As that process has gone along, I've gone through several stages where I unplugged for a minute, for a while.*

*S: Plugged in to...*

*Nathan: To... the narrative. Like, helping and being – and caring so much but getting disappointed. Over – And not – not only by the patients, but also by the system. So, then I decided to step away from it. Right? ...And when I stepped away from it, being unplugged, I was focusing on me. And now that I'm starting to feel more, um, more familiar with myself as an individual, I'm wanting to kinda go back into it with a different understanding.*

Nathan was frustrated by some of his patients' inability to change harmful patterns. However, he also articulated that the emotional toll of being invested in caring for patients over time was exacerbated by the recognition that "the system" was failing them.

As we talked about the time that she worked after clinic or by phone on the weekends, Ava (RN) mentioned that she "tried" not to work on her time off.

*S: This may seem like an obvious question, but I'm just curious, like, what makes you want to keep that boundary or minimize that...?*

*Ava: Uh, well, I had to do it because, like, I actually, um, I feel... a lot of responsibility – I guess – for patients. Like, because, you know, this is a big responsibility. You are... trying to help them take care of themselves. So, they depend on us to be these things, but, at the same time... I'm not really taking care of myself. I was getting, like, overwhelmed a lot. So, I'm just now kind of starting to put those boundaries in place. Like, um, especially on my, on the weekends. Yesterday, I left at 5 which I hadn't done in a long time. Um, so I just – I realized, like, in order for me to be able to help provide for them, I have to kinda also start taking care of myself and put boundaries in place and... let other people also help, you know, do what needs to be done.*

*S: Yeah, okay. What enabled you to go home yesterday at 5 that hadn't before?*

*Ava: Well, I realized that, like, nothing was life threatening that I had left to do [She laughs]... And I was caught up, I guess you could say... I only had 10 [messages] in my box. I'm like, if I have less than 15, I feel okay.*

The potential for burnout underlies Ava's efforts at self-care and Nathan's decision to "unplug for a minute." What is interesting to me is their framing of these choices. These common ways of talking about and resisting burnout are a form of engaging with risk and potential that does not overdetermine the outcome. Nothing is "life-threatening" and so Ava can afford to wait until tomorrow and rely on others for help. Nathan does not see "unplugging" as a threat to his care, but a necessary process to re-enter it. These coping strategies do not solve the underlying problems of clinical work; burnout will continue to be

a threat. For the moment, though, they each reinstated the potential to provide care under these conditions.

Despite – or perhaps because of – decades of usage in research and everyday language, the definition of burnout remains amorphous. It has recently become a matter of concern after reports that healthcare providers were experiencing burnout at alarmingly high rates, but tracing trends is vexed by the multiple definitions and measures of burnout (Knox et al. 2018).<sup>146</sup> In my research, some described burnout as a phase or feeling that comes and goes. For others, it is chronic. In some cases, it threatens to end a career. Because I worked with those who were (still) actively practicing, I do not address clinicians and staff who have left practice entirely. However, anticipation of burnout is part of why many providers worked part-time and some staff wished to.

One of the many reasons for anxieties about provider and staff burnout are its potential to disrupt continuity of care (Willard-Grace et al. 2019). Burnout threatens continuity while long-term relationships seems to be one of its primary antidotes. Given that continuity is associated with greater patient and provider satisfaction, care quality and cost effectiveness, some experts have proposed measuring and incentivizing continuity as part of value-based payment. Bazemore et al (2018) observe that primary care has more metrics than any other field in the Quality Payment Plan (part of Medicare) but most are disease-specific rather than centering on the defining features of primary care, including

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<sup>146</sup> One experienced provider told me that despite colleagues noting how happy she is at work, she worried about burnout because of these reports. She said: “I could still be burned out. Like I don’t even know! You don’t even know if you’re burned out. I’m like, ‘Am I burned out?’ I don’t even know. Everybody’s burned out! Am I burned out?” We were both laughing and she added: “I mean I trained at a time where, like, they never talked about it, right?”

continuity. Meanwhile, the best way to operationalize continuity for measurement and research is subject to debate.

In research and policy, continuity in primary care is often framed primarily in terms of a single patient-provider relationship.<sup>147</sup> This one-to-one relationship is highly valued in the clinics I studied in terms of having providers see their own patients. However, as I have illustrated, continuity is also forged and maintained by and across the care team. This begins at the front desk, where patients smile at being recognized by the clerical staff. It carries through to interactions with MAs and nurses, like Emily and Samuel in chapter 3. I use a broad definition of continuity here, inclusive of relationships with the team and with individual providers or staff over a long period of time, even when a patient sees others in between visits with their “primary.” In fact, teams enhanced this form of continuity through full-time staff coverage – as one MA put it, “I’m here more than the doctor” – and in transitions of care, such as when a new provider learned from the MA about the personalities and preferences of their patients.<sup>148</sup>

Another challenge to incentivizing continuity over the long term is that broader economic and political forces like gentrification and displacement and changes in health policy shape continuity in ways that are outside of the clinic’s control. One clinic I studied whose patient population had always had an African American majority had just noted that

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<sup>147</sup> Most insurance claims-derived measures are based on a mathematical approximation of how often one sees their assigned provider versus another clinician within a given time period or illness episode, often fairly short. Rodriguez et al (2008) argue that administrative claims data is more reliable than patient report in researching the relationships between continuity and other measures because there is a larger effect size with patient report. However, they also suggest that more information is needed about continuity within teams from a patient perspective, given that current metrics of continuity are based on a one-to-one relationship.

<sup>148</sup> Haggerty et al (2003) review the concept of continuity across mental health, nursing and primary care. They define three types of continuity including informational, management and relational continuity. All three can manifest in closely integrated teams.



this was no longer the case. Some patients had moved out of the area. Others who had obtained other insurance options through the Affordable Care Act had gone to other clinics. “Our new patients coming in are younger, healthier, usually between jobs... And so, it's a lot of churn. So, we gain and we lose [close to half of our patient population] each year,” their director told me. This was an unusually high rate of attrition and replacement. It posed a challenge for interpreting population health measures over time. Yet despite this clinic’s demographic change, I only saw a handful of these young, healthy, 20-something patients between jobs. The sense of continuity in the clinic was based on the care of families or the older patients with more conditions who come to the clinic more frequently. Most of these patients were African American.

Provided they could remain living in the area, some patients never left the safety-net clinics, or returned when they lost work that had given them access to the private system.

*S: Do you have a lot of patients that you've sort of lost and then gotten back or just lost because of insurance?*

*Dr. Huynh: You know, that's part of why I like it here. I mean, we – we probably take care of what they call, like, the “super poor.” Right? They almost never get off Medi-Cal. And so, no. I mean – no. There's some, right, they can maybe get a job. They might lose their job, or they get a job and then they [get insurance and leave]. Which is cool, right, like it's cool for them. But I would say that's not the majority of the patients I have.*

Dr. Huynh’s observation points to the instability of care continuity generated by an employment-based insurance system. A recent study found that loss of a “usual source of care” is less common for older adults with Medicaid than the general population (Nothelle

et al. 2018). In a perverse way, the economic precarity of Dr. Huynh's long-term patient population and their reliance on public insurance created a form of stability in their care.<sup>149</sup>

While incentivizing continuity comes to make sense within the logic of healthcare regulation, it is unclear what this would mean depending on how it is operationalized or understood in broader perspective. Continuity in primary care is often understood over a much longer term than existing metrics measure. In this analysis, I use continuity in a broader sense than current continuity metrics suppose, including continuity of information and access through teams and interrupted but enduring relationships (Starfield 1998; Haggerty et al. 2003).<sup>150</sup> In this usage, continuity is not only a principle but an experience central to the provision of primary care and the endurance of practitioners.

### **Still Here**

One day while I was sitting with an eligibility worker, Isabella, she recognized a young man at the front desk. "I remember you!" she exclaimed to the patient, who was there for an orientation clinic visit with a nurse. He had come to the same clinic as a child, and Isabella had been working there since then. She was able to register him with the same primary care provider that he had had as a kid. "Whoa, alright," he said, sounding surprised. After he took a seat in the waiting room, Isabella said to me, "It's so weird when you see babies and they're all grown up." It was remarkable that both the provider and Isabella had been working in the same clinic long enough to be there for his return.

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<sup>149</sup> In her ethnographic analysis of evidence production surrounding drug use during pregnancy, Kelly Knight (2015) observes that the accessibility of the poor enables certain kinds of practices, including anthropological research and intervention by clinics and non-profits. These practices become dependent on the poverty that they aim to address.

<sup>150</sup> Barbara Starfield (1998) argued that "longitudinality" was a better term than "continuity" for this paradigmatic feature of primary care because it would continue through interruptions.

This moment crystalized the promise of continuous commitment to patients that is an ideal of primary care in community clinics. It was also a reminder that economic and social circumstances keep many patients in or return them to the safety net. The structural vulnerability of the patients served by the clinics I studied raise the stakes of both an over-determined narrative of care's failure in this setting and an optimistic narrative of possibility (c.f. Ortner 2016). In this chapter I have described the complexity of the potential of continuity.

The idea of continuity as a moral good and source of fulfillment independent of its correlation with other measures was exemplified in comments like this:

*PCP: I think the thing that makes me feel the most fulfilled in my role is my relationship with my patients. It's not at all how my patients are doing with their health. Like, [it's] great if their blood pressure is controlled and diabetes is controlled, but that's not the part that makes me feel the most fulfilled. The part that makes me feel the most fulfilled is, like, my patient who is super debilitated by multiple problems gets it together to take a trip to Nigeria with her family and brings me a box of chocolates to thank me for helping her. Or, you know, my HIV patient that manages to take her HIV meds throughout her entire pregnancy, so she delivers an HIV-negative baby. ... It's literally the little things, the either relationship things or just the little successes that a patient achieves. It's not their metrics. It's not their control of their diabetes. It's not any of that. It's like the small, little successes. That are literally measured in one-on-one time with that patient.*

This provider's motivation was grounded in specific, personal accomplishments enabled by her relationships with patients over time. And, she also elsewhere insisted on the value of metrics and population health techniques for ensuring that she did not inadvertently neglect any of her patients amidst the pressing demands of clinic flow. Neither scale of care was fundamentally more important, but reckoning with risk and possibility meant moving between them.

Primary care is charged with prevention and chronic care management, both of which often require taking a long-term view in absence of an ending or cure. I asked some clinicians and staff to tell me about patients they had long-term relationships with and how that influenced their time together. Rather than conveying simple bonds and successes, they often gave examples that highlighted challenges and benefits together.

Dr. Lee told me about her relationship with a patient who has schizophrenia and uncontrolled diabetes, describing how sometimes therapeutic interaction entails letting go of medical notions of success:

*It has taken me many years, but I found that one of the most therapeutic things that we can do is to sit quietly together, and she likes to hold my hand. So, most visits, I try to make space to sit quietly, for a minute, and hold hands. [Laughing:] I did not learn that in medical school. But it seems to be therapeutic for her, and therapeutic for me. Rather than, I mean, I feel like I spent years just scrolling through her problem list and offering her one more test that she won't agree to, and even talking about her 3-pack-a-day smoking history, which I still try to talk to her about, but there is something in that relational connection that's a good thing and good to hold onto.*

This connection is not only therapeutic for the patient, but the patient's desire to hold hands in silence results in a sort of care for her provider. It is only after years of trying to offer one more test, and still trying to offer smoking cessation, that this minute of quiet connection has become a defining feature of their relationship.

Dr. Moore told me about a patient who had come in and out of her care for many years. Her choice of this story conveyed elements of continuity that continued despite interruptions:

*Dr. Moore: You know, what's coming to mind is... a patient who I think I've known since I started here. So, I think she was seven or eight [when I met her] and she*

*had a congenital heart disease and had had [multiple] surgeries... She was one of our other provider's patients first and then when that provider left, she became my [patient] – So, I visited her at [the university hospital] when she had [surgery] – you know, she was a kid. And then I saw her through her adolescence and then she didn't come in for a while. Um, and then she got pregnant and had a baby who is now my patient as well... She has unfortunately developed a chronic pain syndrome. And [she] had at different times gotten opiates and we've talked a lot about – I continued them for a little while and then we talked about other things... So, we've had a lot of different tries at things and then, you know, she definitely was convinced that really the only thing that helps her pain is opiates. And I was just saying, "You know, I'm just not comfortable managing [your pain with opiates]" – plus she has really severe heart failure... She manages her heart failure, I think, exceptionally well [now]. And she still asks for opiates every time I see her. And so, I – I guess [in terms of how we spend our time in clinic] I'm trying to get that out right up front. 'Cause otherwise it comes at the end. You know?*

*S: ...Do you feel like having such a long relationship with her has made your interaction around opiates easier or harder?*

*Dr. Moore: That's a good question because she left for a while. I think she got frustrated with me and went to [the university hospital], where many of her specialists are... So, she went for a couple of years and then came back. So, um. Yeah, I guess it influenced her in a way, you know. For whatever reason, she came back. 'Cause I feel like – They gave her what she wanted and then I continued it for a minute and then said, you know, "Again. I think we're like at the same place where this is going to be a chronic thing and I just don't – I'm not convinced this is what's – it's not like you got better – it's not like you were better. You were kinda the same. And now you just have this dangerous medicine now. So...*

*I mean, maybe easier in the sense that, I guess, bottom line is I'm going to be here for her. And so, she left and came back. And so, I guess she knows that at some level. And then – again, if she feels like she wants to try [another doctor], I don't feel badly about that. I feel like it's totally her prerogative and, you know, maybe someone's going to see something else I'm missing. I always [tell her other doctors], "Call me for anything," because I know ... it's a lot to kind of get through to figure out where she's coming from and all she's been through. So, I can be a resource for that, but they can manage, you know, [her] care...*

*But – so yeah, I think in a way easier. I don't feel like it's easy every single time. It's not easy to say no. Honestly.*

The fact that opioid medications figured in this story was not unique. Several providers mentioned conflict over opioid prescribing as a strain on continuity and a source of burnout. This situates the abstract ideal of continuity within the shifting politics of chronic pain and opioid management, highlighting that continuity of relationship includes navigating changes in the social environment of care.<sup>151</sup>

In Dr. Moore's story, there is a discrepancy between her view on the risks and benefits of managing this patient's pain with opioids and those of some of her patient's other doctors. These could stem from differences in training. They could also be contingent on the temporal horizons within which one imagines her treatment. Dr. Moore draws on her past experience ("you were kind of the same") and anticipates the near- and long-term risks of complicating her heart condition or of her developing dependency. Their long-term relationship and repeated exchanges about opioids both make it difficult to say no and help her to manage time within the visit by addressing the topic up front.

In this narrative, continuity appears in multiple forms. Dr. Moore took over care for this patient from another doctor in the same clinic. She has known the patient for most of the patient's life and now cares for her child as well. She offers to be a source of knowledge continuity even as the patient seeks care from specialists and other generalists. Yet, continuity is also defined by the patient's knowledge that she could always come back.

One of the moments that most articulated to me the ethics of continuous relationship was the encounter between Dr. Erickson and Mr. Carl. Mr. Carl was a patient without a stable home who had a traumatic brain injury and needed surgery in 6 weeks. Dr.

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<sup>151</sup> For further discussion of time pressure and continuity as matters of concern with regard to safer opioid prescribing in safety-net settings, see: Satterwhite et al. 2019.

Erickson had arranged a place for him in a residential healthcare facility until then. Right when we walked in to his room, Mr. Carl said, “It’s not over yet.” Dr. Erickson sat down and commiserated: “It’s not over.” After acknowledging how traumatic the year had been for him, she said, “I want to get you through [your procedure]. And then I want to get you through 2018 and I want it to be as boring as possible.” “Me too,” he replied.

At the end of the visit, Dr. Erickson told Mr. Carl that she was comforted by the fact that he was in a residential program, so he had a lot of people looking out for him. She told him that she was always happy to see him when he felt he needed it, but she did not feel the need to schedule a follow-up appointment right way. Dr. Erickson took comfort in the support available to Mr. Carl outside the clinic. Without that, the visit likely would have been more complicated, and Mr. Carl would require more frequent follow-up. This sense of “getting you through” articulates a form of commitment, a quality of continuity that cannot be captured by quantitative measures nor necessarily compromised by letting others look out for Mr. Carl for a while.

One RN told me, “I’ve had patients tell me that [the clinic is] really like their second home... I’m surprised when people say that. Like, how connected they are to their clinic. Right? Like, I barely see my doctor, right? ... I guess because they’ve gone there for so long or... But people really do feel connected.” This nurse’s distinction between her own relationship to the doctor and some of her patients’ sense of attachment may be related to the social vulnerability and medical complexity of the patients that defined notions of continuity in this clinic.<sup>152</sup> Notably, theirs was a relationship with the clinic as a whole – the

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<sup>152</sup> For an excellent analysis of the ways in which people seek and find ambivalent forms of care and a sort of home within disciplinary institutions, see *Jailcare* by Carolyn Sufrin (2017).

staff, providers and other patients. Based on the interactions I witnessed and the narratives I have recounted here, I imagine this sense of home to be as complex as familial relationships but defined by the commitment to still be there when needed.<sup>153</sup>

The potential for *care over time* is fundamental to the practice of primary care. The meaning of a symptom may be found in a decade of knowledge about a patient or may gain clarity only after more time has passed (c.f. Irving and Holden 2013). Sometimes, making space for possibility in primary care takes the form of setting temporally-bound but significant goals – a baby born without HIV, a trip to Nigeria. Some patients may need more now and others more next time. These forms of reckoning with potential include forms of deferral at the individual level that enable other forms of care for a collective of patients in the present and future.

### **Where to from here?**

As Alice poignantly described above, the responsibility involved in providing primary care in safety-net clinics is both rewarding and potentially overwhelming. Burnout is not simply a complaint about or symptom of overwork but speaks to the unnerving feeling of being unable to care for patients properly. Dr. Bennett told me:

*I don't see anything that's happening moving in a direction that's really towards the best for patients. I mean, maybe better convenience for folks. And that's fine if you have a UTI or a sore throat, but, you know, for patients with chronic conditions that need ongoing management, that's just not going to work. And*

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<sup>153</sup> Knowing patients over a long period of time did not always entail fondness, even as it did familiarity and commitment. This sentiment was implicit in one provider's comment after telling me that she had known some of her patients for 10 years. She sighed and laughed as she said, "That's a long time to know someone sometimes." With certain patients, providers could feel stuck in a bad pattern. A couple of providers reflected that the value placed on continuity can make one feel obligated to sustain relationships with patients that are failing both parties. When continuity became undesirable, patients risked leaving the care of the clinic, but if the tensions were addressed, colleagues could sometimes identify another provider whose personality would be just right for that particular patient. More often, these dynamics were not all-or-nothing.



*yeah, I mean, it's looking pretty bleak, truthfully, as things are headed the way things are headed for primary care providers, or people who want to go into primary care and to find this to be a fulfilling career.*

Dr. Bennett described an overwhelming sense of being the “safety net” for patients, responsible for following up every condition, symptom and lab ordered by others without adequate time to do so. Her critique focused on the fear that she felt with this responsibility. “So, it’s a total setup for failure or feeling like you’re failing constantly,” she said, “And we’ve all come into situations where it’s scary. You’re like, ‘How can I really do right by this person?’” She also felt that trust was both essential and difficult to establish under time pressure, especially when working with socially vulnerable patients.

I often ended interviews by asking people to tell me what they wish they could have or do – suspending the apparent limits of the current system – to improve the experience of time in primary care for themselves and their patients. Answers often centered on ways of changing the schedule or hiring a few more staff. It seemed difficult for people to think more broadly after I had asked so many questions about their current practice. One provider explicitly linked his wishes, and anticipation of their failure, to a broader political history:

*S: Is there anything else that you feel like would make a big difference either for patients or providers in settings like [your clinic]? Like, if you could have whatever you wanted.*

*Dr. Wilson: Well, oh man – are we talking about on a systems level or are we talking on a societal level?*

*S: Whatever you want.*

*Dr. Wilson: Okay, on a societal level, Medicare for All or nationalized healthcare. Getting the insurance companies out of the loop. Getting patients put at the forefront rather than money being put at the forefront... So, reversing course on a societal level and making healthcare, education and housing priorities that supersede the priority to make profit. If we do that, it's going to be enormously*

*fantastic. If we don't do that, it's gonna be very unpleasant. Since we're not doing it, it's going to be very unpleasant.*

Dr. Wilson went on to say that this was part of a decades-long process of politics and social policies “going off the rails.” He articulated the harm that these policies did to his patients and acknowledged that his ability to observe this process with a degree of fascination stemmed from his position as a securely-employed professional white man. From this privileged position, he continued to enjoy his work despite its dysfunction. Importantly, he was committed to *staying* amidst the dysfunction.<sup>154</sup>

Continuity of relationships was consistently an important source of fulfillment for primary care clinicians and staff. Meanwhile, forces that might threaten continuity – from disruptions in care by displacement to intensifying workloads and time pressure – risk undermining the sustainability of the work. The practices of those I studied illustrate that one key to negotiating these possibilities and threats is the ability to tack between multiple demands of the present and future without losing a sense of urgency or potential.<sup>155</sup> The possibility to care over time motivates staff and providers to work incrementally toward some ideal of “good” care despite the slowness, absence or regression of structural change. In the conclusion, I reflect on how this orientation to time and scale could contribute to anthropological and political responses to healthcare organization and practice.

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<sup>154</sup> This commentary is reminiscent of the essay on absurdity that I introduced in the introduction. Camus (1991:52, 54) writes that the absurd offers a “heart-rending and marvelous wager.” Life in the face of the absurd involves constant confrontation. He calls this confrontation “revolt,” which is “not aspiration,” but “the certainty of a crushing fate, without the resignation that ought to accompany it.” There is a similar sense of absurdity to this research, as the problem of time in primary care is so well known as to be a given, yet rarely fully analyzed or confronted in its complexity. The hegemonic logics of healthcare financing make it difficult to imagine a way out, and yet it seems important to keep describing their effects.

<sup>155</sup> While I have described the detrimental effects of incrementality on clinic staff in the expansion of primary care tasks, here I am drawing out the positive potential of incrementality to begin mitigating or addressing larger social problems (c.f. Ahmann 2018; Petryna 2013).

## Conclusion: Scaling Time and Care

A generalized sense of temporal acceleration has shaped and reinforced much work on time in the social sciences and critiques of healthcare. In response, slowness holds appeal as an antidote (e.g. Sweet 2012, 2017). By tracing the shepherd's paradox through the multiple temporal registers of primary care practice and administration, I draw attention to the limits of dichotomous temporal framings like Fast and Slow for assuring better care for patients as a collective (c.f. Wilk 2006; Sharma 2014). Ethnographic attention to the rhythms and tempos of primary care yields a much more complicated picture.<sup>156</sup>

I have shown how the frictions in care practice that are articulated as a lack of time play out and continue to pose challenges to caregivers and to the aspiration of improving health outcomes. By focusing on time as an actor and object of study in and of itself, I have drawn out the ways that the moral stakes of primary care are structured through temporalities and logics that shift and displace one another. In a moment where time seems to be a problem across multiple spheres, my analysis demonstrates how anthropological engagement with time and temporality can be used as a lens into social questions regarding ethics, governance, work and care.

In primary care for socially vulnerable patients, multiple temporal registers with often contradictory ethical entailments are readily visible to practitioners. This knowledge

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<sup>156</sup> For example, I have traced the moralization of speed through concerns about access and wait times, as well as the persistence of elements that Victoria Sweet (2012, 2017) assigns to "slow medicine" in the form of care continuity. Other scholars have critiqued this fast/slow binary in the setting of Slow Food and other slow "spaces" (Sharma 2014). Calls for slowness tend to center the experience of a few and sidestep questions of distribution. Richard Wilk (2006) writes that the figure of the "slow" operates within a linear narrative of progress, in which the slow is being overtaken or pushed out by the fast. This runs the risk of fostering a sense of doom. "There are many causes for concern and an urgent need for activism," writes Wilk, "but in many ways we are better off without the tinge of inevitability, the sense of fighting against a leviathan" that comes with this type of thinking (2006, 21).

seems to disappear as one moves toward the vantage points of both policy and some social critiques of medicine. Public narratives around primary care obscure contradictions as they call for equity, timeliness and patient-centeredness without addressing the potential tensions between these terms. Many proposals for primary care “transformation” remain based on fundamentally the same principle that led to a “crisis,” namely that by doing more with less, efficiency can be ever-increased in the name of patient-centeredness. Attention to the varied temporal and ethical registers of primary care in the safety net allows one to recognize the need for urgent change without reasserting the potential of what has not worked, nor inscribing care in a narrative of inevitable failure (Timmermans and Buchbinder 2013; Ortner 2016; Petryna 2017).<sup>157</sup>

In this dissertation, I have explored the ways in which issues of time and temporality articulate with notions of the individual and population and the forms of care that each requires. I have argued that concern about patients waiting moralizes speed and efficiency in the clinic. This aspiration to timeliness for the collective of patients is in a “constant state of tension” with ideals of comprehensive and attentive care for each individual. The schedule, designed to meet fiscal and access requirements, does not reflect the variable needs of complex patients, but relies on a logic of *enslotment*, in which patients are interchangeable occupants of uniform slots. I have examined the many practices that clinicians and staff use to adapt the schedule to patients and patients to the schedule in the name of clinic flow. The non-congruence between the temporal norms of the clinic and patient needs can configure certain patients as difficult or deviant. It also leads to a sense of

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<sup>157</sup> In “Dark Anthropology and its Others,” Ortner (2016) calls for more anthropology of resistance as a middle ground between work on neoliberalism and governmentality and anthropologies of “the good” that bracket power and violence. Camus (1991) describes the act of persistence in the face of absurdity “rebellion.” I see the everyday ethics and practices of primary care workers committed to staying amidst the tensions of time in primary care as part of this middle ground.

temporal fragility as clinic teams work to bridge the gap. I have argued that the forms of temporal interdependency involved in teamwork are essential to the functioning of the clinic and reflect the values attributed to each team member's labor.

The sense of potentially unlimited demand that drives that efforts to "protect" time through clinical teamwork is not only derived from face-to-face patient care, but from documentation requirements and the proliferation of incentive-backed quality monitoring and improvement metrics. I described the vexing experience of pursuing constant improvement toward multiple aims that often pull in different directions. I have traced the disjunctures in scale implicit in the various uses of screening and metrics. The use of population level metrics can serve to generate a sense of urgency around individuals' chronic, preventive and mental health needs otherwise neglected under time pressure. Meanwhile, the tempo of reporting requirements and metric-based payment incentives is out of sync with the temporality of sustainable organizational or political change. This repeatedly places clinic staff in a position of taking on additional responsibilities and confronting the limits of time and the contradictions between their obligations to individual patients, the collective and each other.

Expressing fatigue at the challenge of providing care for a high-need population within profound organizational and temporal constraints, a nursing supervisor asked me: "How much longer can we do this?" The question speaks to an understanding that our health and social systems are in need of profound change. Focus on one visit, one session, or one reporting period may require or enable forms of care that cannot be sustained. Meanwhile, within the dominant logics of healthcare efficiency, the techniques I have described in this dissertation risk being understood as scalable practices rather than survival strategies (Tsing 2012). In this dissertation, I am interested in a different kind of scaling.

The mandate of primary care and its incremental expansion through new practices of screening and accountability create forms of incoherence and absurdity. As I have argued, care over time entails reckoning with contradictory obligations to individuals, to the collective and to the needs of the institution, in part by moving between temporal registers and time horizons. This technique of tacking between time frames and obligations is a form of scale-making. In response to recent anthropological critiques of scaling up in business and governance, Carr and Lempert (2016) write that anthropology has always been about scale in a different sense:

A few anthropologists have concertedly and critically examined the scalar habits of the discipline. For instance, Marilyn Strathern, who defines scale as ‘the organization of perspectives on objects of knowledge and enquiry’ (2004, xvi), suggests that anthropological analysis is, in its very essence, a scale-making endeavor. It is so because ethnographers must find ways to cope with cultural complexity so as to make it legible, and to do so we tack back and forth between different ways of looking at the same things, whether through different sets of eyes, with different degrees of focus, or with different ways of relating to our object... [Carr and Lempert 2016:5]

Carr and Lempert’s collection analyzes the pragmatics of scale as useful for orientation and valuation when “ideals of social life stand in tension with notions of what is practically achievable.”<sup>158</sup> *Individual, collective* and *population* are scalar concepts, as are structure and practice. My use of these concepts throughout this dissertation have served to draw out the complexity of time and to alter what is visible as ethically salient.

While there is room for movement and creativity, scaled ways of seeing are enforced by institutions and social norms (Carr and Lempert 2016). I have traced examples

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<sup>158</sup> As linguistic anthropologists, Carr and Lempert are interested in pragmatics in the sense of studying the ways that social context shapes meaning.

of these scalar orientations and their temporal entailments in each chapter of this dissertation. In the last chapter, I traced how those who work in primary care move between temporal frames as a type of scaling practice that enables critical action rather than either naive hope or cynical paralysis (c.f. Ortner 2016; Petryna 2017). My own analysis has also grappled with scale and potential, attending to what is currently “doable” in primary care as well as what may become possible or foreclosed (c.f. Bear 2014a).<sup>159</sup>

What could a similar approach in policy and critique accomplish in addressing the social roots of poor health and a broken system? Could this make primary care a more “doable” and even fulfilling job in each role? Embedded in the everyday practices and reflections of the practitioners I studied is a profound critique of the current organization of care even as they operate within it (c.f. Brodwin 2013). My research shows that an adequate assessment of healthcare practice, whether in policy or anthropological critique, must take time more seriously. Such an engagement must grapple with similar questions of scale, such as the complex relationships between population health and individual care, efficiency and efficacy, short and long term to respond to the injustice manifest in the current system *and* make sense of how practitioners create an imperfect space for care in the meantime.

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<sup>159</sup> One of the questions on the staff survey that was described in chapter 6 asks respondents to rate the strength of their belief that, “Primary care is a more doable job in my clinic this year compared to last year.” I found this wording a striking standard by which to measure work experience. “Doable” as opposed to “feasible” seems more firmly grounded in what is presently possible than potentially so.

## Appendix A: Glossary of Clinic Roles

As a basic orientation to the many actors in the primary care clinic, I will narrate the sequence of people you might encounter as a patient in these clinics. Each of these roles entails more than is presented here. This glossary aims to orient you to the terms for each clinical role:

When you arrive, you will be registered by an **eligibility worker**, who validates your insurance and contact information. You may be greeted and checked in electronically by the eligibility worker or a health worker at the **front desk**, notifying the clinical staff of your arrival.

A **medical assistant (MA)**, seeing that you have arrived, will come and call your name, escorting you back to a scale and then the visit room, measuring your vital signs and asking standard questions about smoking, medication refills, recent care received elsewhere, or screening tests for which you are due. Then, they will ask you to wait for your **primary care provider (PCP)**. Provider or PCP refers to the physician or nurse practitioner primarily responsible for your care.

If you dropped in without an appointment, you will likely be called back instead by a **nurse (RN)**, who will assess your concerns and treat you directly or consult the “Provider of the Day” (POD). If you have a chronic condition like diabetes or hypertension, you may have an appointment with the nurse for monitoring and education. Even if you do not interact with an RN during your visit, chances are they (or your medical assistant) have done work behind the scenes to prepare your vaccinations or obtain authorization for medications or referrals from your insurance provider.

After your visit with your PCP, the medical assistant will come back with anything the doctor ordered during your visit. They may draw blood for labs or tell you to pick up your prescription at the pharmacy. If your PCP made a referral, the MA will advise you on how to make that appointment.

The clinic also has “behavioral health” staff to help with mental health concerns and access to social services. (Behavioral health integration is not a primary focus of my study, but important for understanding how PCPs enlist the help of colleagues with some of the most time-intensive patient care work). Depending on their availability, if your PCP requests



their help, a **behavioral health clinician (BHC)** may introduce themselves. **Behavioral assistants (BAs)** offer smoking cessation resources and do the work of keeping track of applications for durable medical equipment or programs like home health and day centers.

There are a number of other actors and roles. Here is quick glossary:

**Porter** – the person who cleans and maintains the clinic facilities.

**Deputy** – the security guard, employed by the sheriff’s department. They usually sit near the entrance to the clinic, in the waiting room, and make rounds a few times a day. They often informally answer patients’ questions about clinic services or resources.

“Leadership” or Management Team:

**Nurse Manager:** An RN who manages the nurses and medical assistants. They work as an RN in the clinic to varying degrees.

**Medical Director:** An MD who manages the PCPs and the other managers. They usually also see patients for a couple clinics a week.

**Administrative Operations Supervisor:** This person supervises clerical staff (eligibility and front desk) and manages scheduling and billing

**Practice Manager:** This person supports other managers and leads quality improvement (QI) initiatives

**Analyst:** Often a younger, more temporary member of clinic staff, they “pull” and analyze data and metric reports for internal or external use

Two other roles did not exist at every clinic that I studied but did at some. Scribes and health coaches are generally young people, many of whom may be interested in health professions and may be paid or volunteer. **Scribes** go into visits with providers and chart a draft of sections of the visit note to assist the provider with documentation. **Health coaches** conduct motivational interviewing and patient education around chronic illness, diet and exercise.

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