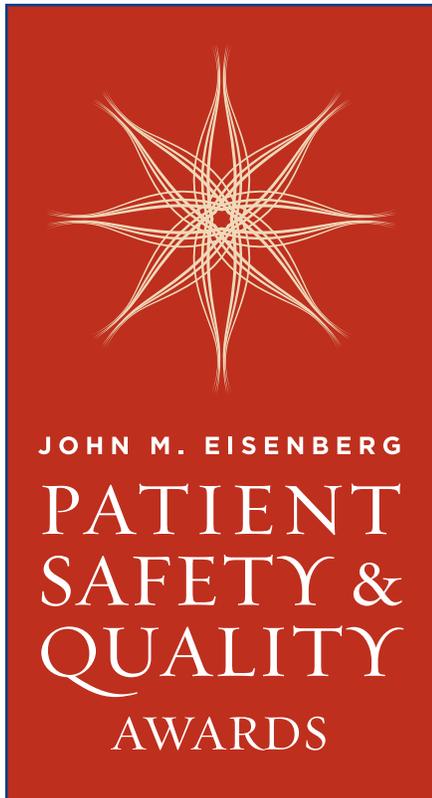


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Improvement from
Front Office to Front Line

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Forum

Patient-Centered Care: Just Ask a Thoughtful Question and Listen

Michael Buist, MB, ChB, MD, FRACP, FCICM

To provide *patient-centered care*, which has been defined by the Institute of Medicine as “care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions,”^{1(p.40)} we need to understand those preferences, needs, and values. Such understanding requires that we listen to our patients on the issues that matter to them and then do something about it. Furthermore, the ability to listen to our patients, most importantly, but also to our colleagues, is the underlying foundation for a culture of respect. A culture of *disrespect* has arguably been the primary reason for the slow pace of improvement in patient safety.²

What we, as physicians, generally do is to talk to our patients in our own “comfort zone.” This may entail, for example, getting consent for a procedure; for inpatients, giving an update on the day’s progress; and providing some thoughts on prognosis. But rarely do we provide our patients and their relatives the opportunity to really explain their own wishes and expectations. Doing just that would constitute a start to delivering truly patient-centered care.

After nearly a quarter of a century as a practicing clinician in internal medicine and critical care, it took two very personal events for me to appreciate the need to listen much better to our patients—and to realize that patient-centered care is not innate but needs to be taught and learned. The first event occurred on my birthday, in August 2009, when my wife had a stillborn baby at 26 weeks’ gestation. Three days earlier, she had noted a sudden decrease in the baby’s movement. We obtained an urgent appointment to see the obstetrician, who, at the start of the consultation, spent time telling the attending medical students about my wife’s rather interesting obstetric history. She then briefly listened for the fetal heart sound and, hearing a heartbeat, said to my wife, “There now, you are making it all up!” To further reassure us, she ordered a fetal ultrasound for that afternoon. That ultrasound revealed no fetal movement, which the obstetrician interpreted to mean that baby was just “lazy.” Later that day, my wife called me and expressed her concern, after which I in turn called my brother, an obstetrician. He asked me how long they had looked for fetal movement with the ultra-

sound and was it for at least 30 minutes, to which I responded that I didn’t know. Sufficiently alarmed, I expressed my concerns in a call to the obstetrician, who responded that the risks of getting the baby delivered at 26 weeks were too great. The next morning, my wife told me that the baby was still not moving and that if we didn’t do something, “we would be burying the baby!” I again called the obstetrician and we went for another ultrasound, which revealed no heartbeat. We subsequently learned from a professor of obstetrics that at 26 weeks the chances are 40% for good survival, 40% for poor survival, and 20% for mortality³—chances that we would have taken. While all this was going on, my wife kept thinking about how she was simply not being listened to.

The second event occurred shortly after, in October 2009, when I had self-diagnosed acute appendicitis, as I have previously described.⁴ In brief, I had an apparently noneventful laparoscopic appendectomy on an afternoon, only to wake up the following morning feeling “woozy.” A blood pressure level of 60 mmHg led the nurse to call in the medical emergency team, which made an electrocardiogram (ECG)-based diagnosis of acute coronary syndrome. I was given a loading dose of aspirin and 5000u of heparin. My issue was that I had to repeatedly tell the staff that I was not having a coronary event, as I knew that the changes on the ECG were all old. However, no one seemed to believe this until someone eventually got a copy of my old ECG. Eventually, I had to make the call that probably saved my life—to get the surgeon back to reoperate. At laparotomy, they found three liters of blood in my peritoneum, the result of difficult dissection and a small laceration from the inferior epigastric artery.

After being discharged from the hospital, I took three months off work from my job as an academic intensive care director and general physician at a major Melbourne hospital. I had time to think and reflect, something that is rare in our busy professional lives. These two personal events led me to the realization that we physicians do not really listen to our patients. It is not that we don’t hear our patients; we are very good at practicing “selective listening,” in which we pick out those patients’ words that

align best with our own clinical interpretation. For example, with reference to my wife's consultation with the obstetrician, I was able to acknowledge that I practiced exactly like that—with the misguided perception that I was a fantastic “teacher on the run.”^{5,6} I could get through a large number of patients, either in clinic or during ward rounds; receive a brief overview from my junior physicians (residents); and then rather than talk to the patient, I would educate the attending medical students in the attempt, as is apparent to me now, to essentially display my mastery of a particular subject. It is not that I wouldn't talk to the patient but that I was always seeking what I considered “pertinent” bits of information rather than the patient's perceptions and expectations.

Since then, I have fundamentally changed the way I do things; I devote my activities in clinics and ward rounds to spending time with the patient, as I encourage medical students and junior physicians to also do. I have made bedside teaching a totally separate activity, with a focus on teaching the medical students and junior physicians the cognitive methods to better understand the whole patient.^{7,8} This teaching has behind it the very fundamental principle of treating the students with respect as adults and equals. So in the very first teaching session, I ask the students about their background, their reasons for doing medicine, and their aspirations in medicine and in life generally. We cannot expect our juniors and students to take a real interest in their patients if we as their mentors are not really interested in them. The teaching of each student group (four to six, penultimate-year medical students) is done in four distinct 90-minute weekly sessions. The sessions are dedicated to getting the “real patient history” from the patient, as opposed to working according to the traditional student checklist of data points. The guiding ethos is to accept the patient as an educated adult who probably has a significant knowledge base and understanding of his or her illness. So rather than asking about presenting complaints and associated symptoms, we get straight to the point of asking the patients about what they understand about their current illness in terms of diagnosis, investigations, and prognosis. I am not saying that learning the skill of interrogating patients about specific symptoms is unimportant, it is just that it seems that this is all we teach and allow students to do. We, as their mentors, I find, need to give the students the permission to ask the real questions of a patient such as, “Now that you have told me about your bowel cancer, what has been explained to you about this, and what are your thoughts about all of this?”

What I find interesting in observing students and junior physicians taking histories is that, despite the checklist inter-

rogation, the patients will still try to tell the student something of importance to them, only for the student to move on to the next part of the history checklist. I call this the phenomenon of the patient trying to open the door to say something that is meaningful to him or her with the intention of helping the student. What I do is go back to that half-open door with the patient and open it up by allowing the patient to express his or her thoughts. Invariably, by doing so crucial information is relayed. How often do we hear from relatives, when we are doing the root cause analysis of serious adverse events, that they say that they tried to tell the staff what was going on, but nobody would listen? So it is all about asking thoughtful questions and picking up and following through with the clues that our patients give us. All too often, they know more and understand more than we give them credit for. We need to give our students the tools and, more importantly, the permission to ask the really important questions of the patients.

To be able to provide patient-centered care, we need to teach it and mentor it. The new mantra needs to be “ask each and every patient you see a thoughtful question,” and then listen to the answer and do something about it! **■**

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References

1. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.
2. Leape LL, et al. Perspective: A culture of respect, part 1: The nature and causes of disrespectful behavior by physicians. *Acad Med*. 2012;87:845–852.
3. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists: Number 38, September 2002. Perinatal care at the threshold of viability. *Obstet Gynecol*. 2002;100:617–624.
4. Buist MD. How I nearly MET my maker: A story of clinical futile cycles and survival. *Jt Comm J Qual Patient Saf*. 2010;36:334–346.
5. Lake FR, Ryan G. Teaching on the run tips 2: Educational guides for teaching in a clinical setting. *Med J Aust*. 2004 May 17;180:527–528.
6. Lake FR, Ryan G. Teaching on the run tips 3: Planning a teaching episode. *Med J Aust*. 2004 Jun 21;180:643–644.
7. Kaufman DM. Applying educational theory in practice. *BMJ*. 2003 Jan 25; 326:213–216.
8. Neuman P, Piele E. Valuing learners' experience and supporting further growth: Educational models to help experienced adult learners in medicine. *BMJ*. 2002 Jul 27;325:200–202.