PSNet
PATIENT SAFETY NETWORK

The "Customer" Is Always Right

February 1, 2007
Sehgal NL. The "Customer" Is Always Right. PSNet [internet]. 2007.
https://psnet.ahrq.gov/web-mm/customer-always-right

Case Objectives

- Understand the importance of identifying a patient's agenda.
- Appreciate the factors that contribute to unmet patient expectations.
- Define the concept of patient-centered care.

The Case

An 18-month-old female was brought to the family medicine clinic with a chief complaint of "rash and diarrhea." Five days earlier, the patient's mother noted a rash on her daughter for which she was advised to administer diphenhydramine (Benadryl) as needed. While the rash improved, the patient developed diarrhea and low-grade fever, prompting a visit to the clinic. During the visit, the mother also revealed that her daughter had fallen from a 1.5-foot-high bed a few hours earlier and appeared unsteady. The mother expressed concern that the child might have a fracture and requested an x-ray.

Physical exam revealed a fussy child with normal vital signs and no evidence of ecchymosis, edema, or localized tenderness in the extremities. The child was somewhat unsteady when placed on the floor to stand and remained uncooperative with an attempt to demonstrate her gait. The resident physician's diagnosis was a "viral syndrome" causing the diarrhea and low-grade fever. He attributed the child's unsteadiness to the Benadryl, perhaps exacerbated by the viral infection. He advised the mother that a fracture was unlikely based on the exam findings. The resident discussed his findings with the attending physician, although he did not specifically mention the mother's request for an x-ray.

Later that evening, the mother returned to the emergency department to request an x-ray because of her daughter's inability to bear weight. An x-ray was performed, which showed a nondisplaced fracture of the tibia, requiring placement of a cast. Frustrated with the sequence of events, the mother felt that her concerns at the first visit were not heard.

The Commentary

For patients and caregivers, this case is bound to generate a range of emotions. The patient or family member might think, "The incompetent doctor should have listened to me because I know my kid better than anyone." Or perhaps, "I should have pushed harder for the x-rays knowing something was wrong." And physicians might say, "I try to listen to patients and families, but if I do everything they ask, there will be no end to it." Regardless of the prism through which this case is viewed, the tension between a patient and family's perspective and that of a provider frequently results in frustration for all, as well as a potentially unsafe outcome. Is there a system fix that would have prevented this scenario? The answer is probably not, unless one defines methods to improve patient-provider communication as a "system."

To analyze this case, we need to consider the patient's agenda, unmet expectations, and the impact of "patient-centered" care.

Identifying the Patient's Agenda Cases like this, in which patients or family members report diverse and seemingly unrelated complaints, are common in acute care settings. Providers often react to a nonlinear history by moving quickly to focus on the "main problem" rather than identifying the broader or complete agenda. Although medical students are taught to begin their history-taking with open-ended questions such as "what brings you into the clinic today?", many providers frequently bypass such questions by noting the top line of the triage form and rapidly directing questions with that chief complaint in mind—as likely occurred in this case. Empirical research bears this out: Only one-third of clinic encounters begin with an open-ended question.(1,2)

Physicians may believe that open-ended questions are ineffective in getting to key clinical issues, although the evidence suggests otherwise. One study found a mere 59% concordance rate between physicians and patients in their understanding of the visit agenda. The rate increased to 85% when patients were given the opportunity to fully express their agenda or concerns.(2)

Why do providers fail to fully solicit a patient's agenda? Many providers worry that they simply lack the time to "open the box" and fear the effects of soliciting their patients' concerns in an open-ended fashion. It turns out that these time concerns are highly overestimated. It is well known that providers tend to interrupt patients' opening statements after only 18–23 seconds. Interestingly, when clinicians hold their tongue and allow patients to finish, patients complete expressing their agenda in a mere 6 additional seconds.(1,3) Effective techniques to elicit patients' complaints include using opening statements such as "what concerns do you have today?" or "how can I help you?" and then adding "anything else?" on repeated occasions. These skills can improve patient and physician satisfaction and prescribing practices and reduce the risk for malpractice claims.(4–7) Recognizing the patient's agenda should be taught, practiced, and evaluated as a specific communication skill and one that is equally as important as recognizing a typical "disease presentation."

Addressing Unmet Expectations What happens when the patient's agenda is not properly identified? Often, patients express dissatisfaction borne of unmet expectations. Studies suggest that nearly 10%–15% of office-based visits are associated with at least one unmet expectation, most frequently the result of physician omissions in history-taking, physical examination, or diagnostic testing.(8–10) While none of these studies addressed specific patient outcomes (e.g., delays in diagnosis), it seems likely that unmet expectations lead to unsatisfied encounters and, in turn, may increase the risk for poor clinical outcomes.

Patient satisfaction is typically assessed via surveys that focus on variables such as the time spent with providers, the quality of the interaction, and the perceived quality of care received. The direct relationship between meeting a patient's expectations and their level of satisfaction is obvious, although whether this relationship improves the quality and safety of care is a more complex question that has not yet been fully answered.

Patient-Centered Care: Does It Improve Patient Safety and Quality of Care? The Institute of Medicine, in their report Crossing the Quality Chasm, defines patient-centered care as "health care that establishes a partnership among practitioners, patients, and their families to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care."(11) The Picker Institute also produced a report on patient-centered care with a definition that included seven specific dimensions (Table).(12) Patient-centered care is simply a call for improved communication and collaboration with patients.

Imagine a patient who comes to the physician's office and states, "I twisted my ankle and I think I need an x-ray." After examining the ankle, the provider determines that the findings are consistent with a sprain and, based on the Ottawa Ankle Rules (13), makes a recommendation for supportive care and decides not to perform an x-ray. After discussion and counseling, the patient responds with, "I'm reassured that you think my ankle is just a sprain and that I don't need an x-ray." While the encounter fits the definition of patient-centered care, a greater challenge might have occurred if the patient still expected an x-ray. Would we characterize the encounter as having been patient-centered and reflective of quality care, even though the patient left unsatisfied? We can envision a number of similar scenarios where patients may expect a certain treatment or diagnostic test even when clinical guidelines would suggest otherwise. Patient satisfaction is one part of being patient-centered, but it shouldn't be the only component. Patients may ask for medications or procedures that could cause them more harm than benefit, and these situations frequently require further discussion about the risks and benefits.

However, as difficult as the above cases can be (particularly for providers facing such challenges each day), they may be easier than ones in which patients ask for tests that are deemed unwarranted by a clinician because they are expensive and low yield. There is an active debate over the role of patient-centered care in an environment of scarce resources, particularly since such care may well be more expensive.(14) Some argue that the patient is "the doctor's master" (15) and that the physician should follow the patient's wishes unless the requested service is harmful. Others argue that clinicians hold an obligation to restrict the use of very expensive, low-yield procedures, even when patients request them. These bipolar views demonstrate the extraordinary tension embedded in the concept of patient-centered care. Although no one would disagree that clinicians should listen carefully to patients and their families while trying to follow their wishes, few would argue that clinicians should do so when the effect would be patient harm or inappropriate use of limited resources. This tension means that measuring patient satisfaction in the absence of other quality and efficiency measures could lead to an undue skewing of the system in the direction of patient-centeredness at the potential cost of other important values, such as quality, safety, efficiency, and equity.

These policy considerations notwithstanding, the present case demonstrates how a patient-centered approach can, at times, markedly improve the quality of care. In this case, a more patient-centered

approach would likely have prevented the delay in diagnosing the child's fracture. Even if an x-ray was not warranted at that initial assessment, a discussion about "why" and a specific plan for follow-up may have reassured the parent (e.g., "If your daughter still seems to be having difficulty with her gait in the next 24 hours, please bring her back to see us as we may need to re-evaluate her leg"). Or the expressed concern by the mother may have caused the clinician to rethink his initial assessment of viral syndrome and medication side effect, potentially "unfreezing" his assessment and avoiding the possibility of anchoring bias.

Thoughtful promotion of patient-centered care deserves our commitment, whether we are organizing health care systems, training future generations of providers, or caring for individual patients. Many of our current systems appear to be designed to meet the needs of providers rather than patients, an observation supported by the lack of widespread adoption of patient-centered practices seen on a recent survey.(16) Organizations such as the Institute for Healthcare Improvement and the Robert Wood Johnson Foundation have partnered to develop initiatives to drive patient-centered care. Their *Transforming Care at the Bedside* effort is a framework for change on medical/surgical units built around improvements in (i) safety and reliability, (ii) care team vitality, (iii) patient-centeredness, and (iv) increased value.(17) In addition, professional societies have developed policy statements on patient-centered care, evidenced by a recent joint publication from the American Academy of Pediatrics and the American College of Emergency Physicians.(18,19) Even as we consider the practical impact of patient-centered care on safety, quality, and efficiency, we also need to reflect on the ethical and professional imperative to keep patients at the center of clinical decision-making.

Take-Home Points

- Using open-ended questions and eliciting a patient's full agenda require little additional time when done well. This communication skill should be taught, practiced, and evaluated in training future health care providers.
- Focusing on patient satisfaction independent of considerations of quality, safety, and efficiency creates an inherent tension that is important to understand.
- Patient-centered care is a necessary commitment, which may contribute to improved patient satisfaction and higher quality and safety in care.

Niraj L. Sehgal, MD, MPH Assistant Professor of Medicine Medical Director, UCSF at Mount Zion
University of California, San Francisco

Faculty Disclosure: *Dr. Sehgal has declared that neither he, nor any immediate member of his family, has a financial arrangement or other relationship with the manufacturers of any commercial products discussed in this continuing medical education activity. In addition, the commentary does not include information regarding investigational or off-label use of pharmaceutical products or medical devices.*

References

1. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA. 1999;281:283-287. [go to PubMed]

2. Dyche L, Swiderski D. The effect of physician solicitation approaches on ability to identify patient concerns. J Gen Intern Med. 2005;20:267-270. [go to PubMed]

3. Beckman HR, Frankel RM. The effect of physician behavior on the collection of data. Ann Intern Med. 1984;101:692-696. [go to PubMed]

4. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. J Gen Intern Med. 1999;14(suppl 1):S34-S40. [go to PubMed]

5. Collins KS, Schoen C, Sandman DR. The Commonwealth Fund Survey of Physician Experiences with Managed Care. New York, NY: The Commonwealth Fund; 1997.

6. Robbins JA, Bertakis KD, Helms LJ, Azari R, Callahan EJ, Creten DA. The influence of physician practice behaviors on patient satisfaction. Fam Med. 1993;25:17-20. [go to PubMed]

7. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. JAMA. 1997;277:553-559. [go to PubMed]

8. Kravitz RL, Callahan EJ, Paterniti D, Antonius D, Dunham M, Lewis CE. Prevalence and sources of patients' unmet expectations for care. Ann Intern Med. 1996;125:730-737. [go to PubMed]

9. Bell RA, Kravitz RL, Thom D, Krupat E, Azari R. Unmet expectations for care and the patient-physician relationship. J Gen Intern Med. 2002;17:817-824. [go to PubMed]

10. Peltenburg M, Fischer JE, Bahrs O, van Dulmen S, van den Brink-Muinen A. The unexpected in primary care: a multicenter study on the emergence of unvoiced patient agenda. Ann Fam Med. 2004;2:534-540. [go to PubMed]

11. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press; 2001.

12. The Institute for Alternative Futures on behalf of The Picker Institute. Patient-Centered Care 2015: Scenarios, Vision, Goals & Next Steps. Camden, ME: The Picker Institute; July 2004.

13. Stiell IG, McKnight RD, Greenberg GH, et al. Implementation of the Ottawa ankle rules. JAMA. 1994;271:827-832. [go to PubMed]

14. Bechel DL, Myers WA, Smith DG. Does patient-centered care pay off? Jt Comm J Qual Improv. 2000;26:400-409. [go to PubMed]

15. Levinsky NG. The doctor's master. N Engl J Med. 1984;311:1573-1575. [go to PubMed]

16. Audet AM, Davis K, Schoenbaum SC. Adoption of patient-centered care practices by physicians: results from a national survey. Arch Intern Med. 2006;166:754-759. [go to PubMed]

17. Rutherford P, Lee B, Grelner A. Transforming Care at the Bedside [white paper]. Boston, MA: Institute for Healthcare Improvement; 2004.

18. American Academy of Pediatrics Committee on Pediatric Emergency Medicine, American College of Emergency Physicians Pediatric Emergency Medicine Committee, O'Malley P, Brown K, Mace SE. Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. Pediatrics. 2006;118:2242-2244. [go to PubMed]

19. Patient- and Family-Centered Care and the Role of the Emergency Physician Providing Care to a Child in the Emergency Department [policy statement]. American College of Emergency Physicians Web site. Available at: http://www.acep.org/webportal/PracticeResources/ PolicyStatements/peds/ptfamctredcare.htm . Accessed January 26, 2007.

Table

Picker Institute's Seven Prime Aspects of Patient-Centered Care (12) Reprinted with permission from *Patient-Centered Care 2015: Scenarios, Vision, Goals & Next Steps*, Copyright The Picker Institute.

Respect for the patient's values, preferences, and expressed needs
Coordination and integration of care
Information, communication, and education
Physical comfort
Emotional support
Involvement of family and friends
Transition and continuity

This project was funded under contract number 75Q80119C00004 from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. The authors are solely responsible for this report's contents, findings, and conclusions, which do not necessarily represent the views of AHRQ. Readers should not interpret any statement in this report as an official position of AHRQ or of the U.S. Department of Health and Human Services. None of the authors has any affiliation or financial involvement that conflicts with the material presented in this report. View AHRQ Disclaimers