



The Heart of the Matter

WILLIAM R. PHILLIPS, MD, MPH, FAFAP

THEODORE J. PHILLIPS ENDOWED PROFESSOR IN FAMILY MEDICINE
UWSOM, SEATTLE

I am running on a treadmill. Perhaps you are, too. Your treadmill may be meeting productivity goals for patient visits, building a successful academic career or balancing work and family. Mine is a real treadmill, the kind that gets faster and steeper every three minutes.

My treadmill exercise is part of my recovery from a big open-heart surgery about three months ago. I had my sclerotic aortic valve, which was too encrusted with barnacles to let blood flow out of my heart, replaced with a new artificial valve fashioned from parts of a horse. My seven-hour operation included some other maneuvers, but I will save you the anatomical details. The procedure went well, my seven-day hospital stay was uncomplicated and I'm doing better and better with my new valve.

I got great care and excellent results. The UW Medical Center is a beautiful facility staffed by highly skilled professionals. The process of care in the clinic was efficient, timely and pleasant. It's clear that they have engaged the Nordstrom customer service consultant. I have no complaints. However, I do have a few observations to share and some thoughts about what they might mean for family medicine.

Throughout the entire course of evaluation, surgery preparation and postop care, no one ever did a history and physical examination. Of course there was one on my chart—excuse me, in my electronic medical record—but it was not the result of anyone sitting down, asking questions, checking facts and trying to make connections between the dots. The document in my record was the result of cutting and pasting from previous documents. The H&P that followed me accreted errors and omissions along the way. It listed allergies I did not have, failed to mention past major surgery, and reported complications I never had. It seems that the patient, the document and the clinician are growing apart.

As in many of our offices, delegation is replacing integration in our patient histories, and format is winning over content in our records. Few believe computerization has made outpatient medical records a

better reflection of the life of the patient or the thoughts of the doctor. Current practice reengineering schemes, including the Patient-Centered Medical Home, are pushing the task of taking the patient's history down to the person with the lowest level of training and experience. Sir William Osler once directed that he would be happy to let any third-year medical student do the patient's physical exam, but he required to take the history himself. Do we believe the patient history is still important? If so, are our medical assistants prepared to provide the best of care?

If the patient history is no longer done and demonstrated by our best physicians, surgeons and teachers, should we expect students to master these skills?

Every encounter in the clinic and the hospital featured the clinician's engagement with the computer, usually first and sometimes foremost. Physicians and nurses now touch the keyboard more than they touch the patient. The set up is even worse in the hospital, with the computer located on the far wall, requiring the clinician to turn her back on the patient. No doubt the computer helped monitor my condition and improve my care. However, the documentation imperative now drives the clinical encounter. Let us not fool ourselves that a few tips from a practice facilitator can make up for the loss of devoted focus on the patient.

The map is not the territory and the medical record is not the patient, even when it is on a computer. Whether on paper or a computer, the records need to reflect the patient as a person and enhance, not block, communication and care.

What an irony that the Patient-Centered Medical Home that relies so heavily on computerization in primary care practices allows the computer to be such a barrier to the focus on the patient. If communication, touch and healing are to be part of our "best practices," then we need to continue the search for ways to make the patient the focus of patient-centered care.

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Surprisingly, the person who spent the most time with me—both before and after my operation—learning about me and answering my questions, was the anesthesiologist. If you add the surgery and recovery time, I am sure that the anesthesiologist spent more time with me than anyone else.

I did not have the privilege of having a medical student involved in my care, only one surgical intern who came in just to pull out my four chest tubes and one fellow who stopped by for a chat on some days.

Somewhere in the hospital, there must have been a team, but I never saw it. Complicated cardiothoracic surgery requires multiple clinicians, technicians and others working in concert to achieve optimum results. I trust that somewhere my attending surgeon was talking with the house staff, the nurses and the others involved in my care: RTs, PTs, OTs, etc. If so, it must've gone on down the hall; it never occurred in my room. Everyone came in one-by-one. I never felt like I had a relationship with a team.

As we move our practices to team-based care, we need to make sure the patient sees and feels that the care team is real and that the team really cares. If we plan to substitute the patient-doctor relationship with a patient-team relationship, we need to understand the consequences. How will these transformations affect continuity of care, doctor-patient relationships, patient adherence and the satisfaction of doctor, patient and other team members? These important questions have not been adequately studied, even though the answers may dictate the future of the specialty of family medicine.

I found that my most important relationship in the hospital was with my nurse. It is the RN and the nursing assistant, who work with you hour-by-hour, answer your calls and give you your treatments. I felt I got great nursing care by women and men who were devoted to my care, at least for a shift. As a patient, I tried to develop a relationship with each nurse, but found that the system made this very difficult. Most of our relationships in family medicine are with a patient over time and across encounters. Not so in the hospital. A new nurse comes on duty each shift. You do your best to connect with her and then she is gone. This key relationship lasts 8 or sometimes 12 hours. Neither patient nor the nurse knows whether you will ever see each other again. I felt the disruption

and disappointment more as the patient than I ever understood it as a doctor.

I appreciated the nurses and their care and I made a point of telling each one. The exchange of gratitude between patient and clinician is an important transaction and I worry that we do not give it the attention it deserves. How often, when your hand reaches for the doorknob as you leave the exam room, does the patient say, "Thank you doctor"? I suspect we don't hear—really hear—those heartfelt thanks nearly enough.

As I got better day-by-day, the nurses and I shared a sense of progress. One day was particularly difficult and we couldn't find anything to relieve my distress. At the end of the shift, I found myself saying, "I'm sure you are a great nurse, and I really appreciate your care; I'm sorry there was nothing we could do to make me feel better."

The process of care is a shared enterprise that engages patient, doctor, nurse and a team big enough to meet the needs of the patient and family. As medical care and medical education change rapidly, family physicians need to provide thoughtful and forceful advocacy on how we create and manage our healing relationships. When we work in teams we must be sure that, along with efficiencies, come feelings. Family medicine is based upon relationships and practice redesign schemes must be based, not just on the patient-centered medical home, but on relationship-centered care if we are to meet the most important needs of both the patient and the caring clinician.

As I continue to heal from my operation, my treadmill will get faster and steeper. I am sure yours will too. Let's work together so that the demands of practice, the pace of change, the power of technology and the charm of novelty do not draw us off course in our true work: the healing of hearts.

