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Telltale signs of patient-centered diagnosis

Abstract: A best-selling book from the mid-1980s was entitled, *All I Really Need to Know I Learned in Kindergarten*. Some doctors may similarly feel that well-worn epigrams from Hippocrates, Osler and others have told them all they really need to know about patient-centered care. The problem is that aphorisms and action are not one and the same. The workup for patient-centered diagnosis takes work, and there are telltale signs along the way. Effective patient engagement requires training and practice. It means incorporating patient-generated data into the diagnostic process. And it means being sensitive to new economic constraints on patients. Ensuring that diagnostic processes and decisions meet the test of patient-centeredness poses a challenge. The new criteria do not replace the professional obligation of beneficence; rather they add an additional obligation of power sharing. While that is neither simple nor easy, it promises better care for patients, a more satisfying clinical encounter and a better health care system for all.

Keywords: agenda setting; diagnostic error; doctor-patient communication; Institute of Medicine; patient-centered care; patient engagement; patient-generated data; remote monitoring.

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A best-selling book from the mid-1980s was entitled, *All I Really Need to Know I Learned in Kindergarten*. Some doctors may similarly feel the well-worn epigrams they learned about in the first years of medical school taught them all they really need to know about patient-centered care.

For instance, there is this from William Osler: “Listen to the patient; he is telling you the diagnosis.” Is there any more succinct argument in favor of patient engagement?

For those sensitive to the power imbalance implicit in the terms “doctor” and “patient,” there is this chestnut from Hippocrates: “It is more important to know what sort of person has a disease than to know what sort of disease a person has.”

The problem, of course, is that aphorisms are not the same as action. A workup for patient-centered diagnosis takes work, and there are telltale signs along the way.

The first step is acknowledging that good intentions are not enough. A recent Institute of Medicine workshop on partnering with patients emphasized that “patient engagement is a skill, not a trait” [1]. The average physician conducts more than 150,000 patient interviews during a practice lifetime, making this encounter potentially “the most powerful, sensitive, and versatile [medical] instrument available” [2]. Achieving that potential, however, does not just happen. A prominent researcher put it this way:

Patient-centered care requires physicians and other healthcare providers to have the communication skills to elicit patients’ true wishes and to recognize and respond to both their needs and their emotional concerns. As much as any technical skill, communication is a sophisticated procedure—one that needs to be taught and honed throughout one’s career [3].

Although veteran practitioners are inevitably confident about their own communication skills, the average physician interrupts the patient’s problem statement after just 18–23 s [4]. If you, doctor, have not noticed this habit, it may be because we patients are prone to pardon the interruption. We want and need to trust you, so we forgive quite a bit when we check off those patient satisfaction ratings. We also blanch at saying something face-to-face, for fear of being labeled a “difficult” patient [5].

Besides, we know you interrupted us because you are eager to help, and we are aware you do not have a lot of time. Interestingly, in a study done in Israel – whose population is not known for passivity – patients who were not interrupted tended to talk for about 30 s in a primary care setting and just 90 s when speaking to a consultant [6].

That is right: we patients are really not too eager to talk your ear off.

The second step in getting to patient-centered diagnosis behaviors is breaking bad habits. Here, too, the evidence provides reason to pause. You and we might both suspect at some level that a quick interruption is a sign of dazzling diagnostic acumen – kind of like hitting the buzzer before Alex Trebek finishes the question on *Jeopardy*. Unfortunately, the truth is more like the scene in the children’s classic, *The Phantom Tollbooth*, where Milo suddenly finds himself on The Island of Conclusions. How

did he get there? “You jumped, of course,” a fellow island occupant explains.

That’s the way most everyone gets here. It’s really quite simple: every time you decide something without having a good reason, you jump to Conclusions whether you like it or not. It’s such an easy trip to make that I’ve been here hundreds of times [7].

Diagnosticians quick to jump on the patient’s initial complaint may never realize they’ve traveled to the Island of Incomplete Information. In a classic 1993 study of diabetics aged 60 and up making return medical visits, 56% reported they had one or more important medical problems that were never raised with their doctor [8]. Twenty years later, the conversational breakdown continues. A comprehensive study of the causes of diagnostic errors pointed to “process breakdowns” by practitioners “pressed for time,” a situation that hurt “the effectiveness of data gathering and synthesis in the patient-provider encounter [9].” Translation: “The doctor did not listen very well.”

A few examples of training available to replace bad habits with good ones include the Four Habits model (“Invest in the beginning; elicit the patient’s perspective; demonstrate empathy; invest in the end”); [10] a patient visit agenda-setting tool (“Better Health Conversations”); [11] and comprehensive programs including video recording and feedback [12]. These and other tools and techniques can ensure that patient engagement and workflow preservation peacefully co-exist.

But training is only a start. The third step in moving towards patient-centered diagnosis is embracing true partnering. The context and culture of today’s doctor-patient encounter are very different from even a decade ago, much less the time of Osler or Hippocrates. The subtext of the doctor-patient conversation was, historically, “Tell me what I need to know so I can decide what to do.” It is shifting to, “Let’s discover what we need to know to make a decision together.”

The verb tense “is shifting” is used deliberately. There’s been much attention paid to a 2001 Institute of Medicine report defining patient-centered care as “respectful of and responsive to individual patient preferences, needs and values [13].” However, the task of turning rhetoric into front-lines reality is a work in progress. Partnering is tough work.

Even physicians who vow support for shared decision making in theory act differently when observed in their office, according to a 2009 study entitled, “Physician as partner or salesman?” During patient visits, the study found, “only partial information was provided about the diagnosis, and most [information] focused on enhancing the chances of accepting the treatment option preferred

by the physician; seldom was there a two-way flow of information – patients and families values and preferences were not explored [14].”

Nonetheless, new arrangements that restructure clinical care, such as the accountable care organization and the patient-centered medical home, are anchored in expectations of clinician-patient partnership. When these arrangements involve Medicare or Medicaid patients, specific regulatory requirements add to the pressure. Moreover, partnering with patients is increasingly placed in an economic as well as clinical context. As the 2013 IOM workshop put it, “Prepared, engaged patients are a fundamental precursor to high-quality care, lower costs and better health [15].”

Better listening skills, breaking bad habits and pursuing partnership are all patient-centered actions that are particularly important in the diagnostic process. The first and most pressing task for the clinician is to “listen first, listen fully,” as an IOM workshop participant phrased it. That sounds easy; we know that for a variety of reasons it is not.

Just as difficult, though in a quite different way, is adapting to a shift in the entire context of the doctor-patient interaction. The slogan, “Nothing about me without me” started out as a patient demand for dialogue, but it is evolving into a description of technological change. When a smart high-school student can build diagnostic algorithms to determine whether a breast mass is malignant or benign or whether a patient has a certain type of leukemia, we’ve gone way beyond “Dr. Google [16].” More prosaically, diagnosticians must learn to incorporate patient-generated data, whether it is a hand-written record of blood sugar levels, sophisticated tracking of sleep habits by Fitbit or OMSignal biosensing clothing recording respiration and heart rate.

The National eHealth Collaborative convened an expert panel to identify use cases and best practices for sharing information between patients and providers and integrating patient-generated health data into clinical workflows. In a July, 2013 report, the group found “projects and experimentations going on all over the country [17].” They will only grow in number and ambition.

Another change in the doctor-patient interaction is economic. Rich benefit plans are an endangered species, and economic constraints on patients are increasingly common. Enrollment in high-deductible health plans grew from four percent of all employer-sponsored plans in 2006 to 17% in 2011. Those numbers are expected to be super-charged by various provisions of the Affordable Care Act. The cost of the test my doctor is ordering “just to be sure” could very well come out of my pocket. Ironically,

this new economic reality gives ammunition to those who have worried that current medical training relies too heavily on tests and not enough on the old-fashioned skills of listening to and touching the patient

Ensuring that diagnostic processes and decisions meet the criteria of patient-centeredness will be a challenge, not least because those criteria continue to evolve. Moreover, these new criteria do not replace the professional obligation of beneficence; rather they add an additional obligation of power sharing. That is neither simple nor easy.

However, the benefits that true patient-centeredness can bring were laid out in a recent article by pioneers in

the movement to improve diagnostic accuracy and reduce errors. The authors suggested that true patient-centered care could result in better care for patients, a more satisfying clinical encounter for doctors and patients alike and a better health care system for all [18]. That is a change that providers and patients alike can embrace.

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