

## Failing at Patient-Centered Care

By Michael S. Barr, MD, MBA, FACP

National Committee for Quality Assurance, Washington, DC

Many people use technology to help them through the day. We get anticipatory guidance about weather, traffic, appointments, birthdays, anniversaries, scheduled maintenance, pending credit card bills, and so on. We also rely on signs, maps, and GPS turn-by-turn directions to guide us to places we have never been without asking anyone for directions. Although technology can provide apps to help us move through life without interacting with other humans, for some needs, patients, families, and caregivers still rely on bipedal, carbon-based life forms called health care professionals to help interpret complex clinical information and provide insight, support, and guidance—and will do so at least for the near future. This is especially important when there are difficult choices or uncertainty and when those in need have no prior personal experience with the matters at hand. These responsibilities are central to providing patient-centered care and align with Osler's truism that "the good physician treats the disease; the great physician treats the patient who has the disease."

Unfortunately, the report by Khimani et al<sup>1</sup> that accompanies this article highlights the unintended consequences of failing at patient-centered care. There are several definitions of patient-centered care,<sup>2-4</sup> but each emphasizes essentially the same key elements: to help patients make informed decisions through education, support, respect, transparency, and partnership. An additional element of patient-centered care is to foster patient autonomy. This is one of the fundamental principles of the 2002 physician charter on medical professionalism, which includes the following component: "Physicians must be honest with their patients and empower them to make informed decisions about their treatment."<sup>5(p244)</sup> No matter how one defines patient-centered care, physicians and their teams must help patients, families, and caregivers understand what to expect at every point in an agreed-on care plan. These are universal responsibilities directly applicable to primary care and specialty care alike.

In the study by Khimani et al,<sup>1</sup> > 62% of patients responding to the survey were surprised to learn that their appointment for a benign hematologic condition was at a cancer center, and > 36% indicated that no explanation was received before their referral. The researchers found that 46.2% and 39.8% of patients experienced an increase in anxiety and stress, respectively. Almost one third of the patients thought the reason for the referral was an evaluation for cancer. These results indicate that the clinical teams involved did not provide adequate context for their patients and missed the mark on at least one important facet of medical professionalism: to educate and empower patients. Although this study focused on referring practices, the hematologists' offices could also have anticipated and addressed what is evidently a fairly common misperception among patients referred for benign hematologic conditions.

The literature is teeming with articles about attempts to achieve aspects of the triple aim<sup>6</sup>: to improve the health of populations, reduce per-capita expense, and improve the experience of care. The study by Khimani et al<sup>1</sup> points to a simple and low-cost opportunity to move the United States toward the triple aim, because research has demonstrated that providing adequate information and setting expectations with patients can lower anxiety and reduce unnecessary care.<sup>7,8</sup> Engaging patients and coordinating care are also two central components of the patient-centered medical-home neighborhood.<sup>9</sup>

There are several limitations to the study by Khimani et al.<sup>1</sup> It was small and focused on a single institution, and the population surveyed was not diverse. In addition, although the authors tried to control for it, almost 40% of the respondents had a history of anxiety, and 28% were actively being treated for anxiety. Finally, the survey tool has not been validated. Nevertheless, the findings should lead every physician and practice to evaluate the way in which patients and families are provided information about referrals and consultation requests. Although the authors hypothesize about the reasons for the lack of setting expectations, the study was not designed for that purpose. A follow-up ethnographic study would be informative.

Physicians are uniquely trained to process multiple sources of clinical information to evaluate, diagnosis, and treat those who entrust their care to us. These abilities are necessary but not sufficient when we consider the full spectrum of patient, family, and caregiver needs. As knowledgeable and technically savvy as a physician might be, it is human compassion, empathy, and guidance that patients seek—especially at a time of uncertainty and fear. There is no app for that.

### Author's Disclosures of Potential Conflicts of Interest

Disclosures provided by the author are available with this article at [jop.ascopubs.org](http://jop.ascopubs.org).

Corresponding author: Michael S. Barr, MD, MBA, FACP, National Committee for Quality Assurance, 1100 13th St NW, Suite 1000, Washington, DC 20005; e-mail: [barr@ncqa.org](mailto:barr@ncqa.org).

Michael S. Barr is a board-certified internist and Executive Vice President for the Quality, Measurement & Research Group at NCQA. Prior to joining NCQA, Dr Barr was Senior Vice President, Division of Medical Practice for the American College of Physicians where he was directly involved in policy development on issues including the patient-centered medical home, medical home neighborhood, interprofessional team-based care, and health information technology. Dr Barr was formerly the Chief Medical Officer for Baltimore Medical System, and served in the U.S. Air Force. In August 2013, he was appointed by Governor Martin O'Malley to the Maryland Health Care Commission. He continues to practice internal medicine part-time in Columbia, MD.

DOI: [10.1200/JOP.2014.002014](https://doi.org/10.1200/JOP.2014.002014); published online ahead of print at [jop.ascopubs.org](http://jop.ascopubs.org) on November 18, 2014.

## References

1. Khimani F, Curley B, Almubarak M: Survey of patients referred to a university cancer center for benign hematology: Quality measures and patient understanding. *J Oncol Pract* doi: [10.1200/JOP.2014.001543](https://doi.org/10.1200/JOP.2014.001543)
2. Institute of Medicine: *Envisioning the National Health Care Quality Report*. Washington, DC, National Academies of Press, 2001
3. Berwick, Donald M: What “patient-centered” should mean: Confessions of an extremist. *Health Aff (Millwood)* 28:w555-w565, 2009
4. Institute of Medicine: *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC, National Academies Press, 2001
5. Medical professionalism in the new millennium: A physician charter. *Ann Intern Med* 136:243-246, 2002
6. Berwick DM, Nolan TW, Whittington J: The triple aim: Care, health, and cost. *Health Aff (Millwood)* 27:759-769, 2008
7. Stewart M, Brown JB, Donner A, et al: The impact of patient-centered care on outcomes. *J Fam Pract* 49:796-804, 2000
8. Bertakis KD, Azari R: Patient-centered care is associated with decreased health care utilization. *J Am Board Fam Med* 24:229-239, 2011
9. Kirschner N, Greenlee MC: The patient-centered medical home neighbor: The interface of the patient-centered medical home with specialty/subspecialty practice—A position paper of the American College of Physicians. [www.acponline.org/advocacy/current\\_policy\\_papers/assets/pcmh\\_neighbors.pdf](http://www.acponline.org/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf)



---

**AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST****Failing at Patient-Centered Care**

*The following represents disclosure information provided by authors of this manuscript. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more information about ASCO's conflict of interest policy, please refer to [www.asco.org/rwc](http://www.asco.org/rwc) or [jop.ascopubs.org/site/misc/ifc.xhtml](http://jop.ascopubs.org/site/misc/ifc.xhtml).*

---

**Michael S. Barr**

*No relationship to disclose*