

## Editors' Comments

### *Service Behaviors That Create Heart for Members, Colleagues and Teams*

**Tom Janisse, MD, Editor-in-Chief**



This Fall issue is dedicated to Service, and includes several articles on the theme that has taken hold in Kaiser Permanente as the single most important competency we need to retain and attract members now and in the future. However, something befuddles many of us. We think that we have delivered good service. Our assumption has been though, that "good medicine" is the good service people want. Good service is not just an efficient delivery process. Rather, the unrecognized critical component is service behavior that creates a heart-felt experience for people. For example, acknowledge that the patient before you is an individual person, and then really connect with them, even momentarily.

### **The Primitive Eye**

Simple human regard, caring behaviors, the personal image we project, and our ability to develop meaningful relationships are the less objective, though more important, components of excellent service. Many of these, as you begin to delineate them, are basic human behaviors that create connection, comfort, and trust between individuals. Simple behaviors become very important because, in unfamiliar settings, strangers default to primitive feelings for clues. Actor Jack Nicholson, speaking about films, sums up for me what is at work in the healthcare encounter:

*"Even in the most sophisticated people, it is the primitive eye that watches the film."*

Clinicians have often missed this level of interaction because of their focus on the content - the words, the knowledge, the synthesis - and their emphasis on the physical aspects and tools of diagnosis and treatment. No training prepared us well for patients evaluating us on how they "feel" about our encounter, in addition to what they "think." Examining the questions we ask in the Star Membership Survey, "politeness and courtesy" are the proxy behaviors that patients often use to evaluate our "knowledge and competence." Since these two sets of behaviors are the ones most responsible for creating the highest member satisfaction, our service behavior must demonstrate this basic human regard. If we just exhibit "knowledge and competence," patients' satisfaction can drop twenty to thirty percent.

### **Concern and Hope**

Picture "Pigpen" (the Snoopy cartoon character) with the cloud of dust around him. Imagine this as an image

of the concern and emotional turmoil that people bring with them into our clinics, laboratories, hospitals and exam rooms every day. Patients flow into our system not only with "a physical concern," but also "feeling concerned." We have to recognize their concern and respond to it: with reassurance, with information and education, with assurances about our work-up, with the comfort inherent in a relationship. This satisfies people when they reflect on their medical encounter with us. If these service behaviors occur, then people are certain they have received the best "medical care." We know they have received the best medical "quality" because we have worked for years to create it. Great medical care is medical quality in the context of service quality. Consider for a moment a Charles Revlon quote:

*"In the factory we manufacture perfume,  
In the store we sell hope."*

### **Seeing Through The Routine**

What is routine for us often passes unrecognized for its significance as a personal human event. When people have a physical malady they can often be concerned for their life, especially in older age when the symptoms can be the first sign of cancer which could take their life in months. Even a symptom that may only keep them from work, or, lesser yet, may just limit their choice of food, causes great concern. All symptoms create anxiety about a change in life. Clinicians may recognize the low probability of a symptom meaning cancer, yet the patient's concern and feeling of impending doom may be full and alive until there is resolution either as a benign diagnosis or the symptoms abate. Many of us know how anxious we feel if our hot water doesn't work at home. What if it's your foot that doesn't work? This is the level of concern that we as clinicians must at least acknowledge and offer reassurance about, as well as offer information or understanding to allow a patient to quiet their emotional and psychological distress.

This is excellent service behavior in healthcare. At times it requires only a few moments or the right approach. Other times it requires many minutes that don't fit into the day's schedule. Clinicians need schedule flexibility to compensate for this. In at least one KP setting, lengthening the appointment time reduced patient demand for subsequent visits. Exploring this association could help to resolve the nearly constant outcry from clinicians that they don't have enough time with their patients to be a good doctor; even if this means not enough time to spend the few moments of pleasantries at the beginning of a visit that

help to create relationship. Or if there isn't enough time to clarify important or even unimportant questions, or appropriate education about a condition or treatment, then clinicians need more time. Patients need it. Is it okay to only leave a patient with the feeling that, "I'll either die or feel better"? More commonly, as a patient is left waiting or treated routinely, they ask themselves, "Am I worth their time?"

### Words From Clinicians Who Satisfy Patients Best

When clinicians from different regions who consistently have high patient satisfaction evaluations are asked what they do to create this, they commonly comment with a variation of the following:

- "I talk to my patients as a person."
- "I introduce myself. I shake their hand. I acknowledge their presence."
- "I explain things to them and involve them in decisions."
- "I am with them when they are with me."

In addition, these clinicians will compliment the people they work with:

- "My support staff should be being honored."
- "Great relations with people is only possible with great people to work with."
- "Consistent nursing staff and long-standing relationships satisfies patients."

### Serving Each Other

Great service behavior stems from attention to people as individuals, and making a real connection with them. How about your colleagues and co-workers? Recognize that each of us seeks good service from each other. We need good service, and we need each other to carry out our work well.

### What To Do?

First, become aware of your common, everyday interactive behaviors. Then add simple elements that may be missing. The most important of these is to connect, personally, for at least a moment. Slow your pace, look into their eyes, suspend your mind and body activity, and realize that this is a big moment. ❖

## Continuing Medical Education

**KM Tan, MD, Associate Editor**



I am delighted by the invitation to join *The Permanente Journal* Editorial Team as the CME Editor. As Tom Janisse mentioned in the Summer issue, *TPJ* is fulfilling its evolving role of serving the Kaiser Permanente clinician community by becoming a vehicle for Category 1 CME credit. As the CME Editor, I will have the pleasure and challenge of selecting four articles in each issue for CME credit, as well as serving as liaison between the Kaiser Permanente National CME Committee and the *TPJ* Editorial Team.

I am both a practicing radiologist and an administrative physician (I am Assistant Physician-in-Chief in Richmond, California). I have been involved in the politics of CME accreditation for close to 25 years—locally, statewide, and nationally. Currently I am a member and senior consultant for the Kaiser Permanente National CME Committee, which has just gained national accreditation.

This issue includes our initial offering of Category 1 CME credit in the form of four diverse articles. First, Jill Steinbruegge's clarion call to Permanente physicians to deliver superior care and service to our members is imperative for Permanente Medicine if we are to succeed in our mission to become the best wherever we are. Second, the review by Miller et al of the impact of antibiotics on emerging bacterial resistance patterns offers succinct suggestions for ameliorating this problem. Third, Drs Frankel and Stein's elegant treatise on distinctive describable behaviors found in our clinical encounters with patients should provide much food for thought as we review our own medical interviewing techniques. Finally, Lawrence et al discuss exercise-induced asthma, a common disease affecting a significant proportion of the population, and offer practical remedies for resolution. Reading these four articles, filling out the enclosed evaluation form and returning it will earn two hours of Category 1 CME credit.

I hope you enjoy reading these and the other articles in *TPJ* and find them useful and informative. We try to offer practical and meaningful information on issues affecting your practice, and we trust that the value-added inducement of CME credit will be appreciated. Let me know your thoughts. ❖

## Clinical Contributions

Arthur L. Klatsky, MD, Associate Editor



### The Single Patient Report (Case Report)

Among health professionals, presentation of narrative patient histories is the backbone of communication about patients. Most of us practice several of its myriad forms: ward rounding presentations, admission or discharge notes, outpatient intake notes, referrals for consultation or consultative responses, etc. Of course, quality varies widely, and we often appropriately abbreviate to the essentials needed for the purpose in mind.

In fact, a detailed narrative presentation about a single case closely simulates real medical practice: Both contain puzzles, mistakes, surprises, and satisfactions. It is easy to see why such presentations are also one of the mainstays of medical teaching, serving as a framework for all sorts of didactic and informal exercises. Properly done, sometimes with the patient present, reviewing the unfolding of a history offers endless opportunities for gaining insight. The feeling of direct or vicarious participation is an important element of the process. The Clinicopathological Conference (CPC), a variant of the patient report, adds interest by hiding the presumed definitive answer to a puzzling case from the discussant and audience until the end of the exercise. The CPC thus has an element of suspense.

In the past, single patient reports (perhaps a less dehumanizing term than "case reports") were also a mainstay of most medical journals. As medical knowledge has expanded, there has been a marked decrease in their number, probably because it has truly become more difficult to find single patient examples which present new concepts or which modify existing concepts. Many journals seek such new knowledge from all articles and, thus, give sole preference to new statistical analyses of data, detailed physiological dissertations, and comprehensive literature reviews or evaluations. Some journals have discontinued publishing individual patient reports altogether, but most continue to include a few. A notable example is the weekly *New England Journal of Medicine* CPC, a venerable but still popular feature of this publication. Readers who practice medicine resonate to the drama and intellectual stimulation of this format.

We agree with those who feel that there is value in well-written single patient reports, and we welcome submission of such reports. The writer should keep in mind the basic requirement that there should be a lesson or lessons for the reader of the report. This issue includes a single patient report (Daderian A. et al. *Esthesioneuroblastoma; A case report and current review of the literature*), which reminds us of the importance of constant vigilance for possible unusual explanations when common symptoms do not respond to treatment. It also includes an article based upon three patient reports (Miller et al: *Emergency Physician Performed Bedside Ultrasound Expedites the Diagnosis of Abdominal Aortic Aneurysms*), which shows how innovative application of available technology may enable rapid diagnosis of a surgical emergency. Most publishable individual patient reports will include something startling or unexpected. In medical practice, the unexpected always carries an implicit lesson; the report should make this lesson quite explicit. Sometimes, this can be expressed in personal terms; we are all humans struggling with decisions in daily medical practice.

The unexpected feature which makes the individual case report noteworthy is not always a rare diagnosis, or some feature of a commoner diagnosis rarely seen. Nor does it need, in any way, to involve laboratory tests or high technology. In fact, it may often consist of some historical feature which gives a clue about a diagnosis. This could be something learned from a surrogate because of cultural inhibitions about presenting certain types of information, failure of a usually effective treatment because of an unusual practice (cultural or personal), exotic travel, or more detailed family history than usually obtained. History remains the most important aspect of medical diagnosis. Such individual case reports are of value, as they always contain a lesson.

It is a given that the writer of a patient narrative will review the literature, but a single patient report need not and should not include a long bibliography. Better than this would be a selective, well-chosen list of about a half-dozen recent reviews as references. The article should be brief, with no more than six double-spaced typed pages, including references and one or two figures or tables. One final caveat: It is probably never wise to claim "the first" patient example of anything. No matter how esoteric a set of circumstances may seem, it is always likely that someone will point out a previous instance of exactly the same phenomenon!

So, please send us your single patient reports. If they conform to the above straightforward criteria, they will be a worthy addition to *The Permanente Journal*. ❖

## Health Systems

Lee Jacobs, MD, Associate Editor



### What will it take to improve KP service? Eight radical thoughts for the next millennium!

What will it take to improve KP service? In an issue of *The Permanente Journal* dedicated to service, this is a question that must be asked. Differentiating ourselves on the basis of service excellence will provide us with the ultimate competitive advantage. Here are eight thoughts on what might enable the Permanente Medical Groups to attain a service-based competitive advantage over the next several years:

1. We will get to the next level of service improvement only after we have team-based care with the appropriate leadership, problem-solving skills, and incentives necessary to address local service issues. The ultimate answers to resolving long-standing service barriers such as appointment access and waiting-room times will come from frontline, committed health care teams, instead of from regional initiatives and programs.

2. We will have to understand and acknowledge the value that nonphysician providers (eg, nurse practitioners, physician assistants, certified nurse midwives) bring to service improvement initiatives. Historically, we have focused on their contributions to efficiency. However, these providers generally have strong patient communication skills and can therefore bond with physicians to increase access, giving the real potential to add tremendous value to the service aspect of our organization.

3. At all levels—health care team, Boards of Directors, the departments—Kaiser Permanente will have to be increasingly intolerant of chronically poor service performers—including physicians. Should there be a future with Permanente for a provider who, regardless of tenure, is unable to attain acceptable patient satisfaction scores?

4. We will have to change the mindset that the “product” we provide is a physician in the exam room. Several other interventions probably meet the needs of patients (see article on DIGMAs in this issue) while benefiting providers of care, as well.

5. We will have to stop trying to tell the “customer” how to behave (“you can’t walk in—we are going to teach you a lesson!”) and start making operational decisions that are truly patient-centered instead of provider-centered. Yes, our patients are “customers” in every sense of the word, and it would be naive to believe that we can improve service levels without all providers of care coming to this conclusion.

6. We will have to establish clear measurements with targets that define service success, keep our focus on these targets, and make certain that our provider and team incentives and leader accountabilities are aligned to accomplish these targets. Stagnation in service scores means that some change is needed in leadership or in processes. Organizational impatience with poor service performance must permeate the Kaiser community.

7. We will need leaders who listen closely to the needs of the frontline caregivers and who do what it takes to support them in providing service excellence. Using tools such as the People Pulse Climate survey will need to be commonplace throughout Permanente.

8. We will have to proactively work on service enhancements in partnership with Health Plan. Only then will it be possible for Permanente physicians and other providers to excel in service.

What do you think about these eight ways for Permanente to enhance service in the next millennium? Let us hear from you! ❖

## External Affairs

Scott Rasgon, MD, Associate Editor



In this age of managed care, we find our organization being lumped with all managed care organizations. We all have felt the frustration of not being differentiated from other managed care organizations by the media. It is often difficult to get our message out to the public. The External Affairs section of *The Permanente Journal* illustrates the uniqueness of our health care organization. In particular, the article by Don Parsons illustrates the value of telling our story in our words. This is one way I believe *The Permanente Journal* will benefit the future of our organization. I hope the *Journal* has value for you in your work. ❖