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Family Medicine

NARRATIVE ESSAY

¿Tiene Prisa?

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I have been Frankie's primary care physician for around 8 years. When I first met him, he was 39 with a goofy personality, newly married for a second time, and in the habit of bringing his wife along to appointments. Frankie spoke of her *alfajores* with reverence—careful to insist they were not better than his mother's, though his smile suggested otherwise. He exuded a love of life through family, food, and small pleasures. I identified Frankie's diabetes and hypertension in 2018, yet he was largely indifferent to both diagnoses. He always pivoted conversations away from target-organ consequences to ask me questions about my daughter or upcoming travels.

Then came the pandemic, and like so many uninsured patients in underserved communities, Frankie disappeared—not intentionally, but structurally. Access eroded, care fragmented, and a portal message I sent in 2021 went unread. By the time I saw him again in 2023, the arc of his disease had advanced beyond anything I could rewind. Frankie started dialysis and our infrequent visits would consist of refilling whichever medications his wife had written down.

I saw him again recently on the first day of April. I knew it was a Wednesday by the well-trained efficiency accelerator revving in my bones. Wednesdays are my heaviest clinic day. Twenty-four patients, each allotted essentially 10 face-to-face minutes to contain years of complexity and humanity. Frankie was already in the room when I entered. His chief complaint read "unsure." I assumed he needed some refills again.

He stood as I walked in, gripping my hand warmly, smiling widely. Turning to his wife, he said, "*¡Este es mi doctor!*" [This is my doctor!] There was pride in his voice—a lavish introduction, a declaration of a treasured relationship.

Clinically, he needed very little. The dialysis nephrologist wanted to adjust his blood pressure regimen. Frankie wanted my approval. The plan was sound. I explained the probable reasoning, discussed the risks and benefits, and began to wrap up. Efficient. Appropriate. Complete.

"Anything else?" I asked, already half turned toward the door.

"Yes," he said. "My hips hurt—a lot. Especially the right."

Only then did I notice the cane resting against the exam table. I realized I hadn't seen him walk in. As he described his pain and stiffness, I nodded, scanning his chart. Renal osteodystrophy. A pubic ramus fracture last year. The orthopedic surgeon documented a referral to physical therapy for this nonoperative condition, but Frankie was still waiting for a call that never came.

I told him, reflexively, that schedulers don't call patients in our system. I gave him the appointment line, knowing the referral had likely expired. I was reminded by the quiet, invisible labor of primary care. Two specialists now seemingly hadn't met Frankie's needs. Earlier that day, I professed to a clerkship student that care coordination often defaults to the only person who consistently shows up in a patient's life. The implied praise was directed at me.

I made a plan, reordered the physical therapy referral, recommended follow-up with the orthopedic surgery clinic, and documented what needed documenting. Then I stood to leave—again.

"*¿Tiene prisa?*" [Are you in a hurry?] he asked.

No patient had ever asked me this before. Frankie was smiling, but only half joking.

I paused. It had been 7 minutes. Epic actually counted it. I had already tried to leave twice.

In that moment, the illusion of efficiency cracked. Frankie hadn't truly conversed with a physician in 10 months. What I had interpreted as a simple visit ("a few questions") was, for him, a rare opening. A chance to be heard, to catch up, to reconnect with someone he trusted.

And there was more. A handicap placard. Forms for SNAP food benefit renewal. Questions about work limitations. Finally, almost as an aside, an earnest question from his wife whether Frankie could resume weight-bearing sexual activity. I sank deeper into my chair, thinking of how many months they hadn't been intimate. Despite having seen them both in my office dozens of times, I never really asked about their marriage. I must not have wanted to open a door that I didn't have time to walk through. But that was precisely the point. I had been managing his glucose and blood pressure, but I had nearly missed his life.

My behavior conveyed a belief that relationships, once established, sustain themselves—that trust built years ago could be drawn upon indefinitely without reinvestment. But relationships in medicine are not static assets; they are living systems that require maintenance, attention, and time.

Frankie didn't come that day for medication approval. He came to reconnect with his doctor. To be seen by someone who knew him not just as a dialysis patient, but as a man who loves his wife's desserts, who carries pride in his identity, who navigates pain, bureaucracy, and intimacy all at once. Yet my efficiency alarm clock was clanging by the eleventh minute.

Primary care demands we constantly triage—to prioritize, to streamline, to move. But there is a cost when efficiency becomes reflexive. The question is not whether I was busy. I was. The question is whether I was present.

I'd like to say that I turned off the computer monitor, sat fully facing the patient, and warmly devoted the rest of the appointment to Frankie. In honest reality, I had two other patients waiting and I didn't sit down a third time.

"*¿Tiene prisa?*" I still hear it as I'm writing about this 3 days later—not as an accusation, but as an invitation. Frankie could have just been ribbing me. After all, I was his *doctor*! That declaration was not just pride in me. It was a claim on me, a reminder that he had trusted me with his life for years, and that I owed him my presence in return. That is what patients return for. So that is what we must choose, repeatedly, to make time for.