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EDITORIAL

There is hope that health care may deliver on its promise

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SUMMARY
Health care is an increasingly bureaucratic environment in which key services are delivered. Individual practitioners can do little to reduce overarching burdens of working in such conditions. It is possible, however, to improve the experience of those who are being served, or even to improve outcomes by paying attention to details that are rarely considered when planning healthcare improvements. The interaction between healthcare practitioners and patients takes place in a private space and involves physical, emotional, and social exchanges that have been shown to impact the success of medical treatment. This editorial identifies the elements of the consultation that warrant special attention.

Key Words
Communication; Health care; Healthcare industry; Healthcare resources; Patient-reported outcomes

INTRODUCTION

Working in health care remains very challenging. Arguably, most healthcare organisations are now more bureaucratic than ever before and therefore more onerous to navigate. In the US, for example, one recent study reported that

> *During the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR [electronic health records] and desk work. While in the examination room with patients, physicians spent 52.9% of the time on direct clinical face time and 37.0% on EHR and desk work. The 21 physicians who completed after-hours diaries reported 1 to 2 hours of after-hours work each night, devoted mostly to EHR tasks.*[1]

Almost at the same time a primary care study concluded "Physicians spend more than one-half of their workday, nearly 6 hours, interacting with the EHR during and after clinic hours".[2]

These relatively recent data-collecting processes increase the burden on healthcare workers. The impact is reported to be similar across nearly all healthcare systems worldwide. Even the simplest task is now replete with administrative tasks that have little to do with clinical care. In one published perspective the author wrote[3]

> *Take inserting a cannula, for example, one of the most routine tasks performed in hospitals. A decade ago it was just quick preparation with an alcohol wipe, and*

> *then in it went. Job done. But now the skin must be cleaned for longer, the cannula inserted, and a non-return valve attached. Then the procedure has to be documented in the notes, including, inexplicably, the cannula's manufacturing batch number, and a separate form started for the visual inspection for phlebitis.*

The causes of job-related stress among healthcare providers include limited resources; government and or corporate micro-management; sensationalist media reports of medical errors and atypical unethical physician conduct; or challenges to the physicians' authority and skills by patients and other healthcare providers.[4]

At the same time, those living with illness—that is, patients—are reported to have increased causes for distress when navigating the healthcare environment. The stress points include limitation of access to services; inadequate healthcare staffing; rationing of services; poor quality of care; attitudes and behaviour of staff; and concern about media reporting of medical errors. [5,6]

There is not much an individual can do to immediately change how health care is funded, healthcare providers' working conditions, the demand for health care, or how that care is organised and coordinated. In the rest of this editorial, I will focus on what the healthcare professional may do today—despite the conditions or location in which they may be working. I propose that health care is not like any other industry. There is already equity in the provider-patient relationship that can be leveraged with attention to the key touch points in the encounter—that is, in the consultation between the only stakeholders (the patient and their healthcare professional) who are personally and privately involved behind closed doors.

When the circumstances are less than ideal, perhaps the only thing that can change is how people respond to one another and how the interaction unfolds. What isn't acknowledged often enough is that in health care the key interaction that usually determines a large part of the outcome, and therefore patient satisfaction, involves only two people behind closed doors, the patient and the healthcare practitioner who is being consulted on that occasion. I explored this in my book the *Art of Doctoring*: I reviewed much of the relevant published research and summarised my own research.[7] From the healthcare practitioners' perspective, several aspects of their interaction with patients can be altered without needing anyone's permission:

1. **The greeting:** It has been demonstrated that when a patient is greeted in a way that welcomes them to the clinic, office, or hospital, there are improved prospects for a better outcome.[8,9]

According to Makoul et al., "Most (78.1%) of the 415 survey respondents reported that they want the physician to shake their hand. We suggest that physicians initially use patients' first and last names and introduce themselves using their own first and last names".[8]

2. **The seating:** Where the patient is seated has been demonstrated to impact patient satisfaction.[10]

It isn't necessarily true that any seat is all that is required. The position and height of that seat relative to the other seat or seats in the room has been shown to have a significant impact on the exchange between patient and healthcare provider. When the patient occupies the bigger seat, the patient appears more engaged and empowered in the consultation.

This also applies in a hospital environment where patients prefer their provider to sit at the bedside during rounds rather than stand. According to Golden et al., "Patients perceived that residents sit infrequently. However, sitting was associated with other positive communication behaviours; this is compatible with the hypothesis that promoting sitting could improve overall patient perceptions of provider communication".[11]

3. **The meeting:** Many aspects of the meeting are amenable to vast improvement with relatively small measures such as more eye contact, exploring the patient's understanding of how health care works rather than framing it as a desire to add to the burdens on the practitioner. It is also important that the practitioner is aware of the limitations of their own knowledge.

Rare diseases are, by definition, rare (sometimes called Zebras), but they exist, and patients who have a rare disease can experience a long diagnostic delay (diagnostic odyssey) if a physician has not followed the breadcrumbs leading to a diagnosis. It has also been shown that physicians may not recognise the typical presentation of what may prove to be more common albeit "rare" life-limiting conditions.[12] Finally, it is important to end the meeting with the patient well. Practitioners who plan how they end their consultations may have better outcomes.[16]

Four issues have particular relevance to the impact on outcomes of meetings between healthcare providers and patients:

1. **Eye contact:** According to Silverman and Kinnersley, "an increasing body of work over the last 20 years has demonstrated the relationship between doctors' non-verbal communication (in the form of eye-contact, head nods and gestures, position and tone of

voice) with the following outcomes: patient satisfaction, patient understanding, physician detection of emotional distress, and physician malpractice claim history".[13]

2. **Context:** According to Kushida et al., "In medical consultations, patients and their problems are not only evaluated in medical terms but also in moral terms. For example, a patient who visits a doctor with trivial problems may be regarded as an 'unreasonable' person who is wasting the doctor's valuable time. And this type of evaluation by the doctor may influence their treatment of the patient."[14]

3. **Zebras:** As Flores et al. explain, "The lack of interest in recognising RDs (Rare Diseases) is a result of inadequate instruction and administrative management of people who are unaware of the prevalence, etiology, and manifestations of RDs as well as the forms of adequate and timely management, which directly harm the patients and their families, affecting them socially, psychologically, and economically and portraying them as rarely able to recover or are beyond recovery".[15]

4. **Ending:** Even on those occasions when the consultation starts off well, "there will still be patients who leave their most embarrassing or worrying concern to the end—when they, at last, have plucked up the courage to raise the issue. We must not brush aside the concern for the sake of short-term efficiency".[16]

As healthcare practitioners there is much we can do to change the way people experience health care. Some of these aspects are not given the consideration they deserve.[17] In the end, only two people are ever involved in the key exchanges of the intimate environment of the clinic, office, or hospital ward. The apparent attitude of the one who facilitates access to resources, the physician who has more power by virtue of their expertise can make all the difference to the outcome. But when it is done well the rewards are worth the effort. Jenkins sums it up well:

> *"most handshakes offered by patients towards the end of consultations reflect patient satisfaction—'the happy handshake'. Indeed, many reasons were recorded using superlatives such as 'very' and 'much' representing a high level of patient satisfaction—'the very happy handshake'".*[18]

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