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The Leading Edge

Structuring the patient–physician encounter: Joint creation of an actionable roadmap to health

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ABSTRACT

The patient's experiences and costs related to their care are largely dictated by each patient–physician interaction along the continuum of care. However, the amount of time that a physician spends with a patient creating a medical action plan is highly variable and often not related to the severity or complexity of the patient's condition. Adding a structured process to guide and inform patient–physician encounters, including outlining expectations and follow-up by both sides is needed. Addressing these barriers to the physician–patient relationship would reduce variation in care, minimize unnecessary trial and error tactics and instead focus on predicted cost effective actions.

1. Introduction

While there is much discussion about appropriate roles and responsibilities for both the provider and the patient within the healthcare system today, there is no debate on the fact that the current situation is untenable. And while universal access in the current reform plan is a laudable goal, we will not be able to sustainably achieve it unless we fundamentally change our system. As a result, there is now an even greater critical need to provide quality care at a lower cost. Solutions to efficiently deliver care have been left to providers. Solutions to efficiently pay for care have been left to insurers, patients and for some, their employers. There are few, if any, systematic partnerships – each player needs to solve their own problem. The failure to create and adopt integrated care delivery systems will result in increased financial losses for health care systems and increased out-of-pocket and insurance expenses for patients. Thus, the fundamental building blocks to create an effective and efficient quality healthcare delivery system still need to be identified, articulated and executed.

An important element is an engaged partnership between the patient and physician that embodies and promotes shared responsibility and trust through actions over time by both parties. How do we create this today? What factors lead to a sustained partnership between a patient and physician?

The patient's experiences and costs related to their care are largely dictated by each patient–physician interaction along the continuum of care. The physician's decisions and activation of a medical diagnostic and treatment action plan is the main driver of health care costs and sets the tone of the patient's experience in the healthcare system. Additionally, the patient's demand for tests and treatments and lack of compliance can further drive up costs. Despite this, the amount of time that a physician spends with a patient considering and creating this medical action plan is highly variable and often not related to the severity or complexity of the patient's disease or condition. The office visit has become a "black box" with no formal structure or predictable outcome. The lack of structure becomes even more critical as cost and time pressures are shortening the direct patient interaction time during the visit.

The cornerstone of the patient's interaction with every part of the system is the initial and subsequent physician office visits. This is the moment where a critical action plan is defined and responsibilities are outlined – formally and informally. Patients take away "the answer" and physicians begin to line up the resources around them to solve "the problem". This is the time and place to ensure that effective communication takes place and resources are being used efficiently. Patient–physician office encounters are also critical in building a trusting and productive working dynamic between the physician and the patient. Without addressing this fundamental access point in health care delivery, care will continue to be fragmented and costly. Adding a structured process to guide, inform and document the patient–physician encounter, including outlining expectations and follow-up by both sides is needed. The rules of engagement between

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the patient and physician must be redefined to successfully create this structure.

2. Today's barriers

The barriers to achieve quality care at a lower cost have been articulated in many articles in the past several years with a rapid proliferation since the enactment of the Accountable Care Act.[1] But questions remain – what is preventing us from achieving sustainable, desirable health outcomes at a lower cost? Will providing structure to the patient–physician interaction be a solution? If we look at this dynamic, a number of barriers to the patient–physician relationship are evident as shown in Table 1. These challenges may be exacerbated by differences in patient expectations based on cultural norms, socio-economic status, and varied access to care and technology.

3. Role of shared health decision-making and barriers to implementation

One approach to overcoming the barriers to an effective patient–physician relationship is through implementation of the principles of shared health decision-making. These principles are based on the effective exchange of information between a provider and patient where medical options based on best practices are vetted and patient desires elicited.[2–6] This is the foundation for creating a joint action plan between a patient and their physician. Although this process of shared health decision-making is considered a critical element of patient engagement, it is rarely achieved in routine clinical practice. This is despite the fact that 86 randomized trials engaging shared decision-making with decision aids in the form of pamphlets, videos or web based tools, demonstrated greater patient understanding of the treatment choice, improved knowledge and realistic perception of outcomes.[2] Physicians generally spend only a small fraction of a 20 min office visit discussing the treatment plan, with shared decision making occurring in only 9% of out-patient office visits.[3,4]

Further exacerbating this problem is the fact that the communication skills necessary for shared decision-making are not routinely taught to physicians and how choices are portrayed need to take into account health literacy and cultural preferences or differences.[5,6] The fact that 80% of the information verbally shared by the provider is forgotten by the patient within 24 h[4,7,8] emphasizes the need to develop written/electronic care plans that can be reviewed and acted upon by the patient outside of the office visit.

Not surprisingly, in a review of 41 publications addressing perceived barriers to implementing shared decision-making, the most commonly cited barriers were limited time, and the perceived lack of applicability to the patient or the clinical situation.[9,10] Positive factors were a motivated physician, and the perception by the physician that it would lead to a positive impact on the patient outcome and the clinical process. Elwyn et al.[6] recently proposed a conceptual approach to facilitate shared decision-making which includes (1) ensuring that the patient knows that reasonable options exist; (2) making the options known; and (3) supporting patient preferences and the decision on what is best. But even with well-intentioned physicians, this model fails if true two-way communication and shared perceptions are not achieved. In a study of patient involvement in immunotherapy for multiple sclerosis, patients' perception of

Table 1
Barriers to the patient–physician relationship.

The isolated transactional nature of the brief office visit	• **Longitudinal care plan** – Patient care is frequently a single snapshot rather than focusing on a longitudinal step-wise care plan beyond the office visit. • **Uncertainty in medicine** – Reluctance to admit uncertainty and incorporate this uncertainty into the step-wise plan; the failure to recalculate the diagnostic or treatment plan if the initial evaluation is unsuccessful. • **Lack of appropriate support systems** for the physician to offer adequate follow-up care through the use of non-MD personnel (e.g., Patient Centered Medical Home or mobile/electronic health solutions).
One-way communication from physician to patient	• **Time** – Little time to engage with the patient. • **No game plan for communication or training to create one** – No plan from the physician as to how to structure the office visit even if they had more time. Once the patient leaves the office, communication generally stops until next office visit. • **Patient perceptions** – Patients' blind faith in physicians – "the doctor knows best and must be right" resulting in an unwillingness or discomfort to ask questions. • **Physician perceptions** – Lack of willingness to engage the patient in their responsibilities for the next steps of their healthcare. As a result, patients quickly become confused or not interested in compliance for physician directed protocol. • **Reliance on technology for "the answer"** – The frequent reliance by physicians and the perception by patients that technology will result in a single clear diagnosis and/or treatment resulting in "silencing" of the conversation and a lack of discussion.
Lack of availability of condition relevant medical information	• **Physician time** – Not enough time to stay up to date on relevant medical advances and appropriate use of current technologies, tests and treatments. • **Physician information access** – Inability to access and appropriately utilize relevant medical information to inform current options for diagnostics and care for individual patients. This may be externally derived information or the physician practices' own internal information including continuous quality improvement. • **Accepting trial and error approach** – Both physician and patient accept trial and error as the standard of care rather than treatment plans informed by data. This is particularly relevant given the rapid changes in diagnostic technology, genetic testing, and the resulting personalized therapeutics approaches.
Lack of "Critical Thinking"	• **Premature diagnostic anchoring** – Reliance on pattern recognition and failure to consider more than one diagnosis. • **Delay in diagnosis** – Premature diagnostic anchoring results in no preemptive plan for alternative diagnostic strategies, leading to a delay in the time to diagnosis and appropriate treatment plan. • **Longer cycle time** – As a result, the "cycle time" from presentation of the problem to activation of an effective solution is prolonged.

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