



A M E R I C A N  
H E A L T H W A Y S  
*Improved health is the outcome.*

 JOHNS HOPKINS

*Defining the  
Patient-Physician  
Relationship for  
the 21st Century*

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Outcomes Summit  
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# F o r e w o r d

The fundamental interaction in health care is the one between patient and physician. That fact, moreover, is likely to remain true for the foreseeable future.

Our world, our lives and the delivery of health care are increasingly complex. As each critical part of the health care delivery system works toward achieving effective and efficient service and quality outcomes, this complexity has often resulted in conflicting requirements, demands and expectations. We believe these realities necessitate consensus among all stakeholders that the patient-physician relationship is the touchstone to which the entire system must align.

If the patient-physician relationship is to be health care's touchstone, however, all parties must understand the essence of that relationship, and the relationship itself must be sound. Achieving those goals requires clearly articulating the expectations of both patients and physicians and then reconciling expectations that may conflict.

The expectations of patients and physicians, explored in the rest of this document, are remarkably similar. The physician and patient participants in the Outcomes Summit consistently reflected their mutual belief that an effective relationship between them depends on mutual acceptance of responsibility for its success.

This document reflects the conferees' beliefs about what constitutes an ideal patient-physician relationship. It specifically does not address barriers to reaching that ideal or strategies for overcoming those barriers. That remains the continuing task for all of us.

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# I n t r o d u c t i o n

*What should the ideal patient-physician relationship of the 21st century look like?*

*Why does it matter?*

*And who should decide?*

*To answer the first question, we must begin by addressing the other two.*

## **Why It Matters**

The patient-physician relationship is fundamental to providing and receiving excellent care, to the healing process and to improved outcomes. Therefore, it is important to understand what elements comprise the relationship—and identify those that make it "good."

We recognize that, ultimately, the answers to the questions posed above will unfold in the privacy, diversity and uniqueness of each patient-physician encounter. Because of the rapidly changing environment that characterizes health care today, however, we need to understand what physicians and patients must do to protect and nurture that relationship.

## **An Increasingly Central Role for Patients**

Many aspects of the patient-physician relationship have been subjects of intense research by the scientific community—and of thoughtful reflection by lay authors and patient advocacy organizations. A substantial body of scientific literature encapsulates that research and informs physicians of ways to enhance their effectiveness. For their part, patients count on an ever-growing collection of books and articles advising them how to take better care of themselves and how to interact more effectively with their doctors.

To many, the characters of "Marcus Welby, M.D.," the popular late-'60s TV series, nostalgically invoke images of a nearly perfect patient-physician relationship: a knowledgeable, beneficent and genuinely caring physician guiding the treatment of respectful, trusting and grateful patients. This private relationship was undisturbed by the vicissitudes of insurance coverage, government regulations or any sort of outside second-guessing. Under such idyllic conditions, the wholesomeness of the patient-physician relationship invariably transcended everything else, even outcomes that are less than ideal for the patient.

As we enter the 21st century, however, the nature of the patient-physician relationship appears to be far more complex. Sweeping changes within and outside the health care sector—such as the growing preponderance of chronic illnesses, new medical technologies, shifting reimbursement practices, the Internet, government regulations, rising costs and changing social norms—are constantly molding patient and physician behavior.

Amid the changes, one of the clearest themes to emerge is the centrality of patients. Increasingly, they are not simply recipients of care or subjects of research but active, informed individuals who wish to know more about their condition and exert greater control over their own care. Donald Berwick, President of the Institute for Healthcare Improvement, captures this new patient-centric focus with the phrase "*nothing about me without me.*"<sup>(1)</sup> The Institute of Medicine report, "Crossing the Quality Chasm,"<sup>(2)</sup> lists patient-centeredness as one of six fundamental pillars of quality.

The principle of patient-centric care is not new. In his Shattuck Lecture in 1988,<sup>(3)</sup> Paul Ellwood crystallized the relevance of the patient's perspective in the evaluation of health outcomes. He also launched an enduring movement to put the principles of patient-centric care into action through the work of the Foundation for Accountability.<sup>(4)</sup> More recently, the Picker Institute<sup>(5)</sup> was founded to research and report on the quality of health care through the patient's eyes and has identified areas that matter most to patients. Going one step further, Debra Roter, a highly respected author and researcher of the patient-physician relationship, states: "Just as the molecular and chemistry-oriented sciences were adopted as the 20th-century medical paradigm, incorporation of the patient's perspective into a relationship-centered medical paradigm has been suggested as appropriate for the 21st century."<sup>(6)</sup>

In an effort to put Dr. Roter's suggestion into action, we believe that it is timely and necessary to revisit the patient-physician relationship.

### **Enabling Patients and Physicians to Define the Patient-Physician Relationship**

Anticipating that fresh ideas and new insights would emerge "from within" if a large group of patients and their physicians could engage in an honest, open dialogue about each other in a neutral setting and on a platform of equality, Johns Hopkins and American Healthways dedicated this year's Outcomes Summit to a consensus conference to define the patient-physician relationship for the 21st century.

At the conference, patients and physicians were encouraged to examine their own real-world interactions in the context of today's trends, technologies and lifestyles. Then, they collaborated to design principles that reflected each other's needs, wants and expectations. The participants began with only one assumption: that the relationship should be rooted in mutual trust and respect.

The participants followed a consensus conference process in working to establish and reconcile patient and physician expectations. The process led them to identify seven principal elements that both patients and physicians believe are essential to the relationship:

1. **COMMUNICATION:** including means of communicating; information gathering; the role of patient self-assessments and feedback; delivery of information; and adequacy of information.
2. **OFFICE EXPERIENCE:** including access to care; office-patient communication; processes for obtaining prescriptions and refills; information forms; and the care environment.
3. **HOSPITAL EXPERIENCE:** including expectations for personalizing care; the physician in charge; communication among members of the health care team, patients, family and patient advocates; discharge planning and the emergency room experience.
4. **EDUCATION:** including information provided by physicians to patients; addressing patients' individual situations; non-physician sources of information; and the role of self-care.



5. **INTEGRATION:** including the sharing of information among all members of the health care team; navigation of the health care system; medical records; and health plan information.
6. **DECISION-MAKING:** including the patient's role; the patient advocate's role; the right of patients to know all evidence-based options; and non-clinical factors that impact medical decisions.
7. **OUTCOMES:** including clinical outcomes; patient-centered outcomes; and physician-centered outcomes.

This document summarizes the results of the collaborative process between the conference participants—more than 200 patients and physicians—and the consensus description of the ideal patient-physician relationship they envisioned.

### **The Impact of Health Care Costs on the Relationship**

Powerful economic forces influence the patient-physician relationship. Directly or indirectly, spiraling costs permeate all health care transactions. They influence when and where patients access health care, what services they use and how they relate to their doctors. For their part, physicians feel overwhelmed by rising malpractice premiums, the cost of new medical technology, constraints on reimbursement and upward pressures on nurses' wages due to the national shortage. Consumers face increasing deductibles, co-payments and co-insurance costs. The cost of prescription drugs is becoming unaffordable. More than 43 million Americans lack health insurance. Payers—the government, insurance companies, employers and private individuals—believe that health care has become unwieldy and increasingly unaffordable.

How can these conditions support a nurturing patient-physician relationship? How can health care become more affordable and of higher quality? Surely, not all ideas generated at the summit will cost money. Many, in fact, are attainable through more creative allocation of existing resources. For those improvements that require new capital, the conferees freely acknowledged that they lacked the expertise to advance specific solutions. Participants also acknowledged that, without payment reform focused on rewarding quality and, above all, good outcomes, the imperative for stronger patient-physician relationships faces a daunting challenge.

- (1) Tom Delbanco, M.D., Donald M. Berwick, M.D., Jo Ivey Boufford, M. S., Edgman-Levitan, P.A., GuÈnter Ollenschla Èger, M.D., Diane Plamping, Ph.D. and Richard G. Rockefeller, M.D. *Healthcare in a Land Called People Power: Nothing About Me Without Me*. Blackwell Science Ltd. 2001 Health Expectations, 4, pp.144±150http: Available from [www.aezq.de/english/english/literature/pdf/dellbank2001.pdf](http://www.aezq.de/english/english/literature/pdf/dellbank2001.pdf)
- (2) Committee on Quality of Health Care in America, Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*.
- (3) Paul Ellwood, "Shattuck Lecture: Outcomes Management: A Technology of Patient Experience." *New England Journal of Medicine* 1988;318:1549–56.
- (4) [www.facct.org](http://www.facct.org)
- (5) [www.pickerinstitute.org](http://www.pickerinstitute.org)
- (6) "The Enduring and Evolving Nature of the Patient-Physician Relationship." *Patient Education & Counseling*. 39(1):5-15, Jan. 2000.

# The Patient-Physician Relationship

The patient-physician relationship is the very heart of health care delivery. It permeates each element that we discuss in this document. In its intimacy and individualized nature, it is unique among professional relationships. At its best, the physician-patient relationship not only gives patients access to health care but also can promote healing. In the scientific realm, mounting evidence demonstrates that the effectiveness of the patient-physician relationship directly relates to health outcomes.

The intimacy of emotions and the private, often uncomfortable sharing of information between patient and physician require a foundation of mutual responsibilities that include:

- Respect
- Open and honest communication
- Trust
- Compassion

This healing relationship often includes friends and family members, patient advocates and other health care professionals. The relationship works best when physicians acknowledge the roles of these individuals and fully integrate them into the care of the patient.

To address social forces that impact it—including economics, technology, time and expectations—the patient-physician relationship must continue to evolve. Patients increasingly see themselves as consumers of health care and look to their physicians for better, more efficient and more effective service. Patients' expectations and market forces lead office practices to change outmoded and inefficient systems. When patients use their role as consumers to fuel self-education about their health, everyone benefits. Technologies such as e-mail and the Internet can potentially enrich the relationship as they expand it beyond the constraints of the one-on-one office visit.

An effective patient-physician relationship creates:

- a mutual understanding of the patient's expectations of the physician—and the physician's expectations of the patient;
- a strong basis for discussing options to achieve expected goals of care;
- a powerful resource for healing and a source of comfort in situations where healing does not occur;
- a resource for learning by both parties;
- a vehicle for navigating the stressful circumstances that accompany acute medical illnesses; and
- a framework for maintaining open discussion and a positive relationship even when there is uncertainty about the medical outcome.

This is a document about patients and providers. However, we expect that the recommendations within this document to apply to all members of the health care team.

# Principal Elements

# C o m m u n i c a t i o n

We list communication first in discussing the patient-physician relationship because, without effective communication, patients and physicians cannot achieve the ideal relationship that leads to the ideal delivery of care. Effective communication—written, verbal or non-verbal—among all members of the health care team is the central building block of the patient-physician relationship and must occur in an environment in which patients and physicians recognize their obligations to each other and work to fulfill them. The goals of communication are to:

- exchange information;
- reach mutually satisfying decisions;
- develop a common understanding; and
- build trust.

## **The Physician's Obligation**

In the ideal exchange, the physician

- commits full attention to the patient;
- creates an environment that preserves the patient's dignity;
- fosters candor in the disclosure of confidential and intimate information;
- conveys genuine concern for the patient's well being; and
- respects the role of the patient advocate and/or caregiver.

## **The Patient's Obligation**

Similarly, the patient's commitment to open, pertinent and well-organized communication enhances the value of the office visit. In advance, patients should

- prepare a list of questions and concerns they wish the physician to address;
- make the physician aware of these questions and concerns at the beginning of the visit;
- share their medical histories as completely and accurately as possible;

### **Perspective on the Importance of Non-Medical Information**

*Elizabeth had always been very open with her doctor about her past problems with alcoholism. She had been sober for 10 years but still considered herself at risk for addictions. She became quite upset when her long-time physician forgot this important issue and prescribed a cough syrup with an alcohol base, which she knew she could not safely take.*

- clearly designate a patient advocate or caregiver and define their role in the care process; and
- establish a single point of contact for providing information to family members.

## RECOMMENDATIONS

Based on our discussions and the sharing of patient and physician perspectives, we offer these summary recommendations for achieving excellence in physician-patient communication:

1. **All parties should acknowledge patients as most knowledgeable about their symptoms**, and patient self-assessments should guide the nature and timing of both the physician's response and of scheduled visits.
2. Patients should recognize the importance of providing feedback for improving their care. **Physicians and their offices should welcome patient feedback and establish safe ways that patients can provide it.**
3. **Physicians should implement a social questionnaire as part of the initial intake, allowing the patient to communicate essential, non-medical information about their lives.** This information should be integrated into ongoing care. Information captured on the social questionnaire should include: marital status and/or significant others, education and occupation, hobbies, religious preference, preferred methods of communication and the patient's preferred level of involvement in health care decisions. Understanding what makes each patient unique can help personalize care and reduce the risk of misunderstanding, error or loss of rapport.
4. **Physicians and support staff must recognize the role of patients' gender, age, race and religion in their treatment and ongoing care.**
5. **Delivering traumatic news to the patient demands that physicians find an appropriate environment** with adequate time and ample consideration for the concerns of the patient, family and/or advocate.

### Perspective on Patient Advocates

*Margaret lives in a retirement home. In recent years, her worsening vision and unsteady gait have meant that she spends more time alone in her apartment. Her daughter Nan visits several times weekly. Nan helps with shopping and takes her mother to doctors' appointments. During Margaret's first appointment, she told her new primary care doctor, "Please communicate with me by contacting my daughter. Lately she has been involved in all of my health care decisions, and I like it that way. She explains things in a way I can understand and, after all, she's the one who carts me around to all of my tests and appointments!"*

- 6. Physicians must respect and incorporate the patient's designated advocate into the care relationship.** Patient advocates, caregivers and family members should be present when appropriate, so that their roles are integrated into the care plan from its outset. In recognizing the legitimate role of advocates and caregivers, physicians should be prepared to fully discuss (1) limitations imposed on their participation by privacy laws and other statutory and regulatory requirements and (2) how other legal instruments (such as durable powers of attorney, living wills and advance directives) may enhance their roles.

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### Perspective on Communicating Options

*John underwent surgery for the second time to have his knee replaced. On the operating table, he suffered his second heart attack. John's cardiac surgeon set a date about two months away for a double bypass and planned to use the conventional method of a heart-bypass machine. While going through his modified physical therapy and exercise plan (in the cardiac rehab center), John met two friends who'd had bypass surgery in the past month. Both recommended a different cardiac surgeon who did not use the bypass machine; the goal of this alternative approach was to reduce the chance of infection and to reduce damage to blood cells. John consulted with this surgeon. After she explained how she would operate, John decided to allow her to perform his bypass operation. John had not known there were options regarding the use of the bypass machine and was grateful to his friends for informing him. He also believed that the first surgeon should have told him about the different surgical options.*

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- 7. Physicians are responsible for providing current, scientifically based "best medical practices" in an ethical and timely fashion.** They should instruct patients on benefits and risks and inform them of all reasonable diagnostic and therapeutic options, even if an option isn't covered by insurance or requires referral to another physician.
- 8. Patients should seek—and physicians should promote—active, collaborative discussions with patients.** They should take care to express medical information in laypersons' terms to ensure full comprehension by patients. The stresses of illness can impair a patient's ability to absorb details of the visit. Effective physicians summarize their recommendations and assess patients' (and/or their advocates') level of understanding, leaving time for additional clarification.
- 9. The patient-physician relationship must mirror our daily lives by relying on methods of communication that are not limited to inflexible, one-on-one visits** but may include e-mail and phone communication, disease management services, Internet access, written or verbal agreements, group visits and universal medical records that are accessible at the point of care.

## OUTCOMES

The outcomes we expect from improving patient-physician communication include:

- Improved patient adherence to recommended therapies
- Improved patient self-care
- Improved comprehension of information given by the physician
- Increased patient satisfaction and more word-of-mouth referrals from happy, established patients to potential new patients
- Increased physician satisfaction
- Improved capacity for physicians to see patients as whole persons, rather than diseases or organ systems
- Improved ability for patients to see physicians as people who also want and need mutually satisfying, therapeutic relationships and are doing their very best to help patients

### **Perspective on Physician-Patient Communication**

*Walter had struggled with pain on his side after a bad bout of shingles. He and his doctor had tried different treatments, with some success; on this night, however, Walter couldn't get to sleep, and the pain was worse than ever. Walter didn't want to awaken his doctor at 2 a.m., so he wrote him an e-mail, knowing that he would receive a response after his doctor got into the office the next morning. Just knowing that he could contact his doctor comforted Walter enough that he could get back to sleep.*

# Office Experience

Patients and physicians agree that office visits can significantly impact the quality of patient health outcomes. Patients often report fondness for their physicians but a dislike of the overall experience of seeking and receiving medical care. This apparent paradox is expressed in the remark, "I love my doctor, but I can't stand the office." While the separation of the physician from the other elements of the office experience is clear from anecdotal evidence, studies make equally clear that patients hold physicians accountable for their entire office experience. Although efforts to improve the office experience should, at a minimum,

result in a more pleasant environment for all parties, the real motivation for such change is to reduce barriers to access, improve efficiencies, improve accountability and deliver better health care.

## Perspective on Access to Care

*While reviewing the chart of his next patient, Dr. Thomas overheard a staff nurse, who had been suffering with a particularly bad cold, complain over the phone to her doctor's office, "What do you mean I will have to wait two weeks to see him? I am sick now!" She was still complaining about access to her physician a minute or two later when her phone rang. From the conversation it was clear that the call was from a patient requesting an office visit. The nurse clearly missed the irony as she explained, "The doctor is really busy and it will be a few weeks before an appointment is available."*

## RECOMMENDATIONS

Based on our discussions, we offer these recommendations concerning the office experience:

### Office Hours, Processes and Consumer Information

- 1. Patients should be able to access health care in a timely fashion.** Physician offices on the front end should clearly communicate to patients the processes for handling routine, urgent or emergency situations as well as lab tests, diagnostics, imaging and other procedures. Patients should also receive information about how results will be communicated to them.
- 2. Details of office policies and procedures should be available in written form** and, whenever possible, mailed or otherwise provided to patients in advance of the first visit. Information should include office location with directions, hours of operation and after-hours and weekend policies.
- 3. Physicians and their staff should review medical information forms periodically to help minimize duplication of information and the consequent burden on patients.** Patients understand the need to fill out these forms but often believe that they are unnecessarily repetitive.



4. **Physicians' office staff should be polite, professional and well trained to facilitate the care experience.**

Patients appreciate a respectful greeting with a smile and a warm, caring attitude. Staff should also help create an environment that is safe and responsive to the patient's cultural background, educational level and physical abilities.

5. **Telephone communication between patients and office can be a very effective and efficient tool,** though this system can also be a source of frustration and should be designed to avoid overload.

6. **Assuring flexible access is essential to a successful patient-physician relationship in a 24-7 world.** Using after-hour services for non-emergencies may reflect patients' inability to communicate with physicians during regular office hours. Patients and physicians recognize that using after-hour services for non-emergencies is undesirable. It can create potentially hazardous conditions because covering physicians lack access to patients' medical records. Further, the volume of non-emergent problems after hours can diminish physicians' responsiveness to real emergencies.

### Scheduling and Timeliness

7. **Physicians should continually evaluate their scheduling systems for effectiveness.** Obtaining a timely appointment with the physician can be a very frustrating experience.

8. **Office visits should be used as opportunities to review care plans, including illnesses, pharmacologic therapies, potential drug-to-drug interactions and any new medications added by other physicians.**

9. **Patients and physicians should project mutual respect for each other by making every effort to be on time for appointments.** Prolonged waits are among the most common sources of patient dissatisfaction with the office experience. When patients or physicians run late for appointments, each should communicate with the other the reasons for the delay. Physicians should explain when unexpected and/or unavoidable delays occur and attempt to make appropriate accommodations, which might include waiting or rescheduling.

### **Perspective on Prescription Refills**

*While on call for another physician group, Dr. Joel was contacted on a Saturday afternoon by an elderly patient wanting to refill her blood-pressure medication. She did not remember the name of the medication, nor did she have the pharmacy number available. She became quite irritated to learn that Dr. Joel was not in the office and did not have her medical record available. Eventually, Dr. Joel was able to phone in enough medication until the patient could contact her physician the following week.*

**10. Patients should arrive prepared for their visits. Physicians should also enter the appointment prepared by taking time to review the patient's information in advance.** There should be a mutual understanding regarding the objectives for the visit and the time allotted to accomplish those objectives.

**11. Physicians and staff should have systems in place to absorb unexpected events without displacing scheduled appointments.**

### Pre-authorizations, Referrals and Refills

**12. A responsive, effective system for referrals and pre-authorizations is essential to an effective patient-physician relationship.** Otherwise, patients often perceive—and may experience—that these systems are barriers to effective care, while physicians may be frustrated by the system's bureaucracy. When pre-authorizations and/or referrals are required by a patient's health plan, physicians should help patients understand both the process and the origin of the mandate. Prior to the office visit, patients should also seek to understand the process and educate themselves about the requirements and benefits of their health plans. Increasing satisfaction with the efficiency of the patient-physician relationship also requires addressing patient dissatisfaction with the process of securing medication refills. Patients, especially those with well-maintained chronic conditions who require ongoing medication, often find the system to be unreasonably burdensome.

**13. Physicians should communicate to patients the value of regular, face-to-face medication reviews** and make clear that, while not always apparent, the review is not just a "rubber stamp." Patients and physicians should work to find a balance to the current medication refill system that appropriately incorporates reasonableness, flexibility and compliance.

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#### **Perspective on Timeliness**

*Luci went for an office visit with Dr. Smith, her primary physician. "Good morning. How are you doing?" the doctor asked as he entered the examining room. "Great," replied Luci, "until an hour and a half ago." The doctor looked perplexed. "What happened an hour and a half ago?" asked Dr. Smith. "That's when you started being late for this appointment," Luci said. The doctor apologized and told her he was in the process of hiring more medical professionals. He has since added a second doctor and a physician's assistant. Now Dr. Smith is seldom more than five or 10 minutes late for any appointment.*

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## OUTCOMES

The outcomes we expect from efforts to reduce delays and improve processes and flow in office care include:

- Markedly enhanced patient satisfaction
- Fewer complaints
- Improved physician and staff satisfaction
- Elimination of dread on the part of patients in coming to physician offices
- Increased willingness among patients to address problems or seek treatment without delay
- Improved patient care

### Perspective on Self-Assessment

*At work one day, Jim developed the alarming sensation that his heart was racing uncontrollably. This had never happened to him before, and he knew that something was wrong. He called his doctor's office with this information and told the nurse that he felt very ill. The nurse told Jim that his doctor would call him back to discuss his symptoms. Two hours later the symptoms persisted, but Jim had not heard from the physician. So he called again, emphasized his concern and again was told to wait for the physician's call. Feeling increasingly unwell, Jim drove himself to the emergency room. The physician detected a very elevated heart rate due to a new diagnosis of a dangerous heart arrhythmia. Jim believed that his doctor had not taken his complaint seriously.*

# Hospital Experience

For the patient, admission to a hospital can be very unfamiliar and scary. The thought of potentially painful procedures and uncertain outcomes compounds this anxiety. In the hospital, patients have limited control over their environment and ability to care for themselves. A strong patient-physician relationship, with communication and coordination between the entire treatment team, greatly aids the patient's ability to cope.

## RECOMMENDATIONS

Based on our discussions, we offer these recommendations related to the hospital experience:

### Expectations for Care

**1. The health care team members should attempt to personalize care in the hospital.**

While the same issues pertaining to office visits apply in hospitals, the potential challenges are magnified by the presence of multiple hospital departments that may not be well integrated. Because they exist to ensure timely and cost-effective treatment of patients on a

large scale, hospital systems often are impersonal. As a result, care can be less personal and more confusing for patients. This situation can be exacerbated when the physician responsible for care of the patient is not the physician with whom the patient has previously established a relationship.

### Physician in Charge

**2. Which physician is in charge of care—and that physician's role—should be clearly defined to the patient.** The physician should outline hospital procedures as well as any additions to the health care team that hospitalization may require. The physician in charge during hospitalization may or may not be the same one with whom the patient is intimately

### **Perspective on Entering the Hospital**

*Kathleen went to her physician for a regular follow-up exam. She mentioned that she had not felt well for the past five days or so.*

*Kathleen said she thought she had food poisoning or possibly a gallbladder problem. Her doctor/internist asked about the symptoms she had experienced—an upset stomach and general malaise. Then the physician recommended that her technicians immediately run some tests and an EKG. Upon reviewing the results of the EKG, the physician calmly told Kathleen, "You did not have food poisoning. You have had a heart attack and you are having one right now." The doctor arranged an immediate transfer for Kathleen to the hospital. The physician informed her that the necessary care would be waiting. When they arrived at the emergency room, they found that the team of specialists and services—including: the cardiologist, echocardiogram, catheterization lab, angioplasty and stent—were on hand. Though Kathleen's physician could not be physically present, her presence was undeniably there.*

acquainted. In an ever-changing system, the physician in charge may be a specialist or hospital-based physician with whom the patient is unfamiliar. A strong patient-physician relationship helps in managing expectations on the front end, so that the patient understands who will be caring for him/her during the hospitalization.

### Communication

3. **Effective communication is imperative to avoid errors.** As the possibility for error increases in a complex hospital environment, proper communication between all members of the health care team helps to mitigate this potential problem. Ensuring that all members have the same accurate information about each patient decreases potential for medication errors, unnecessary testing and other problems that might otherwise arise.
4. **Prior to procedures, an appropriate member of the hospital staff must educate patients about what to expect and answer their questions.** Communication with the patient, family and advocates is also imperative. All must understand what to expect each day—from laboratory evaluations to radiological or invasive procedures—and the reasons for the testing. Such communication is not an accessory to care but an important component of the overall care.
5. **Communication with family, as approved by the patient, should be coordinated by a designated family member or advocate.** Though the objective is to keep all informed, the very nature of human communication creates potential for confusion. Such confusion can arise when multiple family members receive clinical information at different times. Even when consistent information is provided, family members may perceive that they have received differing and/or conflicting information. Patients can avoid this stress by delegating a family member or advocate to be responsible for relaying medical information.

#### **Perspective on the ER**

*Sam went to the emergency room around midnight after experiencing severe pain due to a kidney stone. The nurse in charge of the reception area moved Sam directly into the examination area and had his wife complete the paperwork. Nurses immediately inquired about Sam's problem, asked him to change into a hospital gown and put him on a gurney. Immediately, a doctor examined Sam, gave instructions on the treatment and took the time to tell him exactly what the treatment would be. An IV was started to help push the stone and relieve the pain. Nurses, who checked on Sam often, told him that a CT scan would be performed around 7 a.m. They explained when he would probably be released, depending on the amount of pain he felt. Although a shift change occurred, the new physician was up to date on Sam's case. After the doctor reviewed the results of Sam's CT scan (performed promptly at 7 a.m.) and his pain subsided, Sam was released. His hospital experience was much better than he had expected.*

## Discharge Planning

- 6. Physicians should ensure comprehensive discharge planning.** The time of discharge typically represents a critical transition from dependent care to an alternate level of care or self-care. The physician in charge must communicate to patients clearly, in writing, any changes in medications as well as expectations with a change in level of care, diet or lifestyle activities. Any necessary ancillary services should be in place for the patient prior to discharge. The physician must arrange outpatient follow-up (including communication with other physicians when necessary) ahead of time, and patients must know whom to contact after leaving the hospital.
- 7. Patients should bring to the outpatient setting either discharge information or signed consent to release inpatient records.**

## Emergency Room

- 8. Almost no visits to the emergency room are planned or scheduled.** In many instances the patient's primary and/or specialist physicians may not be present or involved. For the most part, there is no concern about which physician provides care in the ER—only an expectation that he or she is capable of treating the injury or illness expeditiously. As with other care settings, **a caring and attentive emergency room staff and timely evaluations are vital to overall patient satisfaction.**
- 9. ER staff should communicate to the patient's responsible physician all arrangements for follow-up care and details of the particular visit.** Patients should receive in writing any changes in medications, diet, lifestyle activities and/or follow-up with their physician.
- 10. A strong patient-physician relationship should ensure that the emergency room is used for "true emergencies,"** not as a walk-in clinic or substitute for an office visit because the physician is unavailable or the office is busy.

### **Perspective on Discharge Planning**

*Mrs. Long was excited finally to be going home as she reached the end of a very long and complicated hospitalization. On the morning of her discharge, Dr. Taylor coordinated a team of discharge planners, who carefully reviewed all of Mrs. Long's needs. A nurse met with her and her son to review all the medications Mrs. Long was to take. A social worker arranged for a home health agency to visit with her in her home and made appointments for the physicians she was to see. The dietician carefully reviewed the diet plans ordered by Dr. Taylor, and the physical therapist reviewed her exercise program. When Mrs. Long left the hospital, she was pleased that all of her follow-up care had been arranged.*

## OUTCOMES

We expect these outcomes from an inpatient experience based on a sound physician-patient relationship:

- Restoration of health and function
- Minimized risk
- Minimized re-admission rate
- Minimized length of stay
- Minimized morbidity
- Minimized mortality

In inpatient experiences where the expected outcome is death (in the near term), there usually is agreement that care should focus on:

- Minimizing pain
- Mitigating fear
- Providing support and comfort

### Perspective on Communication

*Achmed, an insulin-requiring patient with Type II diabetes, was admitted to the hospital after experiencing abdominal pain and weight loss. On the morning of his scheduled CT scan of the abdomen, he received a full dose of 70/30 insulin—even though he was fasting before the test. While in the radiology suite he became lethargic and difficult to arouse, with a measured glucose that was dangerously low. Over the next two hours he responded to IV injections of glucose. However, the scan had to be postponed, necessitating an extra day in the hospital.*

Education is the "drug of choice" for prevention and treatment of every medical condition. The educational process is continuous and requires regular assessment and/or update. Education must occur in each element of the patient-physician relationship. Its main goal is to promote behavioral changes that are inherently difficult yet essential to achieving optimal health potential. "Behavior change" includes both therapeutic lifestyle changes and adherence to treatment recommendations.

## Perspective on Education

*Jane was diagnosed with Type II diabetes. Her endocrinologist gave her a glucose monitor to test and record her blood sugar levels, but she received no guidance or any written information about her chronic condition. The endocrinologist referred Jane to a nutritionist, who discussed Jane's condition, nutrition, exercise and weight control. Soon after Jane's diagnosis, a disease management company contacted her to discuss its role in helping her manage the diabetes. A nurse began asking questions about test results, such as blood pressure, blood sugar and A1C readings. Jane was familiar with the blood pressure and blood sugar readings but had no idea what an A1C was or how it related to diabetes. The nurse explained what it meant and how important it was to managing Jane's condition. In addition, the nurse sent literature to Jane about diabetes. Jane found these documents very useful. In fact, she studied the packets of information and found charts and recommendations that she could discuss with her endocrinologist. Jane is now educated about diabetes. She feels empowered to make sure her physician follows the standards of care for her treatment.*

## Perspective on Patient Responsibilities

*Dr. Mary sends all of her patients a copy of their test results. When a new condition is detected, she includes a one- or two-page educational paper with the results and asks the patient to review the information (their "homework") before returning to discuss the condition and review treatment options. Surprisingly, a large number of her patients said they "did not have the time" to do their homework before the follow-up visit—compromising their ability to participate in their health care.*

## RECOMMENDATIONS

Based on our discussions, we offer these recommendations related to patient education:

### Self-Care

- 1 Self-care (or self-management) involves improving one's health potential through education, monitoring, adherence to evidence-based guidelines and active involvement in the decision-making process with the health care team. **Patients and physicians must work as partners to create an ever-evolving self-care program** tailored to patients' resources, needs, desires and ability to understand. Physicians must encourage patients to be involved in self-care and offer resources relevant to the patient's condition.



2. **Education should address physician/patient knowledge differences, culture and language.** The level of education should be appropriate to the individual.
3. **Each patient should receive a tailored education package.**
4. **Physicians should be open to education by the patient.**
5. **Physicians should discuss with patients the risks associated with prescribed treatment** or recommendations (or failure to adhere to them).
6. **Patients should assume ultimate responsibility for managing their condition** and use self-care opportunities provided.

**Sources of Information**

7. **Physicians should furnish patients with educational materials or resources** such as: handouts, website links, health/self-care-oriented media (e.g., magazines, videotapes, CDs, DVDs, disease management programs), community support groups or seminars, group educational sessions, hospital-based medical libraries and health fairs/expos.
8. **Physicians should familiarize themselves with guidelines appropriate to a given condition and work with patients to understand and incorporate them into the treatment plan.** Expert panels, using results from well-designed clinical trials, have developed evidence-based guidelines for management of most chronic conditions. These guidelines validate and support treatments that lead to improved health outcomes. Adherence to evidence-based guidelines helps ensure cost-effective application of medical technology for testing and treatment. It also ensures that all members of the health care team consistently reinforce the educational message to patients.

**Perspective on Non-Medical Sources of Information**

*Tony visited Dr. Claire about his high cholesterol. In spite of his attempts to improve his nutrition, the cholesterol levels were still high enough to warrant treatment with a statin, an important family of prescription medications that have been shown to lower cholesterol and improve survival. Tony did not want to take a prescription medication yet, partly because of the low risk for liver inflammation associated with statin drugs and partly because of the drug's expense. He had visited a local health food store and wanted to start an herbal product. Dr. Claire researched the product, Red Yeast Rice, and found that it contains a low dose of lovastatin, a prescription drug in the statin family. Dr. Claire approved the use of Red Yeast Rice as long as Tony was willing to undergo the same laboratory monitoring as if he were using a prescribed statin. He agreed, and subsequent testing demonstrated adequate lowering of his cholesterol without evidence of liver inflammation.*

9. **Patients should assume responsibility for incorporating the guidelines into their self-care programs.**

10. Given the widespread availability of health-related information, patients may obtain information from resources other than those offered by the health care team (including the Internet, newspapers, friends, family, pharmaceutical-sponsored advertising and other non-medically trained sources). **Patients should share with physicians any outside information with providers involving changes in the prescribed treatment program.**

11. **Physicians should remain objective when reviewing outside information**—including the use of alternative/non-traditional therapies, which can range in value from potentially harmful to of no proven benefit (or danger) to valid and useful.

### **Perspective on Social and Cultural Factors**

*Dr. Alice diagnosed Javier with high blood pressure during his initial visit and gave him a new prescription and a handout on a low-fat and low-salt diet. A week later, Javier called the office asking for a referral to a dietician who could teach him and his wife about substitutions they could make while preserving their traditional Hispanic diet.*

## **OUTCOMES**

We believe that following the above recommendations will lead to:

- Improved patient recognition of important symptoms
- More informed decisions by patients
- Positive patient behavior changes
- Patients taking a more active role in their care
- A strong foundation to facilitate self-care
- Improved clinical outcomes

# I n t e g r a t i o n

In the context of the patient-physician relationship, integration involves the shared responsibility for assimilating all clinical information into a readily accessible format for all members of the health care team. Having accurate and current medical information available enables physicians to obtain a complete picture of each patient. It also promotes better care, reduces waste, improves efficiency and avoids duplicating services.

## RECOMMENDATIONS

Based on our discussions, we offer these recommendations related to integration:

### Navigation/Facilitation

1. The medical system is a complex entity that includes all facets of health care delivery inside and outside the office or hospital. **Physicians (or their staffs) should facilitate patients' movement through the system in a prompt and efficient manner**, recognizing that in certain circumstances patients may prefer to take primary responsibility for scheduling medical services with specialists.
2. **Patients who choose to schedule their own appointments with specialists should recognize their responsibility to inform the primary physician** about this preference and the results of those interactions.

### Information Sharing

3. Sharing medical information among all members of the health care team in a timely manner is critical. **Physicians should make every effort, with patient consent, to send relevant clinical information (e.g., labs, tests, procedures) to appropriate members of the health care team.**

### **Perspective on Information Sharing**

*Dr. Robert saw a new patient, Dawn, a 53-year-old female with multiple medical problems who transferred to his practice because of a change in insurance carriers. Dawn knew little about her medical history, and Dr. Robert saw her without the benefit of past medical records, test results or a personal medical record. Routine testing revealed abnormal liver results, which Dawn stated was a new problem. Dr. Robert ordered additional diagnostic tests. Only when Dr. Robert received medical records from Dawn's previous physician did he discover that Dawn had abnormal liver tests for several years; all of the additional tests he had ordered had been performed just 14 months earlier, with the same results. Had Dr. Robert received this information, he would not have ordered the additional tests.*

### **Perspective on Facilitation**

*Christina owned her own business, and her busy schedule varied from day to day. Her primary physician, Dr. Anna, wanted Christina to see a dermatologist to evaluate some suspicious skin lesions. Christina wanted to schedule her own appointment, but Dr. Anna insisted on having her staff schedule it for her. After several unsuccessful attempts to find a time that Christina was available to be seen, they allowed her to schedule her own appointment.*

4. **Both patients and physicians recognize that an electronic medical record is the optimal method for having current medical information readily available to the health care team.** This record is crucial to care coordination and a key mechanism for facilitating the accurate sharing and integration of medical information.
5. The personal medical record is a patient-maintained record of medical and surgical history, allergies, intolerances, medications (prescription and over-the-counter), social history (tobacco and/or alcohol use) and family history. The record can be a hard copy or in digital format, where it can be useful when an electronic record is not available or accessible. **Patients should take responsibility for owning, maintaining and sharing their personal medical records with all members of the health care team.** Patients should keep an abbreviated record with them at all times.
6. **Patients should insist on obtaining a copy of ALL TEST RESULTS (office, emergency room, hospital, etc.) to share with appropriate members of the health care team.** When copies of test results are included, an up-to-date personal medical record functions as a surrogate electronic record if the latter is unavailable.

### **Health Plan Information**

7. To coordinate delivery of health care services with each patient efficiently, **physicians must remain abreast of specific formularies and benefits for each health plan**, as well as testing facilities, participating hospitals and specialists.

### **Perspective on Personal Medical Records**

*Tim is a 68-year-old with several chronic diseases and a recently diagnosed condition requiring visits to multiple new physicians. On his home computer he began keeping a personal medical record to reduce the amount of time he spent relating his entire medical history each time he saw a new doctor. He kept his record on paper and also on a computer disk. He soon discovered that keeping and regularly updating this record had a profound effect on the sense of control he felt over his conditions. He worked harder at improving his lifestyle and no longer missed any doses of medication. He was able to play an active role in keeping all physicians up to date.*

8. **Patients have a responsibility to be knowledgeable about their health care coverage.** They can then make informed decisions about physician-recommended testing or treatment based on specific insurance policy coverage, understanding that some costs may be out-of-pocket. Physicians must inform patients of the available scientific evidence behind such recommendations.

## OUTCOMES

We believe that following the above recommendations will lead to:

- Patient-physician-developed strategies that offer opportunities for empowered patients to take a more active role in choosing treatment options and developing desired outcomes.
- Patient and physician recognition of the important medicinal value of a therapeutic rapport.
- Physicians viewing patients as whole persons, not just as diseases or organ systems. Likewise, patients viewing physicians as individuals who need trusting, honest and respectful relationships with their patients.
- Physicians continually recommending health-promoting lifestyle changes. Patients working to understand the importance of managing their diseases and taking responsibility when their lifestyles negatively impact their diseases and health outcomes.

### **Perspective on Health Care Coverage**

*After his older brother recently sustained his first heart attack at 47, Kevin worried that he might also be at risk for premature heart disease. He scheduled an appointment with his primary physician, Dr. Clint. Testing revealed that Kevin's routine cholesterol panel, glucose and blood pressure were normal. Dr. Clint informed Kevin that additional testing was now available to better evaluate his risk and provided him with appropriate printed information and Internet resources. After doing research, Kevin spent his own money to have the testing, which was not covered under his insurance plan. The tests showed that Kevin was at risk for cardiovascular disease. The testing helped guide treatment decisions to reduce his risk for heart attack or stroke.*

# Decision - Making

## Perspective on Decision-Making

*Sarah was scheduled for hemodialysis treatment on Mondays, Wednesdays and Fridays from 1:00 to 5:00 p.m. At each treatment, Sarah would ask to be removed one hour early, at 4:00 p.m. The physician was frustrated, believing that Sarah did not want to finish the treatment. In reality, Sarah was a single mother who had to pick up her daughter from school each day at 4:30 p.m. Sarah's priority was her daughter. A better treatment decision would have been to find a time of day that did not conflict with her family obligations.*

Decision-making in health care requires a complete understanding by the patient, from the physician, of the risks and benefits associated with all options, including the costs. It involves mutual conclusions between the patient and physician. Family members, designated patient advocates and other health care professionals also have important impacts on the decision-making process.

In facilitating this process, physicians should outline all treatment options (including those not covered by the patient's insurance plan) and discuss their efficacy. After providing explanations, physicians must assess patients' understanding of these options to ensure they have communicated clearly. Information provided by physicians should be current and conform to good scientific evidence.

## RECOMMENDATIONS

Based on our discussions, we offer these recommendations related to decision-making:

- 1. In the decision-making process, physicians should consider personal, religious, economic and psychosocial factors**—not just clinical factors—and include them in treatment options and scheduling decisions.
- 2. Physicians are obliged to see that patients receive sufficient information** to be able to ask questions and understand the answers and consequences of the decision.

## Perspective on Adherence to Therapeutics

*Mary Ann was diagnosed with hypothyroidism and began thyroid hormone replacement therapy. She came back for visits every 2-3 months. At each visit, she said she was taking the medication, but her laboratory tests showed no significant improvement. Her doctor kept increasing the prescribed dose to try to correct her thyroid level. In truth, Mary Ann had not been taking the medication but did not want to tell her doctor. About a year went by, and she decided she should start taking the medication. She began taking a very high dose of the latest prescription. She developed severe toxicity and nearly died. During a long stay in the ICU, Mary Ann finally explained what had happened. Her failure to adhere to the prescribed medication regimen inhibited the doctor's ability to make an informed decision.*

3. **Patients are obliged to educate themselves sufficiently to ask questions and participate in the decision.**
4. **Physicians and patients should explicitly define and discuss realistic expectations and goals regarding testing and treatment.**
5. **Patients have the right to know all of their evidence-based diagnostic and therapeutic options regardless of their physicians' personal beliefs.**
6. **Physicians should make patients aware of potential or real conflicts of interest resulting from their recommendations of diagnostic and therapeutic options.**
7. **Patients have the responsibility to fully disclose their adherence to recommendations for testing and treatment.** Less than full disclosure about use of prescribed medications can create significant safety issues. Physicians should provide an atmosphere that encourages honesty, allowing patients to feel free to discuss deviations from the treatment plan.
8. **Early in their relationship with physicians, patients should identify and define the role of all patient advocates who can participate in making decisions on their behalf.**
9. **Patients should be encouraged to document preferences for care in writing** for circumstances when they may be unable to participate in decision-making. Physicians and patients should implement previously accepted documents, such as living wills and powers of attorney, and place such wishes in patients' charts.
10. **Patients and physicians should be able to discuss their views on the use of alternative and non-traditional therapies as well as non-treatment.**
11. **Physicians should use evidence-based and patient-appropriate guidelines that recognize the individuality of each**

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### **Perspective on Documenting Preferences**

*Daniel, an elderly man with irreversible medical problems, was admitted to the ICU. The physician had had a close relationship with Daniel and his daughter, with whom Daniel had lived for the past three years. In the absence of a living will, his daughter and the physician believed that no artificial life-sustaining measures should be used. Daniel's son, the only other immediate kin, who had been away for several years and who had minimal contact with his father, felt strongly that Daniel desired a "chance." Daniel's failure to provide advance directives or name a legally designated patient advocate led to an otherwise avoidable conflict between his children.*

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**patient.** Physicians also must rely on the "art" of practicing medicine. Physicians need to recognize when strict adherence to guidelines and standards might not be in the best interest of their patients.

## OUTCOMES

We believe that following the above recommendations will lead to:

- All participants feeling that their input into a decision was heard and appropriately valued.
- Decisions that reflect best available evidence and patient preferences.
- Better patient adherence to treatment regimens.

### **Perspective on the "Art" of Medicine**

*Maria visited her primary care doctor complaining of low-back pain. She shared that her mother had recently died of breast cancer. The breast cancer had spread to her lower back, and the cancer diagnosis was made following an x-ray for low-back pain. Although Maria had no fever, weight loss or other signs of cancer, she expressed concern that her low-back pain might also be the result of cancer. The doctor knew that evidence-based guidelines would not dictate a diagnostic x-ray; however, the doctor ordered the x-ray at the time of the visit. The doctor believed that the back pain would most likely resolve without therapy. He also recognized that the x-ray itself was therapeutic in relieving Maria's anxiety about cancer.*



# O u t c o m e s

Generally, an outcome is the result of a process. We often define outcomes in terms of measurable data and a specific time frame for measurement. A good health care outcome, however, may be defined in different ways by different people who may not share the same perspective.

The overarching consensus of patients and physicians is that the quality of their relationship matters; the better the relationship, the better the outcomes of care will be. This view requires a mutual understanding of what those outcomes can and should be.

After much debate, we realized that patients and physicians came to our discussion with very different conceptions of what the word "outcome" means. They also had firm yet very different ideas of what "outcomes" should be. Repeatedly, patients and physicians expressed the view that "we both want the same things." However, they recognized that, in their respective roles of dispensing and receiving care, something frequently was lost in translation.

To bridge this gap in understanding, we believe that ongoing dialogue between physicians and patients about their differing views of what constitutes a good outcome is essential. Understanding these differing views will challenge physicians to go beyond their clinical experience and view outcomes through the eyes of their patients.

As a result of our discussions, we concluded that three general categories of outcomes might be impacted by the patient-physician relationship:

## **1. Clinical or disease-specific outcomes**

Physicians are taught to think of outcomes as concrete, measurable and modifiable endpoints in the care of patients. However, the relative importance of each outcome can be widely disparate, even among physicians within the same specialty. This type of outcome includes specific measures and treatment goals, usually based on range of a laboratory determination (for example, A1C < 7.0 is a measure of appropriate glycemic control in a diabetic patient). These outcomes may also reflect certain practice measures. Such technically oriented outcomes may be the only type recognized by traditionally educated physicians.

## 2. Patient-centered outcomes

Patients tended to focus on the impact of illness or the relationship with their physician on their lives. A patient might describe a good treatment outcome as *"treat the symptoms and cure the illness"* or *"minimize the impact of this disease on my life."*

Patients also recognized that the complex set of transactions set in motion to preserve or optimize health could affect multiple other dimensions of their lives, including the capacity to work, quality of life, financial state and self-image. This is especially true for patients with chronic illnesses who, in addition to the services they receive from physicians, face a substantial burden of self-care.

One patient identified the ability to self-manage effectively and with confidence as a key component of the definition of health outcome: *"My ideal health outcome would be if I could manage my condition with minimal treatment (i.e., doctor visits, medicines etc.) or complications (i.e., heart disease, renal failure, blindness, etc.) in order to live a productive, fulfilling, happy and long life."*

Meanwhile, one physician who had worked to improve the quality of bronchoscopy (a common invasive procedure in which a flexible camera is passed into a patient's lungs) wrote after gathering outcomes data: *"We believed that our colleagues would be motivated to perform the procedure in a way that resulted in less pain and more patient satisfaction. We were very surprised to learn that many physicians questioned the utility of these findings."*

## 3. Physician-centered outcomes

Discussions among physicians and the group recognized that satisfaction and life-oriented outcomes are also desirable to physicians for improving the patient-physician relationship. Physicians described these outcomes as: *"I want to be able to concentrate on the joy I've always felt in the practice of medicine instead of the worry that I have about paperwork of authorizations";* and *"At the end of the day, I feel good when I know I've connected with a patient and that it made a difference to both of us."*

Through the consensus process, we arrived at an expanded view of the outcomes of a good patient-physician relationship. Our view reflects patients' opinions that decisions about their health care impact multiple dimensions of their lives—and that these dimensions are of

paramount importance in defining a successful, satisfying health care experience. Many physicians, especially after participating in this process, reached the same conclusion.

In the patients' own words, "outcomes" were defined as "the particular mixture of quality of life, longevity, and cost (both in financial and physical terms) that gives one the most satisfaction after facing a particular health issue."

A physician provided a very similar definition: "Mutually respectful and fully understood agreement about the journey and outcome of the health care engagement or episode..."

Outcomes also should reflect the potential input and needs of other stakeholders in health care, including:

- Payers
- Employers
- Designated patient advocates
- Family members
- Society

Addressing outcomes for these stakeholders is outside the scope of this work.

## RECOMMENDATIONS

To maximize the effectiveness of the physician-patient relationship, we recommend that:

- 1. Patients and physicians should understand and discuss clinical practice outcomes.** We have defined elsewhere the barriers to achieving these traditional objectives. However, we recognize that physicians and patients alike must understand why evidence-based outcomes are important in order to achieve these objectives.
- 2. Physicians must appreciate patient-centered outcomes as valid objectives.** Physicians are not generally taught to recognize the voice or experience of patients as important contributors to desired outcomes. Physicians should specifically recognize patient-centered outcomes, which should be included in physician education. We believe that physician attitudes about patient-centered outcomes must be shaped in medical school and that scientific research must incorporate the patient's perspective into its objectives.

We recognize a number of other barriers to achieving desired patient-centered outcomes, including: insufficient or unreliable clinical information; lack of communication or inability to communicate effectively; lack of trust between patient and physician; lack of appropriate coordination of care; lack of physician cooperation; legal and societal barriers on the patient side; past experiences of patients; and the need to work with too many "caregivers." We have explored these issues elsewhere in this document.

3. **Physician-centered outcomes must be objectively defined and advocated in the health system.** Perhaps one reason that so many physicians tend to focus on numeric or scientific outcomes, instead of patient-centered outcomes described above, is that they sometimes forget to include their own needs in the practice of medicine.
4. **Physicians have responsibility for providing patients with information and tools for self-care, and patients have responsibility to take advantage of them.** Because the pursuit of outcomes is itself a process, the challenging question of measuring the outcome of self-efficacy as a byproduct of a good patient-physician relationship remains open for discussion.

# A f t e r w o r d

In addition to developing and distributing this consensus document, the conference sponsors have arranged to evaluate the impact of the conference on the relationships among the physician-patient participants. The hypothesis evaluated through this research is:

**Patients and physicians will indicate enhanced understanding of aspects of the patient-physician relationship on a survey after participating in a focused meeting.**

The evaluation includes a survey of physician and patient participants administered before the meeting and again one to six months afterward to measure change in attitudes, beliefs and self-reported actions. Results from this research will be released when available.

In addition, while the stated purpose of this document is to define an ideal state of the patient-physician relationship, the conferees also recognize that there are times when it may be necessary for one party or the other to terminate that relationship. In such circumstances, the conferees concurred that each party has a responsibility to assure a smooth and safe transition to a new physician.

# Definitions

**CAREGIVER:**

One who assists in the delivery or implementation of a patient's treatment plan. The caregiver may also be acting as the patient advocate (see definition below).

**CLINICAL INFORMATION:**

A record of the patient's past medical/surgical history, allergies, intolerances, medications, social history and family history.

**COMMUNICATION:**

Communication addresses the following aspects of the patient-physician relationship:

- Participants and their roles
- Threats to communication
- Vital ingredients or components of effective communication
- Necessary environment and processes to build/support good communication
- Outcomes of optimal communication

**DECISION-MAKING:**

The process by which some or all key participants determine care and desired outcomes.

**EDUCATION:**

The movement of information from an informed source to one who is interested in or benefits from that information.

**ELECTRONIC MEDICAL RECORD:**

A computer-based system of maintaining a patient's medical record in digital form. Eventually, technology may allow methods for confidentially sharing this information with members of the health care team.

**EVIDENCE-BASED GUIDELINES:**

Systematically developed statements derived from relevant research and clinical expertise that are intended to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

**HEALTH CARE TEAM:**

All members participating in the delivery of health care services to a given patient under the guidance of a physician. This team may include the patient, primary physician, specialist

physician (office or hospital), physician assistant and nurse practitioner, in addition to non-physician ancillary personnel such as a nurse educator, physical therapist and optometrist.

**HOSPITAL EXPERIENCE:**

The comprehensive experience of care during a hospitalization.

**HOSPITALIST:**

A physician who serves hospitalized patients and returns them to their primary care physician upon discharge from the hospital.

**INTEGRATION:**

Shared responsibility for assimilating all clinical information into a readily accessible format for all members of the health care team.

**MEDICAL BEST PRACTICES:**

State-of-the-art medicine delivered in the most effective yet efficient manner, resulting in improved patient health and reduced medical cost.

**OFFICE EXPERIENCE:**

The comprehensive care experience in the physician's office.

**OUTCOMES:**

Results, products or effects of delivering health care.

**OUTSIDE INFORMATION:**

Medical information obtained from resources other than the patient's physician. Such sources may include friends, family, co-workers, newspapers, Internet and alternative care physicians. Outside information may or may not be medically valid.

**PATIENT:**

An individual who receives medical attention, care or treatment.

**PATIENT ADVOCATE\*:**

A person acting on behalf of or in collaboration with the patient. Advocates are often used by individuals who may be impaired by age, disability, mental/emotional state or chronic illness. An advocate's role may include helping patients capture information during the office visit, reviewing the office visit, conducting additional research about the patient's condition, communicating with family members, serving as a sounding board for the

various therapeutic options presented by the physician, making logistical arrangements for visits/treatments, and assisting with insurance issues.

*\*Notwithstanding existing legal definitions, the definition above is intended to depict the vital interaction between the patient, patient advocate, physician and/or the physician's staff.*

**PATIENT-PHYSICIAN RELATIONSHIP:**

A therapeutic relationship based on trust, honesty, respect and a mutual desire to improve health outcomes.

**PERSONAL MEDICAL RECORD:**

A patient-maintained record of medical and surgical history, allergies, intolerances, medications (prescription and over-the-counter), social history (tobacco and/or alcohol use) and family history. The record can be a hard copy or in digital format, where it can be useful when an electronic record is not available or accessible.

**PRIMARY PHYSICIAN:**

The physician responsible for the general medical care of a given patient. The primary physician is trained to care for the majority of health care issues that a patient will face.

**SELF-CARE:**

The concept (also termed "self-management") of improving one's health outcome through education, monitoring, adherence to evidence-based guidelines and active involvement in the decision-making process with the health care team.



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