A Focus on Patient-Centered Care and Office Practice Management

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William F Pfeiffer, MD

Historically, the medical industry has not been noted for excellence in customer service. With changing times, the need to address this issue has become more important. This article discusses the Pediatric Department at KP Honolulu’s approach to changing the systems to work for the end result: serving patients.

Staff Empowerment, A Prescription For Success.
Cynthia R Copp, MSN, APRN, CPNP; Christine Agpaoa, CMA; Sandra Carvalho; William F Pfeiffer, MD

By empowering staff and by equipping them with effective, reliable tools, leaders give all members of the team an opportunity to realize their full potential. This article explores the KP Honolulu Pediatric Department’s experience.

Optimal Office Practice Support: A Systemic Approach to Improving Efficiency and Support in Medical Offices.
Darla S Holland, MD; Darlene C Squires, M Sc, OD

In response to economic and practical pressures, the KP Orange Medical Service Area commissioned the Optimal Office Practice Support project. This article discusses the goals, processes, products, and learnings from this project.

Blue Sky Care Delivery 2015, Part 1.
Ruth Brentari; Terhilda Garrido; Robert Mittman; Louise Liang, MD; Allan Weiland, MD; Andrew M Wiesenthal, MD; Richard D Cordova

The Care Delivery IT Portfolio Advisory Committee sponsored two working sessions known as Blue Sky Vision Development and Implications. The objective was to develop a vision of KP’s future care delivery model. This article is the first of a three-part series that is an overview of those meetings, including the centerpiece case vignettes.

CPC Corner:
An Overview of Empathy.
James T Hardee, MD

Appropriate use of empathy as a communication tool facilitates the clinical interview. This article defines empathy and explores its uses, barriers, and value.

Physicians as Leaders:
What Physicians Can Do to Improve Patient Care and to Enhance Their Everyday Work Experience.
Deborah Konitsney, PhD

This article is adapted from a chapter, Focus on the Patient, in the resource guide, Creating the Best Place to Practice: What Physicians Can Do to Improve Patient Care and to Enhance their Everyday Work Experience.

Transitions of Clinical Information Systems.
Andrew M Wiesenthal, MD

A Perspective on the Women’s Health Initiative Findings.
Gavin Jacobson, MD

A MOMENT IN TIME
SCPMT Celebrates Its “First 50 Years”.
Chad Fifer

The year 2003 marks the 50th anniversary of the Southern California Permanente Medical Group. This article gives a brief overview of its history and the celebratory events planned for this year.

Celebrating a Medical Center’s Anniversary and an Emotional Reunion.
Steve Gilford

The 60th Anniversary of the Oakland Medical Center reunited a doctor and patient who met in 1941 at the naissance of the Permanente Medical Groups. Their story is detailed here as a reflection of the success of Dr Sidney Garfield’s dream.

PHYSICIANS IN THE NEWS

Physician News Roundup.
Barbara Caruso, BA

This is a brief outline of events of national significance within Kaiser Permanente.

Calling all Artists …
Submit your artwork to The Permanente Journal to be included in a medical artistic tradition of seven years. Interested? See page 74 for details.

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Submitting Artwork: Send us a high-quality color photograph of your art no smaller than 4”x5” and no larger than 8”x10”. Please include a cover letter explaining Kaiser Permanente association, art background, medium and a brief statement about the artwork (description, inspiration, etc). Electronic and e-mail submissions are accepted, 600 dpi resolution is required.

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Because this issue of The Permanente Journal focuses on patient-centered care, I thought it worthwhile to explore what this type of care might look like in our daily practices. Although physicians describe their practices as patient centered, in fact, upon closer scrutiny, many of our clinical practices may tend toward processes of care that are more provider centered than patient centered.

Patient-Centered Care Defined
In general terms, care is considered patient centered when the processes and culture (attitude and behaviors) of an organization, office, team, or individual practitioner address first and foremost the wants and needs of the patient.

To determine if care is patient centered, an assessment of several of the processes of the patients’ care experience can be undertaken:

- The service criteria consist of appointment accessibility and the level of effectiveness of the clinician-patient communication (see the Roundtable discussion on page 26).
- The affordability criteria consist of the deliberations and actions concerning the cost of care.
- The quality criteria include the assessment of diagnostic and therapeutic interventions based on what is most appropriate for the patient.

So How Does Your Practice Rate?
Answer these three questions to better understand where your team’s practice falls on the spectrum of patient- rather than physician- and/or staff-centered care:

1. Accessibility—When we consider schedule changes or process changes, do we first consider what the patient wishes and what the patient needs … or do we consider what works best for us—the physicians and staff?
2. Interpersonal—Do I listen to the patient to understand the feelings, perspectives, and desires of the patient and involve him or her in treatment options … or, since I am the trained expert and know what is best, do I tell the patient what to do?
3. Affordability and Quality—Do I keep abreast of the quality and cost options of care to provide the patient with the most appropriate choices … or do I simply go with the newest and/or the most expensive approach?

Patient-Centered Care—How Does Your Organization Rate?
Although our first reaction is to consider patient-centered care only at the team/office or individual practitioner level, a comprehensive assessment must also include the overall organization in which the teams and practitioners operate.

Here’s an interesting question for leaders of your medical group or health care organization to consider:
If the three questions listed above were asked of the leader of your organization, are you confident that s/he would conclude your organization truly puts the patient first?

If you and your organization’s leadership are not in full agreement with the responses to these key questions, I expect this topic will provide a constructive dialogue.

The Core Issue of the US Health Care Crisis: Individual Patient-Versus Population-Centered Care
The challenge: Balancing the needs of the individual patient with those of the community of patients. This is probably the most important issue confronting policy makers as they deal with the US health care system. Is there an inherent conflict in developing a health care program that is strongly patient centered while at the same time being sensitive to the needs of the overall population? Why do some feel it is appropriate to use Nexum for the individual patient and then complain about the cost of health care and the rising number of uninsured? Can care be provided so that it is both best for the individual patient and for the community?

The answer is absolutely “yes.” The organizational structure, incentive alignment, culture, and accountabilities of the Permanente Medical Groups provide a model that addresses this essential balance. The Permanente practitioners, along with their KP Health Plan partners, dem-
onstrate daily how physicians can be strong advocates for their individual patients while practicing in an organization that can justifiably claim to be doing what is best for the broader population of the community.

Unfortunately, this cannot be said for any other entity involved in setting health care policy! Not politicians. Not hospitals. Not pharmaceutical companies. Not solo practitioners. In these settings, the incentives and accountabilities are not aligned, so none is in position to be the best advocate for the individual patient and at the same time act appropriately for the collective communities.

Attention US policy makers: Only strong group models such as Kaiser Permanente can claim this advocacy position.

One Last Comment ...
Providing care that is patient centered—the goal of all of us called to serve in medicine—is, in many ways, more difficult today because of the changing role the patient has assumed in their care experience as well as the increasing financial tensions on the clinician-patient relationship. However, if we keep our vision of how we want to provide care in the forefront, we will continue to enjoy a level of professional satisfaction that can only originate from the caring of our patients.

So what do you think—is your practice patient centered? Is your organization patient centered?

Only strong group models such as Kaiser Permanente can claim this advocacy position.

letters to the editor

From our Readers …

The Permanente Journal,

I think the recent issues on weight management have been excellent, and feel that the article by Dr Willett should be required reading for every practitioner. I talked to one of our nutritionists who wasn’t aware of the articles and hadn’t seen the Journal recently. Could these two issues be sent to all of our Nutritionists?

Keep up the good work.

Stu Levy, MD
Family Practice, NWP

—Reply

We are happy to hear you found this series useful. We unfortunately are not funded for distribution to nutritionists. However, the full content is available online, and can be downloaded and printed. Please pass this information on, www.kp.org/permanentejournal.

Editor

The Permanente Journal,

I read The Permanente Journal with great interest. You do excellent work. In particular, I am always struck by the high quality of the art pieces and photographs you select. We have outstanding people in our program nationwide. The Journal is quite a treat in comparison with the marginal, and often very poor, work in The New England Journal of Medicine.

John Swartzel, MD
Internal Medicine, North Interstate Clinic, Portland, OR
Successful Practices in the Physician’s Work Environment

Three Regions: Three Levels of Development

Foundational Linkage Research

In 1998, *The Permanente Journal (TPJ)* published an article defining the value of linking performance measures from two different satisfaction surveys: employee and member.¹ The “Linkage” subgroup of the interregional Care Experience Council (CEC) explored the relationship between highly satisfied employees and highly satisfied members. They identified the employee survey questions that correlated with member satisfaction survey questions and then identified and interviewed those high-performing teams.² This information can be used to improve aspects of the work environment by focusing on activities that have the greatest potential return on investment.

Application of Research

As a refinement and follow-up process, the “MD Work Environment” subgroup of the CEC explored the linkage between physician and patient satisfaction. The key drivers of physician satisfaction were identified and found to be consistent with the key drivers of employee satisfaction. High-performing teams were again identified and interviewed. In 2002, *TPJ* published the research findings.³ A summary of the key findings can be found in the sidebar below, “Summary of Successful Practice Findings,” and the contrasting practices of the high-rated vs the medium- and low-rated teams are listed in Table 1.

Transfer of Successful Practices

To begin to transfer these successful practices, the Care Experience Council, in partnership with four regions, sponsored a workshop at the 2003 National Primary Care Conference, at which high-performing physician team leaders and team members discussed, in interactive sessions, their team development, processes, and tools. Three of those teams present summaries of their work in four articles in this issue. Hawaii pediatrician Bill Pfeiffer, MD, describes early multidisciplinary team development (page 32), and Cynthia Copp, ARPN, reviews the Hawaii team’s processes (page 37). Georgia internist James Hipkens, MD, recounts sustaining a high-performing team in the face of losing the founding team leader (page 29); and Southern California internist Darla Holland, MD, describes facilitywide implementation of improving efficiency and support in office practice (page 42).

This series of articles represents the culmination of linkage research leading to identifying key drivers of physician and employee satisfaction, leading to identification of high-performing teams, leading to team descriptions of processes and tools for high performance, leading to transfer of those practices. The two modes of transfer include interactive presentations at a national educational conference and publication in *The Permanente Journal* to communicate these results.

Summary of Successful Practice Findings

The teams with the highest morale and patient satisfaction were characterized by:
- The use of principles to guide behavior
- Leadership by example
- Team development
- Generous recognition, and
- Goal-setting within the team’s sphere of influence

The medium- and low-teams did well on some of the practice categories but hadn’t consistently addressed others. There were multiple routes to success—Each high-performing team found its own way to accomplish these five categories of successful practices.
Table 1. Contrasting practices of highly rated vs medium- or low-rated teams

<table>
<thead>
<tr>
<th>Team practices</th>
<th>Practices of highly rated teams (high physician and patient satisfaction scores)</th>
<th>Medium- or low-rated teams (medium or low physician and patient satisfaction scores)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connect principles and values of</td>
<td>Use principles to solve problems, align goals, and unify team (eg, “Treat patients &amp; team like family,” First in quality, first in service”)</td>
<td>Lack connection of principles to daily work</td>
</tr>
<tr>
<td>team and region to daily work</td>
<td>Value patients and team (spend time in team and individual development, eg, training, meetings, consultants, and facilitators)</td>
<td>Focus primarily on patient satisfaction</td>
</tr>
<tr>
<td>Service beliefs</td>
<td>Believe clinical and service quality are compatible goals</td>
<td>Believe quality and service are mutually exclusive</td>
</tr>
<tr>
<td>Demonstrate physician leadership by</td>
<td>Physicians communicate high standards, exemplify (not just talk about) what is expected</td>
<td>Less conscious of effects of modeling on each other</td>
</tr>
<tr>
<td>example</td>
<td>Include staff and Associate Providers (APs) in decisions—“Everyone has a voice”</td>
<td>Lack staff and AP input in decision making</td>
</tr>
<tr>
<td>Emphasize role clarity</td>
<td>Address complaints and translate into plans</td>
<td>Protect group, try to cope</td>
</tr>
<tr>
<td>Emphasize interdependence</td>
<td>Physician-leader sets clear direction</td>
<td>Physician-leader’s direction is less clear</td>
</tr>
<tr>
<td>Selection</td>
<td>Emphasize selection for team fit—they will wait for the right person</td>
<td>Less emphasis on team fit</td>
</tr>
<tr>
<td>Role clarity</td>
<td>Know roles of all team members (permit interdependence)</td>
<td>Have less clarity on roles of others</td>
</tr>
<tr>
<td>Inclusiveness</td>
<td>Be respectful—use input from all team members</td>
<td>Have a physician-centered hierarchy</td>
</tr>
<tr>
<td>Model expected behavior</td>
<td>Support each other so all can finish on time</td>
<td>Have individuals struggling alone in silos</td>
</tr>
<tr>
<td>Model expected behavior</td>
<td>Feel they are “in this together” so they can “give up the turf”</td>
<td></td>
</tr>
<tr>
<td>Interdependence</td>
<td>Use team-level data to track performance, including team satisfaction</td>
<td>Tend to track patient satisfaction only</td>
</tr>
<tr>
<td>Track performance</td>
<td>Set achievable goals</td>
<td>Set sights too high (eg, regional decisions)</td>
</tr>
<tr>
<td>Set goals within team’s sphere of</td>
<td>Clarity scope of team influence</td>
<td>Perceive no team influence</td>
</tr>
<tr>
<td>Team development</td>
<td>Pursue goals within sphere of influence (start small)</td>
<td></td>
</tr>
<tr>
<td>Source of improvement</td>
<td>Take responsibility for improvements, but use outside help (training, analytical support, consultants, leaders)</td>
<td>Look outside of team for improvement</td>
</tr>
<tr>
<td>Recognize and constructive feedback</td>
<td>Convey verbal, individualized, 1:1 recognition from members and patients</td>
<td>Have insufficient recognition</td>
</tr>
<tr>
<td>Recognition</td>
<td>Make staff and associate provider recognition a priority</td>
<td>Fail to convey patient comments to team</td>
</tr>
<tr>
<td>Constructive feedback</td>
<td>Provide recognition at the team level</td>
<td></td>
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<tr>
<td></td>
<td>Address interpersonal concerns in a timely manner</td>
<td>Tolerate interpersonal problems</td>
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<td></td>
<td>Give learning feedback to all (even physicians)</td>
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</table>

References


Charged with the task of identifying a guiding framework, strategies, and actions for a comprehensive approach to the treatment and prevention of overweight and obesity, 47 public and private sector professionals convened in Washington, DC, August 14 and 15, 2003, for a roundtable discussion entitled: “Prevention and Treatment of Overweight and Obesity: Toward a Roadmap for Advocacy and Action.” The roundtable was jointly sponsored by the Robert Wood Johnson Foundation, the Kaiser Permanente Care Management Institute, the Kaiser Permanente Institute for Health Policy, the Centers for Disease Control and Prevention, the American Association of Health Plans, HealthPartners, and the Washington Business Group on Health. The purpose of this meeting was to identify priorities to address the epidemic of overweight and obesity, which now affects more than half of the adult population1 and 15% of the children and adolescents in the United States.2 The meeting brought together key stakeholders, including policy makers; health care delivery systems; researchers; and representatives of employers, the food industry, schools, and nongovernmental organizations directly affected by the impact of obesity.

**Major Themes**

Participants were given the tasks of 1) identifying the components of a guiding framework for a comprehensive approach to treatment and prevention of overweight and obesity; and 2) identifying and prioritizing strategies and actions. The major themes of discussion during plenary and small group sessions are listed below.

**A Guiding Framework**

At its core, a model that promotes both treatment and prevention of overweight and obesity should place the individual within his or her community—not within the health care system. Participants felt that a guiding framework must emphasize community resources critical for helping individuals make healthy choices and manage their weight. Health care systems must also be embedded within the framework—ideally in a manner that allows them to complement the prevention-oriented work of public health systems and community-based organizations. A conceptual model should also incorporate other players in the larger environment—such as government, media, academia, and industry groups—acknowledging the significant role they play in the pervasive environmental factors driving the prevalence of overweight and obesity. Participants also indicated that an ideal model would have a population-based approach that leverages community resources to reach even people who infrequently access health care systems.

**Messages and Communication**

Roundtable participants engaged in discussion about the language and messages that are used to communicate the obesity problem with the American public. Several participants noted that current communication about the “obesity crisis” does not resonate well with the public. Research shows that patients are uncomfortable with physicians using the terms “obese” or “fat” to discuss their weight problem.3 People find these labels demeaning and discouraging. Additionally, messages focusing on long-term health risk reduction are less effective for engaging people in behavior change than are messages acknowledging the more immediate well-being of a person.

**Environment and Community**

The role of the environment and community in treatment and prevention of overweight and obesity was...
discussed at length. Participants recognized that motivational interventions delivered in the medical care system can only go so far in solving the obesity problem—environmental and community support are crucial to changing sedentary lifestyle and encouraging healthy food choices. Within the context of an integrated, guiding framework, environment encompasses culture, media, advertising, the food industry, community design, and public policy. Community includes families, schools, worksites, religious and other community organizations.

**Medical Care System**

The pervasive nature of the obesity problem calls for an immediate and active role in treatment for the medical care system. A key challenge to treating obesity is shifting the paradigm that has characterized disease management in which the patient is a passive recipient of care. A new paradigm must focus on patient self-management interventions. Organizations like Kaiser Permanente and HealthPartners have been actively promoting the understanding of how to increase the effectiveness of programs for management of the severely obese. However, the “medicalization” of the obesity problem is not the most effective strategy. Participants acknowledged that solutions should be based on a public health approach that has a strong foundation outside the medical care system. Discussion focused on the need for models of collaboration at the local level between medical care systems, public health systems, and community organizations.

**Research**

The need for additional research was a theme that arose repeatedly throughout the meeting. Research along multiple dimensions can help to develop effective interventions for prevention and treatment of overweight and obesity and to make better use of existing resources. Although participants acknowledged that several organizations are already pursuing research agendas, they identified a need to synthesize current knowledge and identify research areas that are not being addressed.

**Suggested Policies and Actions**

The pressure points for public policy and other action related to the obesity issue include:

1. schools and youth-serving organizations;
2. worksites and employer programs;
3. community support programs, services, and policies;
4. community design;
5. the food industry—including meal retailers, food retailers, food manufacturers, and food producers;
6. the health care system; and
7. communication and public advocacy.

Participants identified and prioritized recommendations to address overweight and obesity for each of the pressure points. The recommendations considered as having the highest priority or greatest potential for impact are highlighted below. These suggestions only scratch the surface of potential actions and policy interventions and are not fully developed because of the limited time for their consideration at the roundtable. They are presented here as examples of policies that could facilitate development of a roadmap for advocacy and action.

**Schools and Youth-Serving Organizations**

The federal government should offer incentives to schools to voluntarily adopt “healthy school nutrition environment” policies that require foods offered in all school venues to meet dietary guidelines.

**Worksite and Employer Programs**

The National Committee for Quality Assurance (NCQA) should develop a measure on frequency of body mass index (BMI) measurement in clinical encounters to be added to the Health Plan Employer Data and Information Set (HEDIS) to provide employers with information about health plan performance and to encourage health plans to align incentives with contracted providers.

**Community Support Programs, Services, and Policies**

Local, state, or federal governments should establish food standards for public venues and buildings to promote healthy eating.

**Community Design for Healthy Eating and Active Living**

To promote development of community environments that support healthy nutrition and activity choices, local governments should mandate “health impact” studies for new construction projects to assess their potential effects on physical activity and the overall health and well-being of citizens in surrounding communities.

**The Food Industry and Food Marketing**

In order to encourage healthy food choices at a societal level, research is needed to better understand the behavioral factors that influence food purchasing and consumption patterns.
Health Care Systems
Public and private funding should be made available to build the knowledge base around overweight and obesity treatment and prevention interventions.

Communications and Public Advocacy
Government and the private sector should provide increased funding for a broad-based media campaign designed to increase public awareness and alter environmental conditions to support good nutrition and physical activity.

Conclusion
In the concluding session of the roundtable, participants agreed that an integrated approach is necessary to make a positive and sustained impact on the nation’s overweight and obesity problem. How that approach is conceptualized within a guiding framework was clearer to participants at the end of the roundtable, but they recognized that additional work is required to flesh out the details and give appropriate emphasis to the various components. Participants identified a window of opportunity, created by the current groundswell of media and public interest, to form a broad-based strategy for coordinated action.

Participants identified a window of opportunity, created by the current groundswell of media and public interest, to form a broad-based strategy for coordinated action.

Efforts should focus on both the local and national levels to achieve the broadest impact; however, more immediate results may be seen at local levels.

Efforts should try to incorporate win-win strategies, with which all stakeholders will have the highest likelihood of success.

“Healthy Eating and Active Living” could serve as a rallying theme for a broad range of stakeholders, providing a foundation for developing messages that unite the medical, public health, and social service communities.

Suggested next steps include widening the circle of participants for further discussion; developing messages for social marketing; identifying and sharing examples of community collaboration; getting consensus on a research agenda to fill the gaps in knowledge; and drafting a policy agenda that builds on the existing knowledge base of effective prevention and treatment approaches.

Acknowledgment
The Centers for Disease Control and Prevention, Kaiser Permanente, and The Robert Wood Johnson Foundation provided financial support for the roundtable discussion.

Reference

Know Where You’re Going
If you don’t know where you’re going, you’ll end up somewhere else.

Yogi Berra, b 1925, baseball player and manager
The "Three Redheaded" Sisters
watercolor
By Patty Stelz, RN

More of Ms Stelz's art can be found on page 73.
Abstracts of Articles Authored or Coauthored by Permanente Clinicians

From the Northwest and Hawaii: Nulliparity and fracture risk in older women: the study of osteoporotic fractures

Whether nulliparity increases fracture risk is unclear from prior studies, which are limited by small samples or lack of measured bone mineral density. No study has evaluated whether the effect of parity differs by skeletal site. We prospectively analyzed the relationship of parity to the risk of incident nontraumatic hip, spine, and wrist fractures in 9704 women aged 65 years or older participating in the Study of Osteoporotic Fractures to determine if parity reduces postmenopausal fracture risk, and if so, if this risk reduction is 1) greater at weight-bearing skeletal sites and 2) independent of bone mineral density. Parity was ascertained by self-report. Incident hip and wrist fractures were determined by physician adjudication of radiology reports (mean follow-up, 9.8 years) and spine fractures by morphometric criteria on serial radiographs. The relationship of parity to hip and wrist fracture was assessed by proportional hazards models. Spine fracture risk was evaluated by logistic regression. Compared with parous women, nulliparous women (n = 1835, 19%) had an increased risk of hip and spine, but not wrist, fractures. In multivariate models, parity remained a significant predictor only for hip fracture. Nulliparous women had a 44% increased risk of hip fractures independent of hip bone mineral density (hazards ratio, 1.44; 95% CI, 1.17-1.78). Among parous women, each additional birth reduced hip fracture risk by 9% (p = 0.03). Additionally, there were no differences in mean total hip, spine, or radial bone mineral density values between nulliparous and parous women after multivariate adjustment. In conclusion, childbearing reduces hip fracture risk by means that may be independent of hip bone mineral density.

From Southern California: Design and evaluation of interventions promoting periconceptional multivitamin use

BACKGROUND: Periconceptional folic acid use reduces the risk of neural tube defects and possibly other birth defects. The effectiveness of two interventions to increase the use of multivitamins among women of childbearing ages was evaluated.

METHODS: Quasi-experimental interrupted time series design with a nonequivalent control group. Participants included female members of Kaiser Foundation Health Plan aged 18 to 39 years residing in the three geographic service areas of California under study from 1998 through 2000. The central component of the direct mail/pharmacy information intervention was the mailing of “starter kits” of 100 multivitamins, while the provider education intervention used primary care providers to deliver the study message. Main outcomes included the use of multivitamins containing folic acid at least four times per week (“regularly”), intention to use multivitamins regularly, and knowledge and attitudes about multivitamins. Outcomes were measured via telephone interviews of nonpregnant women of childbearing age.

RESULTS: A total of 3438 women were interviewed. There was a small but significant increase in the percentage of women using multivitamins in the direct mail/pharmacy information intervention group at the beginning of the intervention period (p = 0.006), but this increase was not sustained after the interventions ended. No other significant change was observed.

CONCLUSIONS: Despite our ability to reach many women of childbearing age with multiple messages about regularly using multivitamins, only a small temporary increase was found in the percentage of women using multivitamins who received the messages in the mail. Other interventions and further evaluation of the impact of food fortification with folic acid should be considered.

CLINICAL IMPLICATION: Although approximately 75% of neural tube defects (NTDs) are preventable by consuming 400 mcg of folic acid (FA) daily during the periconceptional period, the proportion of childbearing-age women taking these vitamins has increased only slightly in the past ten years. Our direct mail campaign was only marginally successful in increasing the proportion of women using multivitamins and education by physicians and other health care providers showed no effect. However, our postimplementation survey showed that only a small proportion of providers implemented the educational intervention in the context of their clinical visits. Women of childbearing age should be encouraged to take a vitamin containing FA every day and to consume foods rich in FA, including foods fortified with FA (cereals, pasta, bread, etc). —JL
Abstracts of Articles Authored or Coauthored by Permanente Clinicians

From the Northwest:

**Fetal fibronectin: the impact of a rapid test on the treatment of women with preterm labor symptoms**


**OBJECTIVE:** The purpose of this study was to determine whether knowledge of the results of a rapid fetal fibronectin test affects treatment decisions during the evaluation and treatment of possible preterm labor. Previous observational studies have suggested that a negative test might help to avoid unnecessary intervention.

**STUDY DESIGN:** This was a randomized study of women who were between 24 weeks and 34 weeks six days of gestation with symptoms of preterm labor and who were seen in three community hospitals. A rapid fetal fibronectin test was performed on all subjects. Patients were assigned randomly to a group whose results were known to physician or to a group whose results were not known. Treatment decisions were at the discretion of the physician.

**RESULTS:** One hundred eight samples were collected between September 2000 and December 2001. There were ten positive fetal fibronectin tests. The overall prevalence of delivery within two weeks for the study population was 2.8%. For women who had negative fetal fibronectin test results, the hospital stay was not significantly shorter when the result was known (6.8 hours) than when it was not known (8.1 hours, \( p = .35 \)). However, when the physician knew the fetal fibronectin status of women with a negative test result who were observed for >6 hours, the hospital stay was shortened 40%, to 22.7 hours from 37.8 hours (\( p = .04 \)).

**CONCLUSION:** Fetal fibronectin testing may be able to supplement clinical judgment in the evaluation of the condition of patients with symptoms of preterm labor. The greatest benefit of fetal fibronectin testing might be for the patient whom the physician judges to be at high risk for imminent delivery. In such patients, the knowledge of a negative fetal fibronectin may shorten the hospital stay.


**CLINICAL IMPLICATION:** Fetal fibronectin testing cannot definitely determine whether a patient with preterm labor symptoms will deliver within the next one to two weeks, but the possibility is moderately increased by a positive test. Prior studies showing a very low likelihood (<2%) of imminent delivery in patients with a negative test were biased by the already low prevalence of imminent delivery in those populations (3%-4%). Our study suggests that testing is probably not needed in most patients presenting with symptoms of preterm labor. For the subgroup of patients whom we now treat aggressively, testing might be helpful in shortening hospital stays. —MP

From Colorado:

**Femoral endarteritis associated with percutaneous suture closure: new technology, challenging complications**


**OBJECTIVE:** Use of percutaneous suture closure devices after catheter-based interventions is increasing. We recently have seen several severe femoral arterial wall infections after use of such devices. The purpose of this study was to examine the incidence, comorbid associations, and management of femoral arterial infections associated with percutaneous suture closure devices.

**METHODS:** We retrospectively reviewed all infectious complications that occurred after 2223 consecutive cardiac catheterization procedures performed over 12 months in a university-affiliated community teaching hospital. Outcome variables included demographics, procedural details, infection, type of arterial reconstruction, mortality, and limb loss.

**RESULTS:** During this study, 822 patients received percutaneous suture devices. Infection developed in six patients (0.7%). The incidence of diabetes in the population undergoing percutaneous suture closure was 219 of 822 patients (26.6%). Three comorbid conditions, noted in multiple patients with infectious complications, included diabetes mellitus, obesity, and placement of a percutaneous suture closure device within the past six months. Invasive femoral endarteritis developed in four patients. Gram-positive cocci predominated in four patients. In one patient with polymicrobial infection catastrophic complications developed, including multiple anastomotic ruptures and hemorrhage. A new method of repair that incorporated double-thickness everted saphenous vein was used in two patients, and safe arterial closure was achieved. There was one late fatality on postoperative day 36. Limb salvage was achieved in all patients.

**CONCLUSIONS:** Femoral endarteritis complicating percutaneous suture closure is a challenging new problem for vascular surgeons and can result in catastrophic complications. Customary techniques that use saphenous vein patch or interposition grafting are not adequate in all circumstances. Successful outcome requires operative exploration in patients with suspected infection. Removal of the percutaneous suture closure device and debridement to normal arterial wall is recommended in all patients with suspected femoral endarteritis, based on positive intraoperative Gram stains or abnormal appearance of the adjacent femoral artery. Early success with an autologous bolster repair is reported. Caution is advised when considering the use of a percutaneous suture closure device in patients with comorbid conditions including diabetes, obesity, and previously implanted devices.

From Northern California:
Use of antibiotics is not associated with decreased risk of myocardial infarction among patients with diabetes

OBJECTIVE: To study the relationship between exposure to antibiotic treatment and risk of subsequent myocardial infarction (MI) in patients with diabetes.

RESEARCH AND DESIGN METHODS: A case-control design was used to assess the effect of previous antibiotic exposure in diabetes patients with acute, nonfatal or fatal MI (case subjects) and individually matched control subjects (four control subjects to one case subject, matched on sex, age, and index date). Subjects were sampled from the Northern California Kaiser Permanente Diabetes Registry, a well-characterized, ethnically diverse diabetic population from Kaiser Permanente Medical Care Program, Northern California Region. MI events were ascertained during a two-year observation period (1998-1999). Separate conditional logistic regression models were specified to assess antibiotic exposure history (cephalosporins only, penicillins only, macrolides only, tetracyclines only, sulfonamides only, etc.). We found no evidence of a protective effect of any of these therapeutic classes of antibiotics during any of the three time frames.

CONCLUSIONS: Our study does not support the hypothesis that use of antibiotics has a protective effect for prevention of coronary heart disease in diabetic patients.


CLINICAL IMPLICATION: Some studies suggest potential benefit of antibiotic use for CHD, but this has not been investigated among diabetics. This case-control study assessed the extent of previous antibiotic exposure among 1401 diabetics with acute, non-fatal or fatal myocardial infarction, with four individually age-sex-matched controls for each case. After adjusting for age, sex, race, and 11 other factors, we found no evidence of a protective effect of any therapeutic antibiotic class during any of three time frames. Our study does not support the hypothesis that use of antibiotics reduces CHD risk in diabetic patients. —AK

From Northern California:
Psychiatric symptoms, impaired function, and medical care costs in an HMO setting

More information is needed regarding the medical care utilization and costs of individuals who report depressed mood, persistent anxiety, panic, and trouble controlling violent behavior. We present findings from a one-year prospective follow-up study of a stratified random sample of adult HMO enrollees (n = 13,777) originally interviewed by telephone. A strong association was observed between these psychiatric symptoms, associated impaired function, and general medical care costs during the year following the interview. After controlling for age, gender, race, medical conditions, and smoking, the mean costs of general medical care were $1948 for respondents who reported none of the psychiatric symptoms or impaired function; $3006 for respondents with all five symptoms but no impaired function; and $3906 for those with all five symptoms and pervasive functional impairment. Persistent anxiety and depressed mood had the greatest impact on total general medical costs, while impaired function was associated with increased likelihood of hospital admission and emergency room use. We conclude that depressed mood, persistent anxiety, and related impaired function are associated with substantial increases in the use and cost of general medical care.

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The Truth
When you have eliminated the impossible, whatever remains, however improbable, must be the truth.

Sir Arthur Conan Doyle, MD, 1859-1930, author
A Case Study of Cauda Equina Syndrome

Abstract
Primary care and emergency care physicians frequently encounter patients with low back strain and sciatica and must be able to recognize the perilous signs of cauda equina syndrome (CES), a condition usually caused by massive disk herniation. Patients with CES may have peripheral neurologic deficits as well as bowel and bladder dysfunction. Emergent magnetic resonance imaging is the study of choice to confirm the diagnosis. Surgical decompression is the only effective treatment for CES. The prognosis depends on initial signs and symptoms, progression of neurologic deterioration, and timeliness of surgical decompression. Recovery may occur immediately after surgery or months or years postoperatively.

Introduction
Low back pain is a common complaint heard frequently by all physicians who provide primary care to adult patients. Because this common type of pain is generally not associated with clinically significant pathology, clinicians may overlook a rare but potentially disabling neurologic affliction such as cauda equina syndrome (CES). Most cases of CES result from lumbar disk herniation with excessive compression on the cauda equina. Clinical features may include low back pain, sciatica, saddle-area anesthesia, motor weakness, sensory deficit, and urinary or fecal incontinence. The condition may progress to permanent incontinence, paraplegia, or both. Therefore, to diagnose and promptly treat CES, clinicians must be able to recognize the signs and symptoms of this neurologic syndrome.

Case Report
A 28-year-old man presented to the emergency department for low back pain and numbness in both lower extremities. Two days earlier, he had sharp, shooting pains in the back and buttocks after moving boxes. The pain was relieved with hydrocodone with acetaminophen. However, on the morning of presentation, the patient awoke with numbness in both lower extremities and had left leg weakness so severe that the patient was unable to stand or walk without support. The patient described the pain as mild while he was supine and worse when he sat or stood. The patient reported some urinary hesitancy, dribbling of urine, and constipation. He did have morning erections. The patient reported that he had had an industrial injury five years before that resulted in a herniated lumbar disk and subsequent laminectomy; he had been doing well since then until the time of presentation.

On physical examination, the patient was alert and oriented and had stable vital signs. The back was not tender when palpated. The straight-leg-raise test to 30º did not elicit additional pain in either leg. Motor strength examination showed some lack of effort on the right side but good motor function in all muscle groups of the right lower extremity. Motor strength of the left lower extremity was decreased to 3 out of 5 in the hamstrings, iliopsoas, and quadriceps muscles; 1 to 2 out of 5 in the ankle and toe plantar flexor muscles; and 0 out of 5 in the ankle dorsiflexor muscles and extensor hallucis longus muscle. Tests of the deep tendon reflexes showed normal right patellar reflex, absent left patellar reflex, and absent Achilles tendon reflexes bilaterally. Sensory examination demonstrated hyperesthesia of the left calf and hypesthesia of the scrotum, perianal area, and left foot. Anal sphincter tone was reduced.

Lumbar spine radiographs revealed mild narrowing of the intervertebral disk spaces between L3-4 and L4-5. Emergent magnetic resonance images (MRI) of the lumbar spine showed herniated disk material located along the left lateral aspect of the vertebral canal. Disk material extending from the body of L3 to the body of L4 resulted in moderate central canal stenosis and compression of the cauda equina.

The radiograph and MRI both showed evidence of previous L4 laminectomy.
A neurosurgery consultation was obtained urgently. The patient received an initial dose of dexamethasone, 10 mg, intravenously, followed by 4-mg intravenous dose every six hours. The patient was taken to the operating room the next morning. An L3 laminectomy was done, and herniated disk material at the level of L3-4 was removed in multiple fragments. Postoperatively, sensory and motor deficits persisted; the patient had decreased sensation on the left side of his penis and perineum, left foot drop, hyperalgesia of the left calf, and decreased anal sphincter tone. He was able to void without use of a catheter but had some difficulty with initiating urination. The patient was transferred to the rehabilitation unit for acute therapy, and the neurologic deficits gradually improved.

One year after surgery, the patient was able to walk, although the gait was broad and slow; he was not able to run. He had regained sensation in the left leg and perineum, although sensation was still mildly decreased. Sexual function was intact; the patient was able to have erections and had penile sensation. The patient was able to urinate, but initiating urination still required effort.

**Discussion**

**Epidemiology of Low Back Pain, Sciatica, and CES**

Seventy to 85% of adults in the United States report experiencing low back pain by the age of 50 years; a national annual incidence of low back pain is 5%. One quarter of patients with back pain have sciatica, a syndrome characterized by pain radiating from the buttocks down the posterior or lateral aspect of the lower limb below the knee. Sciatica may be associated with motor, reflex, or sensory deficits. The most common cause of sciatica is herniation of the lower lumbar intervertebral disks, most often involving the disk between L4-5 and less often the disk between L5-S1 or L3-4; herniation causes compression or irritation of the lumbar nerve roots. Symptomatic disk herniation most commonly occurs in patients who are 30 to 50 years old, although such herniation can occur at any age. In contrast to sciatica, cases of CES after disk herniation are relatively rare; according to Chang et al, the incidence of CES due to lumbar disk herniation has been reported to range from 1% to 10% of operated disk cases.

**Etiology of CES**

The adult spinal cord terminates at the level of vertebra L1 to L2 with the terminal bundle of lumbar and sacral nerve roots within the spinal canal forming the cauda equina below; the nerve roots then separate and exit at their specific foramina. Compression of the cauda equina is most commonly caused by herniation of a large quantity of lumbar disk material, often in association with degenerative or congenital spinal stenosis, and can result in CES. According to Delamarter et al, extremely rare causes of CES include compression by tumor, fracture, penetrating trauma, chiropractic manipulation, chemonucleolysis, postoperative hematoma, free epidural fat graft, and ankylosing spondylitis.

Risk factors for disk herniation include obesity, male gender, age more than 40 years, heavier lifetime loading during occupational and leisure time activities, and history of back disorders. Factors associated with degeneration of the intervertebral disk include genetic factors and changes in disk hydration and collagen. These factors reduce effectiveness of the nucleus pulposus (the inner disk layer) for absorbing shock, providing resistance to compression, and permitting flexibility of the vertebral column. Instead, the nucleus transmits a greater portion of applied loads to the surrounding annulus asymmetrically, an imbalance that may lead to weakness of the annulus and herniation of the nucleus pulposus material into the spinal canal.

**Clinical Presentation and Physical Examination for CES**

Three variations of CES have been described: 1) acute CES that occurs suddenly in patients without previous low back problems; 2) acute neurologic deficit in patients who have history of back pain and sciatica; and 3) gradual progression to CES in patients who have chronic back pain and sciatica. However, in more than 85% of the cases, the signs and symptoms of CES develop in less than 24 hours. Signs of CES include severe bilateral sciatica; bilateral foot weakness; saddle-type hypesthesia or anesthesia in the areas innervated by nerve roots S2 to S5; and retention or incontinence of urine, stool, or both. Thus, asking all patients with back pain about the presence of associated neurologic deficits is imperative and should include questions about lower extremity and saddle paresthesia, numbness, weakness, gait disturbance, bowel or bladder dysfunction, and impotence. Positive responses to these symptoms warrant further investigation to rule out the diagnosis of CES. Coughing, sitting, or bearing down (Valsalva maneuver) may aggravate sciatic pain, and lying supine may alleviate pain. The straight-leg-raise test, during which the examiner raises the supine patient’s fully extended leg up to 70 degrees, is considered positive for disk herniation and nerve irritation when it produces a radicu-

**Compression of the cauda equina is most commonly caused by herniation of a large quantity of lumbar disk material, often in association with degenerative or congenital spinal stenosis.**
lar pain radiating down the lower limb to below the knee in one or both limbs at between 30 and 60 degrees. A positive straight-leg-raise test result for the limb on the affected side is 80% sensitive and 40% specific for disk herniation, a result which suggests involvement of the L5 to S1 nerve roots or the sciatic nerve. A positive straight-leg-raise test result for the limb on the contralateral side is 25% sensitive and 90% specific for disk herniation, a result which suggests involvement of the L2 to L4 nerve roots.

Neurologic examination should evaluate each of the spinal nerve roots. Lumbar disk herniation typically affects the nerve root inferior to the disk space. Thus, herniation of the L4-5 intervertebral disc would typically impinge on the L5 nerve root. Sensory examination should be conducted using both light touch and pinprick; cold temperature sensation can be easily tested using the cold metal end of a tuning fork. Sensory, motor, and reflex innervation by nerve roots L1 through S5 are summarized in Table 1. Because the L4 nerve root controls ankle dorsiflexion, the L4 nerve root can be tested by heel walking. The L5 nerve root can be evaluated by using the Trendelenburg test. The Trendelenburg test requires the patient to stand on one leg and the physician to stand behind the patient with hands on the patient’s hips; a drop in the pelvis on the side opposite the raised leg implies presence of either L5 nerve root or hip joint pathology.

CES or spinal cord compression should be considered until proven otherwise in all patients who have low back pain with bowel or bladder incontinence. Bladder dysfunction usually is secondary to detrusor muscle weakness and an areflexic bladder; this dysfunction initially causes urinary retention followed by overflow incontinence in later stages. Patients who have back pain with urinary incontinence but who have normal neurologic examination results should have a urinary postvoid residual volume measured. A postvoid residual volume greater than 100 mL indicates overflow incontinence and mandates further evaluation; a volume less than 100 mL rules out diagnosis of CES. The anal wink reflex, elicited by gently stroking the skin lateral to the anus, normally causes reflexive contraction of the external anal sphincter. Rectal examination should be done to assess anal sphincter tone and sensation if any of the characteristic signs or symptoms of CES are present.

### Diagnosis, Treatment, and Prognosis of CES

Although plain radiographs are of limited value for diagnosing lumbar disk herniation, they can be used to rule out other pathology. Plain lumbar spinal radiographs should be obtained if neurologic dysfunction is discovered on physical examination or if patient
history suggests the presence of tumor, infection, or fracture. Although radiograph findings are often unremarkable, the presence of decreased disk height may be suggestive of disk herniation.}

Computed tomography (CT) or magnetic resonance imaging (MRI) may be considered for evaluation of a patient with signs of disk herniation. MRI is the widely accepted standard for the rapid and complete evaluation of a patient with clinically significant spinal pathology and should be obtained emergently when the diagnosis of CES is suspected. Abnormalities on MRI are commonly found in asymptomatic patients; MRI should therefore be used as a means of confirming a diagnosis in the presence of neurologic signs rather than as a screening tool. In the series of CES cases reported by Shapiro, 75% of CT or MR images of CES cases showed large quantities of disk material occupying more than one third of the spinal canal diameter.

Treatment with high doses of steroids may provide rapid relief of pain as well as improve function while appropriate diagnostic studies and consultations are being obtained. Dexamethasone is commonly given intravenously at doses of 4 to 100 mg.

CES is an absolute indication for emergent surgical decompression; laminectomy followed by gentle retraction of the cauda equina (to avoid complications of increased neurologic compromise) and diskectomy is the technique of choice. Timing of the decompression has not been unanimously agreed upon. Traditionally, patients with CES who have undergone surgery within 24 hours of initial symptoms are believed to have clinically significantly better neurologic recovery. However, some studies found no statistically significant improvement in outcome between patients surgically treated within 24 hours compared with those surgically treated within 24 to 48 hours. Other studies suggest that surgery performed on an expedient rather than emergent basis did not compromise neurologic recovery.

Outcome for patients with CES can be predicted primarily by their symptoms at presentation. Patients who are ambulatory at initial evaluation generally remain ambulatory; those who are paretic but can walk with assistance have a 50% chance of walking unassisted after recovery; those who are paralyzed when seen initially rarely will walk again. About 79% of patients who require urinary catheterization at initial evaluation will continue to use a catheter after recovery. Patients with a history of chronic low back pain have an increased risk of urinary and rectal dysfunction after surgery. Postoperative recovery time can range from months to years. Most patients improve within the first two years after surgical decompression, although some continue to clinically improve for up to five years after surgery.

Conclusion

Acute compression of the cauda equina is a neurologically compromising and potentially debilitating syndrome. Physicians who evaluate low back pain must be able to recognize the signs and symptoms of this relatively rare but critical spinal syndrome and must expedite emergent evaluation with appropriate history and physical examination, imaging studies, and consultations. Patients with neurologic deficits of the lower extremities, perianal region, scrotum, penis, bowel or bladder (or both) need further evaluation. Patients with bowel or bladder incontinence should be considered to have neurologic spinal compromise until proven otherwise and need emergent imaging studies, preferably MRI. If the diagnosis of CES is confirmed, surgical intervention should be done as soon as possible to prevent progression of neurologic symptoms and to allow maximum neurologic recovery.

Acknowledgment

Robert Sallis, MD, Advisor, Family Medicine Residency Program, reviewed the manuscript.

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A Case Study of Cauda Equina Syndrome


Last of the Ivory Towers

Do you realize that you have one of the last of the Ivory Towers? You have no Senatorial responsibility. You don’t have committees, you don’t have to work on registration committees, admission groups and waste your time. You don’t have to teach in the sense that we do in Academia. You really study.

Theodore van Brunt, former Director of the Department of Research quoting a man he described as a world-class epidemiologist from the University of California at Berkeley. As a co-investigator on a DOR project, the epidemiologist had been very impressed by the research conditions at Kaiser Permanente and at the Department of Research.

The Permanente Journal/ Fall 2003/ Volume 7 No. 4
Understanding Noncompliant Behavior: Definitions and Causes

Abstract
Noncompliant behavior of patients frequently interferes with effectiveness of treatment for a variety of medical conditions and can have serious consequences. Most clinicians have had little training in identifying the common causes of patients’ noncompliant behavior, and clinicians have few tools to cope with this type of behavior. The goals of this article are to define noncompliant behavior, to discuss the most common reasons for noncompliance, and to provide new insight into noncompliant behavior that clinicians can use to design more effective strategies for coping with noncompliant patients.

Introduction
Some of the more frustrating experiences I have had as a physician have involved patients who refuse to follow my perfectly good clinical advice. Whether it was advice for using prescription medicine, for follow-up visits, for important clinical tests or surgical procedures, or for making crucial lifestyle modifications, a few patients steadfastly refuse my well-intended prescriptions or recommendations.

Early in my career, I assumed that these refusals just indicated a lack of understanding; if my patients could comprehend the seriousness of their problems and the necessity of the recommended solutions, only the most dense and stubborn of people would fail to heed my advice. My solution, therefore, for all noncompliant behavior (NCB) was to repeat—more emphatically—why my recommendations were important and to reiterate my explanations and dire predictions until I felt that the patient could comprehend and would comply.

The frequent failure of this approach led me, during the course of more than 25 years in clinical medicine, to adjust my attitude and to try to understand the causes of NCB. I am now attempting to share some of what I have learned with other frustrated clinicians. This article arises from a presentation I developed for a Medicine-Behavioral Medicine conference on this topic. In preparing this talk, a Medline search revealed a dearth of relevant articles in the medical literature. My goal is to approach the topic in a way that speaks directly to the problems we encounter in our daily practice and to apply a holistic and practical understanding to the issues involved.

But first I want to give credit where credit is due: Almost everything useful I know about NCB I have learned from my patients themselves. The most helpful things I have ever done with noncompliant patients have been to ask questions, not to lecture, and to be willing to listen to what patients say. These activities are often very difficult to do within the time constraints of clinical practice. Sometimes I have to “suspend” the clock and my usual clinical approach and just tell the patient that I’m frustrated and concerned and that I need to know what he or she understands about the disease process and problems being faced. And then I’ll just be quiet and listen as nonjudgmentally as possible.

Defining Noncompliant Behavior
“Noncompliant behavior” is an awkward phrase, although widely used. It conveys what the patient isn’t doing, a negative concept, rather than what the patient is doing. I believe that were we able to sufficiently understand our patients, their lives, what their illnesses mean to them, and how they cope with their illnesses, every act of noncompliance would seem to make sense—at least at some level. I know that the term “nonadherence” has replaced “noncompliance” in some circles because “nonadherence” is less value-laden and does not imply a rigid hierarchical relationship between physician and patient. I have used “noncompliance” or “noncompliant behavior” in this article because I believe it is in the lexicon of the audience of frustrated physicians I am attempting to ad-
dress and because I believe that the tone and content of this article explore and critique the concept of patient “compliance.”

In defining NCB, I use the following four criteria: 1) the patient's medical problem is potentially serious and poses a clinically significant risk to length or quality of life; 2) at least one treatment exists that if followed correctly, will markedly reduce this risk; 3) the patient has easy access to the treatment or treatments; and 4) the patient deviates significantly from most patients (with similar medical problems) in degree of compliance with medical advice, treatment, or follow-up in a way that directly or potentially jeopardizes the patient’s health or quality of life.

Few patients fully comply with all of our recommendations. Most Type II diabetic patients never lose much weight; many hypertensive patients forget to take a few pills and miss a few medical appointments; some patients with advanced cancer shun conventional (and predictably ineffective) treatment and instead pursue alternative therapy. The NCB I discuss here is more dramatic and more obviously damaging; for example, Type II diabetic patients who visit their physician less than once a year, who frequently run out of medication, and whose blood glucose levels are always poorly controlled (with HbA1c >13%, for example) are demonstrating NCB. Patients who have obvious (palpable) breast cancer but who refuse surgery illustrate a different and less common type of NCB.

**Common Causes of Noncompliant Behavior**

I have found that, similar to many other problems in medicine, NCB is caused by multiple, often intertwined factors. For example, problems in communication are often related to cultural issues. Any patient may be influenced by more than one of these causative factors, and I am sure many other factors exist that I have not yet encountered or do not yet understand. Instead of my earlier ineffective tactic of repeatedly hammering the same advice and information into the resistant ears of my noncompliant patients, I found that making the effort to understand the causes of each patient's NCB helps me tailor an approach to removing obstacles and encouraging the patient's full participation in their own health care.

**Failure of Communication and Lack of Comprehension**

As I have stated, early in my career I thought most NCB was caused by my failure to communicate and thus by a patient's inability to comprehend my advice. Patients differ greatly in levels of education, intelligence, and language skills. An explanation of a disease process delivered in English may be perfectly clear to a native English speaker who graduated college but may be totally unintelligible to someone who did not graduate from high school or who speaks English as a second language. One of our duties as physicians is to give patients our explanation of their health problems and our recommended solutions using terms that are clear and meaningful to each patient. However, very little of our physician training is designed to facilitate this vital communication. We also lack tools and time to monitor how successfully we are communicating with our patients. Many patients are too polite—or too embarrassed—to speak out when their physician unintentionally confuses or mystifies them. These patients suffer in silent bewilderment.

Physicians are highly educated, typically have above-average intelligence, and belong to a culture that values education and intelligence; we often do not understand how intimidating we can be to others. Although some of our patients may have below-average intelligence, our duty to effectively communicate with them remains. Many years ago, I was a medical consultant for an organization that supported independent living for developmentally disabled young adults; many of their clients were my patients. They were, almost without fail, wonderful patients. They looked forward to their visits with me; they worked hard to understand what I said and recommended; and they appreciated my attention. People who have limited intelligence can be excellent and compliant patients.

Patients may be unable to comprehend our explanations and advice for other reasons. For example, progressive dementia can have an insidious onset in older patients, who may remain well-adapted socially and whose behavior may seem appropriate. Sometimes NCB in a patient who previously had been compliant is the first clue to what may be a significant degree of dementia. I now use the Mini-Mental State Examination for a newly noncompliant elderly patient and am often surprised by poor scores.

**Cultural Issues**

We filter our understanding of life's important experiences through the values and concepts of the culture in which we grew up. This filtering process certainly applies to our understanding of good health, causes of medical problems, and effective medical care. The greater the discordance between the cul-
Denial in mild forms is of considerable value ... Denial in more severe form can be crippling and maladaptive.

Denial in mild forms is of considerable value—otherwise, we would all be preoccupied with our problems and unable to function within our daily life. Denial in more severe form can be crippling and maladaptive. In my experience, denial is especially common in long-term diabetic patients whose diabetes was either of juvenile or of midlife onset. Good blood glucose control demands enormous effort compared with control of signs or symptoms of other common chronic illnesses, such as hypertension. The diabetic patient must pay close attention to diet and exercise; monitor blood glucose levels at home, a process requiring finger sticks; schedule frequent blood tests; and take pills, insulin injections, or both. Contemplating these complex requirements along with the long-term risk of blindness, kidney failure, and cardiovascular complications may stimulate denial in many patients.

In evaluating depression as a cause of NCB, I do not only include patients with a clear diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders but also patients whose depressed mood and defeatist attitude sabotage their ability to deal with their medical condition. Patients who have more severe depression may engage in NCB that appears suicidal and that may lead to an abrupt and early death, for example, a patient with insulin-dependent diabetes who will not self-monitor blood glucose levels and who is frequently hypoglycemic.

Patients with bipolar disorders are often unpredictable, and their degree of compliance varies, depending on their mood state. Patients who are clinically psychotic or who have thought disorders with psychotic features present one of the greatest challenges to addressing NCB. For example, a patient who is delusional and paranoid may refuse psychiatric care and live independently. This patient could refuse treatment for a serious disease, such as early-stage breast cancer. Despite enormous effort, a physician may be unable to convince the patient of the seriousness of the disease; in fact, the patient may stop coming to office visits and may stop answering letters or phone calls from the physician.

Secondary Gain

Some patients feel rewarded for remaining sick. In my experience, the most common reward is being classified as medically disabled: the patient is considered unable to work or requires long-term modification of duties. In this way, NCB (and a worsening or stationary health status) is financially rewarded, and the patient is removed from a stressful or onerous work situation. I believe that often this is not a conscious process, such as deliberate malingering or premeditated self-sabotage, but instead that subconscious positive reinforcement occurs when NCB results in the patient continuing to be classified as medically disabled.

Patients who receive and enjoy special attention from family members while in poor health may engage in NCB.

Psychosocial Stress

An overwhelmed patient is often ineffective at self-care. Many of our patients face complex and stressful living situations. Realities such as...
poverty, long hours working in multiple jobs, difficult parenting problems, or troubled relationships can leave people exhausted, feeling besieged, and simply unable to cope with the added time and energy required to fully manage a chronic illness. Feeling trapped and hopeless destroys that sense of optimism for the future that usually helps motivate good self-care for chronic illness.

For many chronic illnesses, such as hypertension, noncompliant patients may feel perfectly healthy until complications such as congestive heart failure or stroke occur. These patients must truly believe the diagnosis and the physician’s advice, have a clear understanding of the consequences of NCB, and develop the ability to prioritize their own needs to take daily medication and keep regular medical appointments even while they feel healthy—in the hope of a healthier future.

**Drug and Alcohol Dependence**

People who are addicted to alcohol or drugs often fail to take care of business in many of life’s arenas and are often erratic or noncompliant with regard to their health care. These patients often suffer from medical complications of their addictions, such as hepatitis C or cirrhosis; because of poor self-care, they are also prone to many other chronic illnesses. Treating the addiction is often prerequisite to treating comorbidities, but the denial that these patients usually have impedes effective medical care. Stress and disorganization in the lives of many addicted patients—as well as health problems—create a formula for massive NCB and poor health outcome.

**Recommendations**

The next time one of the patients in your practice engages in NCB, take a minute to think about what may be causing this behavior. Ask questions: Does the patient understand the health problem (or the consequences of NCB) or have suggestions on how self-care behavior could be improved? Using the general categories I have suggested—and any of your own creation—develop a differential diagnosis for the cause or causes of the patient’s NCB. As with many complex medical problems, a deeper understanding of the roots of the problem can suggest steps toward its solution. Discussing the case with a colleague may help generate a fresh perspective and a new approach.

Most important, I suggest that you consider NCB a challenge—not a failure. In a planned future paper on this topic, I will present solutions and some practical tools, with case examples, to help deal with noncompliant behavior.

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**Acknowledgment**

Kate Scannell, MD, reviewed the manuscript.

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**To Learn from the Experience of Others**

Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so.

*Last Chance to See, Douglas Adams, 1952-2001, author*
The 805 Interchange sweeps gracefully to magnificent monolith height above the San Diego River Valley. More of Dr Fremland's art can be found on the cover and on page 58.
How Can Busy Physicians Better Manage Laboratory Results?

Introduction

It’s 6:00 pm. You’ve seen all your patients, answered your messages, completed your prescription refill requests, and faxed back your last work release. The only task remaining is to review the laboratory test results that came back during the afternoon. This job—acting on abnormal test results and communicating findings—is a critically important part of the care we deliver and can occupy a substantial portion of a physician’s day.

I have personally been interested in how we manage our lab results and have surveyed internists and family practitioners in the KP Southern California Region for their thoughts on this topic. Most have reported that they spend about one hour each day managing laboratory test results. In this article, I share some lab management techniques which may help you streamline your day.

The Electronic Medical Record

In the KP Southern California Region, we have yet to implement the electronic medical record (EMR); therefore, I have written this article from the perspective of the “EMR-naive” practitioner. I hope, however, that even those physicians who currently use the EMR will find this discussion useful. In this article, I share some lab management techniques which may help you streamline your day.

Evidence-Based Ordering Of Laboratory Tests

Ordering laboratory tests sensibly is probably the most important aspect of efficiently managing laboratory test results. The inevitable false positive results of unnecessary tests consume much valuable time, whether a clinician spends this time explaining the results to concerned patients or requesting additional tests. To paraphrase an old saw, “Order all the necessary tests and not one test more.” In practice, achieving this goal is difficult because of many considerations (in addition to the patient’s medical history and physical examination findings) that factor into our patterns of ordering laboratory tests. When we order these tests simply because we believe the patient will leave our office more satisfied, we may be the ones disappointed. Contrary to what some may believe, a study from the KP Northern California Region showed that, when controlled for other variables, even a dramatic increase in ordering laboratory tests or imaging would not produce a meaningful change in patient satisfaction scores. (Kristen Hannum Gregory, PhD, unpublished data, May 1999). Moreover, ordering more laboratory tests compounds a doctor’s workload by inviting more messages from patients about test results (S Winarko, MD, unpublished data, 1998). In my experience, the most unnecessary increase in workload is imposed by healthy (“worried well”) patients who are seen for a routine visit or physical examination and leave the office clutching a long list of lab orders. Fortunately, at least for these healthy patients, we can benefit from a wealth of data on the laboratory screening tests appropriate for each interval of life. The US Preventative Services Task Force Recommendations and KP’s clinical practice guidelines are particularly helpful in this regard. For patients without risk factors who are seeing their doctor for a routine periodic health examination, only the following five screening tests (excluding radiologic, nuclear, and endoscopic procedures) are supported by either “good” or “fair” evidence:

- Measurement of fasting blood glucose level every five years starting at age 45;¹
- Measurement of blood cholesterol level once between age 20 and 25 years and then every five years, starting at age 35 for men and at age 45 for women;¹,²
- Annual chlamydia testing for sexually active females age 25 and younger;¹,²
- Annual fecal occult blood testing (as an option or in addition to the five screening tests appropriate for each interval of life.

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to periodic sigmoidoscopy) starting at age 50;1,2 and
• Pap smear testing every three years after two normal annual Pap smear test results in females who are or have been sexually active.1,2

What To Do When Patients Demand Tests
The challenge for physicians with demanding patients is to balance their expectations with the requirements of evidence-based medicine. Contrary to what many doctors believe, I find that most patients readily accept an office visit without an accompanying trip to the phlebotomist if I first explain to them that no blood testing is indicated. Patients who nonetheless desire laboratory testing or who demand a specific test must be managed carefully because abruptly denying their request may alienate these patients. Instead of bluntly responding “No, I will not order that test,” a clinician is more likely to invite rational discussion by saying “Let me tell you my thoughts” if the requested testing is poorly advised or “I’d be glad to order that test, but first let’s talk” if the testing is a reasonable option. Asking the reasons behind a request might also provide valuable information and clues on how to address the patient’s concerns specifically. Sometimes a third person—someone behind the scenes—orchestrates the demand for testing; in those cases, a discussion with that person (with the patient’s consent) may better satisfy all parties.

Managing Your Results
Because primary care practitioners are ultimately responsible for managing laboratory results, we all justifiably concern ourselves with careful review and follow-up of abnormal test results. For example, we all live in fear of the positive stool occult blood test result that falls through the cracks. Each of us has set up our own system to guide patients with abnormal results through telephone discussion and repeat testing, a second discussion, and perhaps additional testing, treatment or consultation with a specialist. More often than not, test results pile up on our desk, remain there for long periods, and risk being misplaced. Better management of this process requires a sophisticated laboratory system and active involvement of the nursing staff and even of the patients themselves.

Laboratory Capability
Most laboratories already stream-line evaluation of abnormal test results by reflexively repeating the test or administering an alternative confirmatory test. For example, an abnormal level of thyroid-stimulating hormone (TSH) triggers testing of the same blood sample for free T4. The patient, unaware of this additional test, is spared a phone call from the doctor and a second trip to the laboratory. Your evaluation of a laboratory result can be further assisted if it is accompanied by contextual information. For example, a notation that the patient is receiving a particular antibiotic is helpful for evaluating a culture and sensitivity result. In a more advanced clinical system, the physician might also be provided historical information such as diagnoses or prior test results for comparison. These “smart” laboratory results could be a great timesaver and can be particularly useful to any physician covering for you who is unfamiliar with your patients.

Nursing Support
Your nursing staff also should be enlisted to support you in managing laboratory test results. However, a call from your nurse to a patient with a mildly abnormal test result might save you time initially but could raise more questions later from your justifiably concerned patient. To avoid this situation, prepare your patients in advance to expect a call from your nurse if a test result is abnormal: Tell your patients that the nurse will call them about any abnormal results and will convey your personal instructions about what action to take. During the visit, try to give patients specific information, such as “I will prescribe potassium for you in case your potassium level is low.” This may allay their fears and increase compliance when the nurse does call. If the abnormality is serious, however, nothing should substitute for a personal call from the physician. Many KP departments use clinical practice algorithms that allow registered nurses to manage specific illnesses. The protocol for urinary tract infection (UTI) exemplifies use of such an algorithm: The nurse obtains the patient’s medical history and symptoms from the patient over the phone while filling out a preprinted questionnaire. A urine culture is seldom necessary and is ordered only if the patient meets certain criteria. The physician then reviews the questionnaire, prescribes appropriate antibiotic therapy, and the nurse makes all the necessary arrangements.

Feedback
During the past few years, I have increasingly found patients to be interested in obtaining precise numeric results of their laboratory tests. These patients are not satisfied with being told simply, “we’ll call you if the results are abnormal.” Automated programs have been developed to give confidential results by
telephone, but many patients are reluctant to try this technology or find it difficult to use. Of the doctors I surveyed, about half use various approaches to relay all or most normal test results to patients. Some doctors send a copy of all laboratory test results directly to the patient’s home. This process can be simplified by folding the test report into a window envelope so that the patient’s name and address are clearly visible. Other doctors send postcards or prewritten documents with a personal comment added or educational material attached. By all accounts, patients genuinely appreciate this information. Contrary to the fear expressed by many doctors—that they will need to field countless calls from alarmed patients—the doctors I queried stated that informing patients of all test results prompted fewer (not more) telephone calls. Other doctors take a different approach: They simply ask their patients to take their prescribed laboratory tests shortly before the next scheduled appointment so that the results can be discussed in person at the visit.

**Patient Accountability**

Enlisting patients in their own follow-up is a final step in managing abnormal test results. Asking patients to call when they complete any retesting not only increases their compliance but also ensures that I review and discuss their case whether the final result is normal or abnormal. Perhaps most importantly, asking patients to make this phone call reinforces the modern proposition that patients must take some responsibility for their own health.

**Conclusion**

Managing laboratory test results is a time-consuming yet critically important aspect of any physician’s work. A surprising fact, however, is that little research has been done on this topic; moreover, physicians seldom discuss their practice strategies with each other. New physicians, in particular, could benefit from having discussion of this topic included in their orientation. Five items are most important to emphasize:

- Order screening laboratory tests in an evidence-based manner;
- Maximize nursing support for communicating with patients and use clinical practice algorithms that include nursing support;
- Give routine feedback to patients about normal laboratory test results (this practice is highly valued by many patients, who can reduce the number of messages that you receive from patients);
- Encourage patients to take responsibility for their health and test results;
- Discuss helpful techniques with other physicians so that “best practices” of test result management can be shared for the benefit of clinicians and patients.

With all the pressures on primary care practitioners, each of us must develop an efficient, reliable system for optimizing management of laboratory test results. Such a system can make this important task a more satisfying part of our day and not simply a burden that keeps us late in the office.

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**Acknowledgments**

Maureen Spell, MD, FACP, Chief of Internal Medicine, and James Evans, MD, of Internal Medicine, reviewed the manuscript and provided valuable suggestions.

The General Internists at the Kaiser Permanente Los Angeles Medical Center and members of the Southern California Permanente Medical Group Regional General Internal Medicine Committee shared with me their thoughts about laboratory management.

**References**

The following are excerpts from recent dialogues with members of Kaiser Permanente’s Interregional Clinician-Patient Communication Leadership Group and The Permanente Medical Group’s (TPMG) Communication Consultants. The focus is the foundation of patient-centered care experience—effective clinician-patient communication in the exam room. I believe our readers will find this dialogue instructive as the participants suggest approaches that are possible despite the limited time we have during office visits.

—Lee Jacobs, MD

The following are excerpts from recent dialogues with members of Kaiser Permanente’s Interregional Clinician-Patient Communication Leadership Group and The Permanente Medical Group’s (TPMG) Communication Consultants. The focus is the foundation of patient-centered care experience—effective clinician-patient communication in the exam room. I believe our readers will find this dialogue instructive as the participants suggest approaches that are possible despite the limited time we have during office visits.

—Lee Jacobs, MD

Patient-Centered Care in the Exam Room—Do we really have the time?

Lee Jacobs, MD: Let’s open by confronting the tension that our physician readers may sense—Do I really have time to make this happen? Help us out, panel: How can Permanente clinicians get any more patient-centered than they are already, considering all the tasks that need to get done in a brief interaction? Isn’t being more “patient centered” an unrealistic expectation?

Meg Graue: Patient-centered care truly acknowledges the patient as an individual. Because this is a real challenge for physicians when they’re seeing so many patients each day, it is important that they make a connection quickly, acknowledge the patient as a person, and then commit to work with them at their individual pace. The belief by the patient that they are important to the physician, and not just one person among many on an assembly line, is essential to providing care that is patient centered.

Terry Stein, MD: I think there are enormous pressures on clinicians to accomplish more and more in less time. So promoting a greater degree of patient-centered care can feel like another imposition. The irony is that using patient-centered approaches can relieve some of the pressures.

Dr Jacobs: We’re all interested in any approaches that might actually diminish the pressure on the clinician. Tell us more, Dr Stein.

Dr Stein: When we are on the “hamster wheel” seeing lots of patients, we put out a lot and get depleted ourselves. Having a sense of connection with our patients by noticing and acknowledging their emotions sustains us, reduces conflict, and makes practice more fun. I hear this over and over again from clinicians—even surgeons—who change to a more patient-centered approach. Also, when we share some control about decision making with our patients, we carry a lighter burden.

Defining Approaches to Patient-Centered Care

Dr Jacobs: Helpful insight, Dr Stein. Realizing that both patient and clinician benefit, let’s identify some approaches available to the clinician. Could you describe what patient-centered care might look like in the exam room?

Ann Eastman, MD: What it comes down to is being with the patient and taking into consideration the whole human being.

Ilene Kasper, MS: The specific skill that helps the physician acknowledge the patient as an individual is empathy. Empathy is both an understanding and an acknowledgment of the patient as a person as well as listening to what the patient has to say.
Patient-Centered Care in the Exam Room at Warp Speed

Vivian Nagy, PhD: Patient-centered care is care from the patient’s perspective, whether provided by primary or specialty care, outpatient or inpatient. Patient-centered care covers not only communication between patients and clinicians but also various aspects of the care experience.

Ms Graue: To provide care that is patient centered, we must discover what the patient expects and then make certain that the physicians’ and the patients’ expectations are aligned. That is foundational for patient-centered care.

Scott Abramson, MD: Less doctor talk, more doctor listen.

Ms Kasper: Perhaps a key component of patient-centered care is how decisions are made. Patient-centered care focuses on what patients perceive their needs to be, what their preferences for treatment are, and what they are or are not willing to do. Good patient-centered care is really a partnership between the clinician and the patient.

Importance of Patient Participation in the Treatment Decision

Dr Jacobs: Good point, Ilene. Providing patients with treatment options and then supporting them in making decisions is essential if patients are to be involved in their own care. In a recent JAMA article, David Mechanic chronicled the increasing level of patients’ knowledge about disease, since 1957, and the level to which patients today want to be involved in selecting their treatment. Do you agree with his assessment?

Ms Kasper: Yes. If physicians can appropriately inform patients of treatment options, using evidence-based medicine when available, the patient is in a better position to make a decision s/he will actually follow.

Ms Graue: We know that involving patients in decisions improves their satisfaction as well as the outcomes. This is not surprising, because by acknowledging and involving the patient, the treatment intervention is more likely to be successful.

Dr Stein: I don’t think we have figured out how to truly engage in shared decision making, especially around complicated decisions, in a 10- or 15-minute office visit. What we can do is find out the patient’s perspective and use collaborative instead of directive language when we talk about the treatment plan.

Dr Nagy: This is especially true in lifestyle changes, such as smoking cessation and weight loss. Interventions that involve consideration for patients’ feelings about what might be especially difficult for them, and what they might be able to achieve as a first step, is more likely to lead to changes in behavior.

Michele Knox, MD: It never ceases to amaze me when I talk with a patient about going ahead with a particular surgical procedure, my assumption about what the patient would choose often ends up being wrong.

Ms Graue: So much can be learned from the patient by simply saying, “I’ve got some ideas about what’s going on, but I’d really like to know what you think.” I’m amazed when I observe visits, and patients respond, “Oh really? You want to know what I think?” We all know that if the patient doesn’t agree with your approach, then we shouldn’t expect a high rate of adherence.

Dr Nagy: It is important. Patients also have some ideas of what the problem or illness could be and may have some unfounded fears based on these theories. If the doctor doesn’t address those fears, the patient leaves still feeling troubled. The extent to which the physician brings out these fears will add to the overall quality of the outcome.

Other Suggestions for the Clinician

Dr Jacobs: In addition to empathy and involving the patient in the decision-making process, does anyone have any other suggestions to help clinicians quickly develop a bond with patients remembering that we have limited time in the exam room?

Ms Graue: We encourage the physicians to get more specific about acknowledging where the patient is at the moment. It is very effective when the physician walks into the room and says, “It looks like you’re in a lot of pain right now” or “It sounds like a really scary experience.” To acknowledge where the patient is right now emotionally and physically confirms that the clinician is aware of the patient’s particular discomfort or worry. When I observe the reaction of patients when physicians say this, I can see the connection being made. The patient’s viewpoint is “You get it, you see me.”

Ms Kasper: To emphasize the value of investing in the beginning of the interview, we encourage physicians to make one nonmedical statement to the patient. If it’s something that you know about them from a previous visit, referring to it can help establish rapport. Something like, “I remember you were going to your daughter’s wedding in Hawaii.” Then, right up front, as Ms Nagy said, check in with how the symptom or illness is affecting the patient’s life and what worries the patient most.
Dr Nagy: Sometimes within the context of empathy or being in the moment, what the patient may be expressing to us could be more than just a symptom. It could be an important value they have. It could be an idea they have about their illness, or it could be a belief they have. Unless we really unearth those things by listening well, we haven’t really made a good connection with our patients.

Ms Graue: I tell clinicians that once a relationship has been built with the patient, it’s time to listen. For many people, when the day is running so fast, it’s really difficult to sit back and allow the patient to share without interruption.

Can Physicians Actually Learn New Approaches?

Dr Jacobs: As trainers, you have experienced clinicians who try these new approaches and feel awkward. In your experience, can clinicians pick up these skills?

Dr Stein: Absolutely. After our training programs, I hear back from people about what they are doing differently and how even simple changes enrich their practice. And I just read a study documenting that physicians who have been in practice for 20 years are able to improve their skills.

Ms Graue: I agree. We teach these approaches on a regular basis as part of our workshops based on the Four Habits model of clinician-patient communication. Clinicians do acquire new skills.

Ms Kasper: I’ve learned that physicians respond very positively to these educational programs—especially to the scripting. When clinicians try new ways of saying things and see that it works, they are more likely to adopt the approach into their practice.

Dr Jacobs: I want to thank the panel for an excellent discussion. I especially appreciate your reminder that despite the time crunch we are all under, basic communication skills in the exam room are the foundation for creating an environment of patient-centered care. Patients as well as clinicians can feel better about the experience. Your emphasis on the importance of involving our patients in treatment options, a skill arena now being referred to as “shared decision making,” seems to be the most important new skill for us to acquire as we strive to provide care that is truly patient centered.

Again, I want to thank all of our panel members for participating today. ❖

Reference


The Potential to Turn a Life Around

Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around.

Leo Buscaglia, 1924-1998, author
Keeping Your Clinical Team Winning: Insights and Experience From the KP Georgia Region

By James Hipkens, MD, PhD

Importance of a Strong Clinical Team

The Kaiser Permanente (KP) Georgia Region has been forming clinical teams and working on team development since 1977. As these teams began to work with their patient panels, the KP Georgia Region gained the clear understanding that highly functional medical teams were essential if patients were to be highly satisfied and bond with their personal care providers (PCPs). Organizing health care delivery using a team model has generated a sense of ownership among all the team members, and this sense of ownership has resulted in greater professional and personal satisfaction in the clinic.

From their years of experience assembling clinical teams, team leaders in the KP Georgia Region have also learned that multiple opportunities exist for continually infusing “new life” into these teams to keep them feeling stimulated and creative. The KP Georgia Region has thus been formulating answers to three major questions: After your team has been established, how do you keep it creative and energized? How do you manage a change in team leadership? What keeps highly functioning teams doing well when major changes take place? The answers are contained in the six guiding rules outlined here.

Rule 1: Establish Sound Principles for Team Behavior

Forming your clinical team is only the first step; ongoing maintenance of the team is critical to its forward motion and continued success. The KP Georgia Region learned this lesson in August 2002 after losing our long-established team leader. At that time, many team members (Table 1) expected that patient satisfaction would fall as a result of this personnel departure, which was hastened by conflicts that arose after the team leader’s resignation letter was delivered. While 3000 patients in the departing team member’s panel awaited reassignment to other PCPs, the other team members were already working nearly to capacity. Moreover, the existing patient panel had been highly bonded to the team since its earliest days.

How were these obstacles resolved? Working under a new team leader for 5 of 12 months of the year, we finished in first place for the region. But this outstanding result did not happen by coincidence. Instead, we had realized that our fundamental behaviors were the secret to our continued success and were responsible for our success in the first place. These behaviors included paying attention to patients’ needs; validating patients’ concerns; setting professional examples that we all could be proud of; acknowledging patients’ time constraints and providing convenient service; and interacting interpersonally with respect, kindness, and compassion.

Rule 2: Emphasize Inclusion and Open Discussion

Even a brief examination of group dynamics shows that all team members want three things: to be included, to be important, and to be listened to. Boredom in one’s profession grows from a sense of isolation and disconnection from other members of the team. To prevent this boredom, we initiated a simple program early on to enhance participation at team meetings: We assigned a “meeting leader,” a “timekeeper,” and a “notetaker” and rotated each position among all team members throughout the year. This practice led to greater appreciation for...
meeting content and for following an agenda while enhancing the ability of team members to contribute individually at each meeting.

**Rule 3: The Team Must Recruit Members for Itself**

Recruiting for the team is another critical issue. We encourage all team members to participate whenever we recruit for new or vacant positions. During the interview, we impress on the applicant the value of intrateam cooperation, the importance of being honest and straightforward about issues currently or potentially affecting the team, and our unique team culture of inclusion that has led to our success. We let interviewees know that we are a busy team with an interesting and appreciative patient panel.

Our mission statement, developed by the team, also has been important in our success and is used in recruitment: We make each new team member aware of this mission before the member joins our team. In particular, we emphasize a key line in our mission statement: “to treat our patients as we would want ourselves to be treated.” This goal provides an instant education for each of us, because we all have had the experience of medical services being impersonal, disrespectful, too costly, or taking too much of our time. Thus, to meet this aspect of our mission, our team members discuss waiting times, tone of voice, personal distractions, and demeanor as these factors relate to patient care. We are pleased to include members on our team who understand and value these concepts. We also like to solve problems quickly; therefore, we remain ready to admit that we have made mistakes and will probably make more mistakes. We recognize that mistakes can energize the learning process and keep it active.

**Rule 4: Practice Medicine “The Way We Were Taught”**

In developing our team values, we reflected on our own medical training and realized that “practicing medicine the way we were taught” needed to become both our value and our mission. Our vision derives from this mission and includes working toward success, creating an environment where our skills help our patients, working to keep our patients satisfied with their medical care, and keeping ourselves professionally challenged. The team ends each week with a great sense of accomplishment and renewed awareness of why we chose to be in health care. Indeed, our team training brought out the question — “Why are we doing this?”, which we must ask ourselves every day. I believe that our patients can almost certainly best answer this question, because their needs are what this business is all about.

**Rule 5: Recognize and Address Boredom, Infighting, and Disrespect**

Because team activities can become mundane, an essential strategy is to look for ways to breathe new life into every team—especially when extremely busy days have generated fatigue and frustration. We try to identify boredom among the professionals in our team, and we make special efforts to challenge these team members with projects that will reinvigorate and enhance their interest in better health care delivery:

- We discuss recent findings learned through continuing medical education and let our staff come up with investigative projects to improve patient encounters.
- Team leaders try to identify interpersonal infighting and bring the issues to the surface quickly to avoid further deepening the divide between individuals or groups in the team. Disrespect is not tolerated in our module.
- We place a high value on respect for patients and team members alike. The need for

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**Table 1. Gwinnett Medical Office Internal Medicine Team A**

<table>
<thead>
<tr>
<th>Name</th>
<th>Certification</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Hipkens, MD, PhD</td>
<td>Board-Certified, Internal Medicine</td>
<td>Team Lead</td>
</tr>
<tr>
<td>Kim Livsey, MD</td>
<td>Board-Certified, Family Practice</td>
<td>Health Care Practitioner</td>
</tr>
<tr>
<td>Thomas Do, MD</td>
<td>Board-Certified, Internal Medicine</td>
<td>Health Care Practitioner</td>
</tr>
<tr>
<td>April Hall, PAC</td>
<td>Certified Physician Assistant</td>
<td>Health Care Practitioner</td>
</tr>
<tr>
<td>Dennis Clayton, PAC</td>
<td>Certified Physician Assistant</td>
<td>Health Care Practitioner</td>
</tr>
<tr>
<td>Brenda Bridges</td>
<td>Registered Nurse, AD</td>
<td>Clinical Supervisor</td>
</tr>
<tr>
<td>Bellzoria Goodman</td>
<td>Registered Nurse, BSN</td>
<td>Team Advice RN</td>
</tr>
<tr>
<td>Janet Glover</td>
<td>Licensed Practical Nurse</td>
<td>LPN Clinical Specialist</td>
</tr>
<tr>
<td>Shirley Jenkins</td>
<td>Licensed Practical Nurse</td>
<td>Health Care Assistant LPN</td>
</tr>
<tr>
<td>Diane Williams</td>
<td>Licensed Practical Nurse</td>
<td>Health Care Assistant LPN</td>
</tr>
<tr>
<td>Betty Van Leal</td>
<td>Licensed Practical Nurse</td>
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<tr>
<td>Paula Trimiar</td>
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<tr>
<td>Danielle Hudgins</td>
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<tr>
<td>Lavern Hager</td>
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<tr>
<td>Gloria Carlisle</td>
<td>Health Care Clerk</td>
<td></td>
</tr>
<tr>
<td>Melina McKeithen</td>
<td></td>
<td>Customer Service Coordinator</td>
</tr>
</tbody>
</table>

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Keeping Your Clinical Team Winning: Insights and Experience From the KP Georgia Region
respect in any group is universal and the sting of disrespect is universal as well. Many problems can be avoided if issues are clearly and openly discussed and team members are encouraged to talk over situations that might lead to a perception of disrespect.

Rule 6: Congratulate One Another for Team Success

After the departure of our team leader, we had anticipated major difficulties with our longstanding, highly functioning delivery of service. With this personnel change, we expected chaos. Looking back, however, we realized that as a team, we had established all the skills we needed for moving forward and continuing to take good care of our patients. We congratulated ourselves for acquiring and developing these skills, and we were honest and forthcoming with our patients about what was occurring within our team.

Conclusion

As part of our team’s successful ongoing development, we try to accommodate both the team and our patients in “above and beyond” ways. We keep them aware of our team’s progress and ongoing PCP assignments as well as those that may be undergoing change. Throughout it all, we give our best, and we acknowledge our efforts and successes. Our patients have told us—and they continue to tell us—that we are doing it right.

Our Original Goal

Our original goal, high quality care at reasonable cost, is as valid today as in ’42. The old saying still stands, ‘If we take care of the Health Plan members, they’ll take care of us.’

Bruce J Sams, MD, former Director of PMG, Inc.
Clinical Renovations: A Scientific Structure for Success

By William F Pfeiffer, MD


The significant problems we face cannot be resolved at the same level of thinking we were at when we created them.
—attributed to Albert Einstein

“... the purpose of bureaucracy is to compensate for incompetence and lack of discipline—a problem that largely goes away if you have the right people in the first place.”
—James C Collins, Good to Great

Introduction

American medicine has produced dramatic and miraculous advances in care over the past several decades, and Kaiser Permanente (KP) has often been at the forefront of innovations in delivering this care. Nonetheless—and although advances in technology and quality have produced major benefits to the American populace—the medical industry nationwide has never been noted for excellence in customer service. While many industries became accustomed to the pressures of competition, this concept remained foreign to medicine. Now, however, times have changed.

The Past—A Problem to be Solved

In the past, the Pediatrics Department at KP Honolulu consistently adhered to standards of efficiency, effectiveness, and customer service that had become common nationally in medicine: Phones often went unanswered; access was often difficult to obtain; systematic approaches to operations either didn’t exist or were obtuse and dysfunctional; and customer service was congruent with these supporting structures. An evident fact was that delivering this level of service to our members was no longer viable—and that neither would we be if we continued in the same way.

We approached this challenge by focusing on three essential needs: well-functioning operations, empowered employees to run these systems, and supportive leaders to help build the systems and facilitate the employees’ performance. This article discusses our approach to changing the systems to work for the end result: serving our patients.

The Diagnostic Approach

Many of our operations did work quite well—just not for our patients. Dysfunction often existed because the system was designed to be effective for someone along the process path; for example, sometimes systems were designed for the ease of employees working at the beginning of the process. Some systems were designed to protect a “weak link”—real or perceived—or to appease a certain interest group or hardened silo. Honest introspection into many of our paradigms revealed uncomfortable patterns that nonetheless needed to be addressed.

Closer inspection showed that most operations were failing because they were designed “backwards”: Focus was placed not on what was needed but on what we thought we could provide. Operations often reflected the bureaucratic hierarchy, not the abilities of employees or the needs of Health Plan members. Systems often evolved from a series of compromises. Although compromise may be politically expedient, systems that result from compromise are usually compromised systems.

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The Reconstruction

The first step in any improvement program is to realize that you can’t do it alone. Nonetheless, our clinical systems were designed and managed predominantly by doctors and nurses—none of whom traditionally are trained in operational processes. We therefore needed to add to the management team a business consultant, an industrial engineer, or sometimes, a referee. We needed professionals to assist us with duties that were outside of our profession.

During our clinical redesign, we developed a structure that can be applied to a variety of settings. In this structure, the hierarchical pyramid is inverted so that the leadership supports the staff with principles, tools, and empowerment, thus allowing them to function at their highest capacity.

We call this approach “gyroscopic operations.” A gyroscope provides stability and maintains direction by using momentum created by rapid rotation of a wheel. Despite outside forces placed upon it, a smoothly operating gyroscope resists movement from its core direction. We wanted our systems to operate in the same manner.

We believe that this approach is one key to our success and can be useful for other clinics. A schematic of this approach is shown in Figure 1.

In this approach, employees are given principles, guidelines, and tools to do their job well. They then perform independently with these principles for guidance and with leadership for support. The support structure is completed by systems (created to allow consistent realization of each goal) and measures (delivered for redirection or fine tuning directly to the employees whose performance is being measured).

Construction of this structure must be accomplished in stages. First, principles and goals are determined. For example, the primary care leadership determined that all patients should have a primary care physician and should see their personal care provider (PCP). Patients should also be seen on the day that they call about an illness. Each of these principles is a universal, intuitive truth that few would challenge.

Once these principles were set forth, a system was designed to achieve each goal. To be effective, the system was set up so that the path of least resistance was to provide the desired service; if employees must “swim upstream” against the system or if they have no tools enabling them to easily perform duties consistent with the guiding principle, then that goal will not be realized fully or consistently. If receptionists are assigned to give patients same-day access, then appointments must be available on that day. If receptionists are assigned to match patients with their PCP, then a functional mechanism must exist by which this assignment can be consistently achieved. Employees need tools that serve them and make it easy to do the work the right way.

The other internal support implemented was measurement that reflects movement toward the guiding principle. These measures are delivered to and reviewed with the employees whose performance is being measured.

These supports are linked to the staff by a local leader chosen from among the employees themselves. This leadership position—an essential piece of our approach—is not recognized officially in the organizational hierarchy but is held by a person to whom the staff look for competence, information, and direction. Moreover, by assuming this leadership role, a staff member implies that all members have the potential to be leaders. This message begins to diffuse sharp de-

![Guiding Principle](image)

**Figure 1. Schematic illustration likens operational structure of KP Honolulu Pediatrics Department to a gyroscope in which functional processes of the clinic are directed toward a guiding principle and are kept in balance by clinical peers. These functional processes operate within a structure of systems and measures and are based on clinic and organizational leadership.**

<table>
<thead>
<tr>
<th>Process</th>
<th>Honolulu pediatrics data</th>
<th>KP Hawaii data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same day access</td>
<td>Available daily</td>
<td>Intermittently a struggle</td>
</tr>
<tr>
<td>Same PCP accessa</td>
<td>93%</td>
<td>79%</td>
</tr>
<tr>
<td>Exit linking</td>
<td>77%</td>
<td>56%</td>
</tr>
<tr>
<td>Health care team</td>
<td>87%</td>
<td>72%</td>
</tr>
<tr>
<td>satisfaction indexb</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data from Regional Data Center, July 2003
b Health Care Team Survey, Spring 2003
Health systems

Marcations in the workplace hierarchy and empowers the staff to think of themselves not only as empowered but as responsible.

Employees using these systems may be considered the flywheel of the gyroscope. Allowed to perform in a low-friction environment, they provide the momentum and stability that keep the system oriented in the direction of its core principles.

We based the new approach on the premise that all people come to work to do a good job. Giving them principled goals, functional systems, and feedback are generally sufficient incentive to create both improvement and satisfaction.

A gyroscope thus provides a metaphor for this structure. The most important part of this structure is the staff, who perform their duties in a functional environment, provide momentum and stability, and maintain direction. The leaders act as a supporting structure and provide a platform on which the employees perform their jobs.

Application and Extrapolation

KP's Health Care Team Leadership provided the principles for quality service and care. A “gyroscopic” structure and new systems were applied to each of these goals, and—when possible—systems were automated to accomplish the goals. Examples of such principles and their operationalization are shown in Figures 2 and 3.

The KP Hawaii Region determined that linking members to their PCPs would be best attained after the first visit to a KP clinic. Medical assistants were chosen as the best suited for performing this function, and systems were designed and automated to accomplish it. Measures were delivered and reviewed with a medical assistant who took an active interest and led in the endeavor. The team and clinic leadership enabled the processes, and the organizational leadership supplied measures and evidence-based principles upon which to focus.

Figure 4 is an abbreviated schematic of operations involved in passage of a patient through a routine clinic visit. As the patient moves through the clinic, a variety of operations occur simultaneously. To be accomplished consistently, goals must be intuitive as well as important to the staff and to patients. Systems must work to achieve these goals easily; the staff must be empowered to maintain and improve each operation; and relevant, actionable measures must be delivered regularly. All these tasks and objectives must be supported...
by the leadership, not imposed by it. Figure 4 shows how this approach for monitoring and correcting aspects of a medical encounter is analogous to the gyroscopic activity of an airplane’s navigational system.

In its clinical redesign, KP’s Honolulu Pediatric Department has focused on several principles set forth by the Health Care Team leadership. By applying the “gyroscopic operations” structure to these goals, processes were automated for consistently achieving the objectives (Table 1) of the clinic’s staff (Table 2).

**Conclusion**

Creating a structure in which employees can perform professionally to the best of their ability makes patients and employees—clinical as well as nonclinical—universally happier. We have learned that if we empower people to do a job well, they will do so. Give them the tools to do it, and they will use them. Build systems that work for the end customer, and these systems will work for everyone. Focus on doing the right things for patients, and the resources already available will usually be sufficient.

We have found that good service is beneficial to patients, physicians, and all other employees. When patients have access to their primary care physician, when receptionists are able to give appointments when patients need them, when physicians are not backlogged or rushed, when flow through the clinic is smooth and expedient, and when staff can perform interdependently to their highest potential, all involved will find themselves much more effective—and possibly, therefore, more contented.

**Acknowledgments**

Suzanne Ivey, BS; Glenn Y Furuya, MA; and Chris Lutz, BS, MBA were consultants on leadership and systems improvement.

**References**


**Additional Reading**

Impending Death

By Kelly Ann Malone

I sense a figure infiltrate,
Devour from within
Embalming me with Frankincense
Where organs once had been

They place me on a heavy board
A lady comes to me
With objects on a silver tray
Of which I cannot see

And as I lay there motionless
She gently strokes my hair
She paints my face with full make-up,
But leaves my body bare

I then look up to see my mom
She holds an ivory dress
I look into her troubled eyes
And see her sheer distress

She runs her hand across my cheek
Her head upon my chest
I hear her moan on top of me
Then starts to get me dressed

They place me on indulgent silk
Pink roses at my feet
I’m draped in my old wedding dress
The grooming is complete

I feel a grasping at my heart,
I cannot catch my breath
I then proceed through panic’s door,
To feel again, my death

Kelly Ann Malone is a Project Analyst in the Regional Cancer Registry in Pasadena, CA. She was born at KP Panorama City and has been writing since she was 12 years old. Her poetic inspirations are Ogden Nash and Dorothy Parker. E-mail: kelly.a.malone@kp.org.
Staff Empowerment, A Prescription For Success

By Cynthia R Copp, MSN, APRN, CPNP
Christine Agpaoa, CMA
Sandra Carvalho
William F Pfeiffer, MD

Introduction

Staff empowerment enables employees to make independent autonomous decisions in almost any situation. This empowerment would necessitate guidelines for the conduct of whatever role staff members occupy. Dunlap et al found that by empowering employees, managers create a nurturing environment in which staff can learn, grow, improve, and function effectively. Staff empowerment gives employees a sense of trust, importance, and capability, thus creating a positive work environment.

Erikson et al stated that empowerment occurs when organizational leaders engage staff in ways that promote personal and professional growth: Leaders help employees to extend their capabilities and thus to make progress toward realizing the staff’s full potential. We found that involving each staff member in clinical processes and operations creates a more committed staff. Thus, during the evolution of our health care team, we invited all the staff to participate in bringing order and contentment to the chaos and frustration existing in the clinic. This mission would necessitate a more functional system, empowered employees, and an increased sense of customer service.

Staff Empowerment

In many large organizations, the workforce often feels frustrated and stifled by not being permitted to have any input into their work. This situation leads to unnecessary stress and lack of productivity (Figures 1,2). At the Kaiser Permanente (KP) Honolulu Pediatric Clinic, staff members (see Table 2, page 35) are invited to be a part of their own operations: They are encouraged not only to identify and “own” the problem but also, in turn, to “own” its solution so that a positive working environment can be created and maintained.

The staff of our pediatric clinic includes five physicians, each of whom is assigned a medical assistant; two nurse practitioners, who share the services of one medical assistant; four registered nurses; one licensed practical nurse in the injection clinic and one “virtual” injection nurse (who may be paged from the nurses’ station to administer immunizations in the patient’s room); and several receptionists. Because several medical assistants in the clinic are pursuing a nursing degree, the staff must use a principled, flexible schedul-
ing scheme. This scheme involves self-scheduling, a process in which the medical assistants state their availability to a scheduler (another medical assistant). The scheduler considers each medical assistant’s preferences and needs while assuring that each physician has adequate medical assistant coverage daily. The medical assistants in the clinic are content because they have input into their schedules and thus support their goals for family life.

Having identified a need among clinic employees for consistent operations, medical assistant Mary Domingo founded our Medical Assistant (MA) Playbook, a 300-page compilation of principles, procedures, protocols, phone numbers, and other important information. In the course of our operations, when any new protocols or changes were to be implemented, clinic employees were invited to add to the Playbook to ensure that clinic functions were consistent and standardized. The Playbook is both an excellent resource for clinic employees and an outstanding training manual for newly hired employees.

**Teamwork**

Writing about clinical management, Mass stated that regardless of the structure and technology of an organization, its most potent leverage for exceptional performance and quality assurance lies within the workforce.

Five years ago, when our health care team was formed, the clinic manager and the health care team leader sought to invest in its people by sending everyone involved with direct patient care to Teamworks, a six-day workshop conducted by Glenn Furuya, a consultant to the KP Hawaii Region. The Teamworks workshop is designed to enhance the experience of being a contributing team member. The program provides skills in group process facilitation, team building, conflict management, problem solving, and quality management. The workshop also helps employees to understand leadership styles, techniques, and systems as well as employee optimization, facilitation, and empowerment. We find that sending employees to this workshop has facilitated cooperation, collaboration, and cohesion within our team.

Most of us who grew up in Hawaii or who have come to call Hawaii our home have had some introduction to traditional Hawaiian values. Eight of these values—and their approximate translation—include aloha (a collection of desirable social, emotional, and spiritual traits which lead to reciprocal, joyous, sharing relationships between people), ohana (family), kuleana (responsibility), kôkua (helpfulness), laulima (cooperativeness), ike (recognition, vision), ho`oponopono (setting things right; correcting problems and conflicts by openly discussing them with forgiveness), and lôkahi (peace, balance, unity, harmony) (Figure 3). These values are vitally important to a fulfilling lifestyle. Our team has adopted these values, which have been accepted into each team member’s inner being and have provided both a common vision and ground rules for creating and maintaining a highly satisfying, enjoyable workplace.

**Communication**

For any relationship to flourish, it must include a vital component: communication. To disseminate information to the staff, two special communication avenues were set up in our clinic: our daily “morning huddle” and our semimonthly team meetings.

The “morning huddle,” as we call it, is the informal daily meeting of medical assistants, registered nurses, and nurse practitioners who are working in the clinic that day. They meet at the nurses’ station from about 8:45 am until about 9:00 am to share any new forms, equipment, protocols, or pertinent information that may affect the workflow. Someone reads aloud the names of the physicians staffing the clinic that day, the medical assistants assigned to work for those practitioners, and the role of each registered nurse on the team. At the end of each morning huddle, a motivational quote is read to create a positive tone for the rest of the day.

Initially, when our health care team started, we found that meeting weekly was important so as to maintain our momentum and vigilance in formulating our principles. Then, as our team moved forward and much of the groundwork was completed, the members decided that such frequent meetings were no
longer necessary but that having regular meetings at least twice monthly was important.

**Demand-Based Scheduling**

I have alluded to chaos previously existing in the clinic: If you had interviewed staff members working in the pediatric clinic before we implemented our clinical renovations, you would have seen a lot of head shaking and frustrated looks on people's faces. As one of our receptionists, Sandy Carvalho, could tell you firsthand the system of scheduling patients for visits to the pediatric clinic was not working well. Now that we have implemented what we call “demand-based scheduling,” access to primary care practitioners has increased tremendously for patients. In addition, clinicians' schedules have become more manageable.

Our system of demand-based scheduling is a simple approach based on principles of patient care; within these patient-based principles, the system is flexible for patients and employees (Figure 4). The fundamental idea of demand-based scheduling is to redistribute supply to meet demand (Figure 5). Demand is characterized by priority level so that patients who are sick or who have other urgent medical problems are seen on a same-day basis, and patients with nonurgent needs receive appointments to fill existing capacity throughout the month. In this system, appointments are readily available, and patients choose the day and time convenient for them. We believe that this patient-centered aspect of the system is an integral part of why it is successful.

Our demand-based scheduling model has had positive results:

- Demand for appointments has become reasonably predictable (Figure 6);
- Access to clinicians is appropriate, timely, and convenient for patients;
- Assisted by an easy-to-use tool, the “fuel gauge” (Figure 7), receptionists can give patients what they need or request;
- Physicians are not backlogged or rushed;
- The clinic runs smoothly and expeditiously;
- Satisfaction is increased for everyone involved—patients, receptionists, and physicians as well as nonphysician medical staff.

**The Associate Clinician Role**

In the past, nurse practitioners working in the KP Honolulu Pediatrics Clinic were required to prepare paperwork, initially interview the patient, and see the patient for an appointment. Despite these nurse practitioners' advanced degree—a master's degree from an institution of higher learning—this scenario paid nurse practitioners for performing clerical duties and failed to use them to their highest capacity.

The primary role of the pediatric nurse practitioner is to perform physical examinations and treat minor acute illness in children. In a functional system that includes a dedicated medical assistant for clerical support, the nurse practitioner has more opportunity to practice a niche specialty in which they serve as expert and as consultant to the physician. Nurse practitioners at our clinic see patients for asthma education, adolescent gynecology, lactation consultation, tuberculosis follow-up, and weight management. When nurse practitioners are supported in this way, they sense that they have a value-
added role within the team. Nurse practitioners are thus empowered and become even more committed to their work, to the team, and to the organization.

A nurse practitioner’s relationship with team members and with other clinicians should be one of interdependence. In the health care industry, no person can—or should—stand alone. A group of people with different and special talents working together toward the same principles can only bring about greater and more innovative results. Thus, in Steven Covey’s *The Seven Habits of Highly Effective People*, interdependence is defined as people combining talents and abilities to create something greater together. Ultimately, this philosophy allows us to tap into the best of each of us and consequently to provide high-quality patient care as well as high staff satisfaction.

**Leadership**

To become happy, well-functioning adults and contributing members of society, children must be allowed to grow and mature independently while constantly receiving parental messages about values. Parents must also communicate to their children reasonable and known limits and provide a structure to allow this communication to occur naturally. Obedient children obey. They do what they are told—no more, no less. Disciplined children are disciples, willingly behaving in accord with the values communicated to them.

Good leadership is like good parenting. We want our employees to be happy, contributing members of our health care team. Our values are stated outright but—even more importantly—they are implied in our many processes and standards. We have regular meetings so that we can review, emphasize, and sometimes even “ventilate” to ensure that we stay on track.

We value the unique contributions that each person brings to the team, and we try to nurture their strengths to meet our patients’ needs. We are not all equal, and we cannot make equal contributions in all areas of our fields; but by allowing all team members to emphasize their own unique strengths, our team has become more than the sum of its individual parts.

We all entered our respective fields because of our desire to contribute. A leader’s job is simply to...
facilitate that desire and to guide that energy. Understanding and accepting this principle, the leaders of the Honolulu pediatrics team developed and implemented the following steps to improve pediatric clinic operations:

- Hire enthusiastic people and clearly delineate their—and your own—tasks and goals.
- Determine your own principles and priorities.
- Evaluate processes and optimize them—as well as the flow of patients through the clinic—by ensuring that all staff focus on the patient.
- Give staff sufficient opportunities to advance their professional skills beyond “putting out fires.”
- Improve the service delivered to patients so that staff can be proud of this service instead of having to defend or apologize for it.

By following these basic steps, a clinic functioning at a suboptimal level of performance can be reengineered into a high-functioning workplace run by an empowered staff who use an effective, patient-focused system.

**Conclusion**

Its workforce is probably the most important aspect of any business or operation. By recognizing the value brought to the organization by productive, committed employees, regular communication, and patient-focused systems, leaders enable workplace operations to run smoothly and successfully. By empowering the staff and by equipping them with effective, reliable tools, leaders can give all members of the team an opportunity to realize their full potential.

**References**


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**Teamwork**

Much can be accomplished by teamwork when no one is concerned about who gets credit.

*John Wooden, b 1910, UCLA Basketball Coach*
Introduction
In the early 1990s, the Kaiser Permanente (KP) Orange County Medical Service Area (MSA) sought to become a leader in delivery of accessible, high-quality health care. Facing major cost challenges and shrinking market share, the Orange County MSA implemented two major changes: 1) decentralizing both primary and specialty care into a dozen different medical office buildings scattered over a large geographical area; and 2) shifting the support staff personnel from registered nurses and licensed vocational nurses to medical assistants. As these two changes coincided with rapid growth of the Health Plan membership, physicians struggled daily to meet the needs of members. In response to the need to improve support and efficiency in the medical offices, the KP leadership in Orange County, California commissioned the Optimal Office Practice Support (OOPS) project. The design phase of the project extended from August 1996 through October 1997; implementation began in March 1998 and is ongoing.

Goals of the OOPS Project
The goals of the OOPS project were simple yet comprehensive:

• Physicians would receive consistent clinical support from competent staff;
• Each team would be supervised by a Team Leader trained to support the medical assistants and to manage the flow of patients and physician messages;
• Examination rooms and special procedure rooms would be consistently stocked with equipment and supplies needed by physicians in daily practice;
• Physicians and other providers of care (such as nurse practitioners and physician assistants) would be grouped into care teams visible to members and matched to those members' needs (eg, Vietnamese-speaking clinicians would be grouped at locations visited by Vietnamese-speaking members);
• Agreements and other tools would be developed to help clinicians to share the work (eg, answering messages from patients, reporting test results, and prescribing medication refills); and
• Receptionists would be recognized as vital members of the team.

Figure 1. Structure of the Optimal Office Practice Support (OOPS) project designed and implemented in the KP Southern California Region. MA = medical assistant; TL = team leader; NP = nurse practitioner; PA = physician assistant; SLL = service line leader.
care team who begin the patient’s care experience—ie, at initial contact at the office visit.

**Process Used by the OOPS Project**

A change effort of this magnitude required—and received—guidance from a multidisciplinary committee, the steering committee, chaired by a physician recognized as a leader by other physicians; by an administrative co-chair at the assistant medical group administrator level; and by an organizational effectiveness consultant whose function was to assist the group in managing change (Figure 1).

Because of the magnitude of the change effort and the natural divisions in the work to be carried out, four multidisciplinary teams were created to address specific aspects of the project: the Clinical Assistant/Team Leader Team, the Physical Layout Team, the Nurse Practitioner/Physician Assistant Team, and the Reception Team (Figure 1). Each team included a representative from each stakeholder group that would be involved in the change effort. Following the partnership model of the steering committee, each team was led jointly by a physician and an administrator at the assistant medical group administrator level.

The Clinical Assistant/Team Leader Team addressed issues of nursing consistency and skills competency and supported team agreements and relationships.

The Physical Layout Team devised guidelines for creating a professional appearance for all parts of office buildings visited by members (eg, waiting rooms, check-in stations, examination rooms, and procedure rooms). This team also developed strategies that would help physicians to decide what supplies would be stocked in examination and procedure rooms and that would enable the staff to stock these supplies easily.

The Nurse Practitioner/Physician Assistant Team created tools to help Health Plan members to better understand the team care concept and to identify their care team. The team also devised both a set of templates and a process for creating work agreements for the teams. The process was designed to clarify the answers to such questions as who prescribes medication refills or handles patient messages when a clinician is away from the office.

The Reception Team worked to standardize appearance of the reception area and the forms used there and developed strategies to meet variable demand at check-in while avoiding long waits in lines.

The project was conducted in two phases: a design phase and an implementation phase. Although the membership of the design teams was different than membership of the implementation teams, some key members served during both phases, mainly to help ensure continuity. During the implementation phase, each team visited each medical office building sequentially to work with a building-based implementation team. Depending on the team product being implemented, the OOPS team conducting the implementation remained involved from start to finish at each building. The mean duration of this process was three months.

Early in the implementation process, teams discovered that the extensive amount of work required for implementing change at each location could not be done without using an explicit “roadmap” of tasks to be accomplished. Each team therefore developed “toolkits” containing templates and timelines for all tasks to be accomplished. This degree of detailed instruction as well as periodic follow-up were necessary to ensure completion of the work.

**Products Created by the Teams**

**Medical Assistant/Team Leader Team**

This team compiled a list of all skills necessary for each staff member of every clinical department. The team also established a process for training and monitoring staff competency in those skills. The team also established guidelines for ensuring that for every clinician, a primary medical assistant would be designated and that this support would be provided with an established level of consistency (ie, at least 80% of the time). The team created the “Provider Preference Guide,” a tool for physicians, nurse practitioners, and physician assistants to clearly state their preferences for work-related items and procedures (eg, glove size, preparing patients presenting with certain problems, or whether the clinicians’ mail would be opened for them.) Templates for agreements between medical assistants and their team leader were devised, and the role of each team leader was clarified. Suggested target ratios were established for the number of clinicians supported by each team leader, although we have found that these target ratios must be adjusted as processes of delivering care become progressively complex.

**Physical Layout Team**

This team created templates for planning specialty-based examination and procedure rooms. Each template consisted of a map taped inside the cabinet to list supplies located in the examination or procedure room. Supplies were orga-
nized in a series of blue plastic bins labeled with the item contained. Each bin was also labeled with a “par” value, a designation intended to assist the restocking process: Items used in high volume would be assigned a high par value, indicated that the items should be stocked in greater quantities.

The team also developed guidelines for ensuring a more professional appearance of examination rooms and nursing stations. For example, items taped to examination room walls were not permitted; instead, items were to be attached to bulletin boards or framed. The appearance of patient check-in stations also was addressed: All personal items were to be kept from members’ view by being located under a mat on the desktop. Items remaining in view were to have an uncluttered appearance.

**Nurse Practitioner/Physician Assistant Team**

This team facilitated development of care teams consisting of physicians, nurse practitioners, and physician assistants. The team also developed visibility tools (e.g., photographs) to be posted in examination rooms of all care team members supporting a given physician. This practice allowed the nurse practitioner or physician assistant assigned to work with a physician to be introduced to the patient at the time of a visit. In addition, agreements were made between physicians and their “practice partners” (nurse practitioner or physician assistant) about how to share the care of patients with chronic conditions (e.g., diabetes). For example, the physician and his or her practice partner could each see the patient separately at alternate visits.

Another product created by the team was a template for formulating agreements about “who will cover for whom” with regard to obtaining and conveying test results, handling messages to and from patients, and prescribing medication refills when team members are away from the office. In addition, tools were created for clearly communicating these agreements.

**Reception Team**

This team examined the forms available and functions being performed in reception areas. The team streamlined the number of forms that receptionists were required to handle and identified communication strategies for use with the “back office” team. The “lead receptionist” position was created so that the group would have a point person for communication about new tasks and systems as well as issues of importance to the team. This team also originated the concept of a “morning report” for each building: For this daily morning event, the staff “huddle” for a few minutes to communicate and plan the day’s work.

**Assessment of OOPS Project Progress**

Throughout the project period, the Steering Committee continually re-evaluated whether or not the issues being discussed were indeed the right issues and whether the changes being attempted were actually happening. Understanding that many things are required to support medical practices and that efforts at change may sometimes become secondary to the struggles of day-to-day operations, the Steering Committee used an audit process to maintain focus. Instead of merely asking, “Do you have agreements between providers about coverage?” each team audited certain key elements of their products. For example, an audit might instruct, “Show me the agreements that your team has made” or “Show me your exam room templates for the pediatricians in your building.” This audit was conducted at the conclusion of the implementation team’s efforts for a building. These audits were necessary to ensure consistent implementation across the medical service area. For the same reason, a semiannual audit process was developed to help teams to maintain focus on an ongoing basis.

Figure 2. Graph shows results of question 11 on 2001 Physician Assessment of Support Service survey distributed to KP physicians in Orange County, California.
A survey also was developed for each group of care team members (physicians, nurse practitioners and physician assistants, team leader, medical assistants, receptionists, and department administrators) in each building. This survey was designed to examine all aspects of the team’s products and to locate opportunities for further improvement.

**Results of Project Assessment**

The results of this effort were measured in many ways. An OOPS audit and survey were done annually; the data from these instruments were used primarily to determine whether the planned work was actually done; whether the constituents of each building perceived these results as helpful; and whether need for improvement remained. Physicians’ perceptions were measured by using relevant questions from the Physician Assessment of Support Services (PASS) study done semiannually by KP in Orange County (Figures 2,3).

The overall staff satisfaction was measured by the People Pulse study, which examines more than OOPS-related issues. In this employee survey, Orange County ranked first in Southern California for 20 of 28 indicators. Health Plan members’ perceptions were inferred from the Meteor study and from the Ambulatory Satisfaction Questionnaire (ASQ) study (Figure 4), two tools used in Orange County to measure satisfaction.

**Learning From the Project**

A project of this size, scope, and length of time produced some key learnings:

- Visible support from senior leaders is essential. This support was embodied by the OOPS project being part of the strategic plan, by carefully allocating key people’s time, and by intervening with regard to key issues to help project teams move forward.
- Physician leadership and involvement is critical. Physicians selected to lead teams were highly regarded by their peers. In addition, physicians served as team co-chairs and were involved in every aspect of implementing the project.
- Allow enough time to successfully anchor the changes. Resist attempts to set overly optimistic or unrealistic timelines.
- Make work easier for target groups. Create processed checklists and toolkits.
- Adapt, adjust, and revise as needed. Ask questions as they arise; listen to complaints and feedback; and change, adapt and revise operations as needed. Use learnings gleaned from each site to implement and adapt products according to the unique needs of each.
The magnitude of change contemplated by the OOPS project required enormous planning, resources, and commitment on the part of everyone …

Conclusions
The magnitude of change contemplated by the OOPS project required enormous planning, resources, and commitment on the part of everyone who worked at KP in Orange County. As often occurs when staff implement efforts to change daily operations, projects begun with much energy are later found to require tools for maintaining processes of change as well as for refocusing efforts. These mechanisms are needed to ensure that all change takes root in the organization and accommodate the continuous, rapid evolution of health care delivery systems—in particular, the electronic medical record. Thus, the need to reassess continuously the basic assumptions and workflow analyses used to design office support systems forms the basis for the OOPS project, whose work is continuing.

Acknowledgments
We would like to acknowledge the following individuals for their contributions to this project: Edward Ellison, MD, Orange County Area Associate Medical Director (2002 through present); Kenneth Bell, MD, Orange County Area Associate Medical Director through 2001; Judy White, MBA, Medical Group Administrator, Orange County Medical Center; Gerald McCall, Senior Vice President and Service Area Manager, Kaiser Foundation Hospital, Anaheim (January 1988 through November 1998); Janice L Head, RN, FACHE, Senior Vice President and Service Area Manager, Kaiser Foundation Hospital, Anaheim (November 1998 through May 2002); Julie Miller-Phipps, MSHA, Senior Vice President and Service Area Manager, Kaiser Foundation Hospital, Anaheim; Diem H Do, MBA, Optimal Office Practice Systems (OOPS) Project Manager (2000 through present); Sharon Hobson, RN, OOPS Project Manager (inception through 2000); Monica Mehren, MD, OOPS Physician Chair (inception through 1998); Peggy Grau, MD, and Judith Maloul, RN, MSA, Medical Assistants/Team Leaders; Sam Constantini, MD, and Priscilla Daniel, RN, Nurse Practitioner/Physician Assistant Team Leaders; David Cordes, MD, and Jeff Hunter, Physical Layout Team Leaders; Brenda Steffensen, MD, and Arlene Lundy, Reception Team Leaders; Debra Freedman, MA, Organizational Research; Maggie H Pierce, RN, and Tam Minh Chung, MD, Leaders Educare Team. Virginia Fitz provided administrative and graphics support; and Juan Domingo, Department of Medical Editing, provided graphics assistance.

Enabling Others to Act
A leader who Enables Others to Act is someone who includes others in the planning; treats others with respect; supports decisions of others; fosters cooperative relationships; provides freedom and choice and/or lets others lead.

Blue Sky Care Delivery 2015, Part 1

Excerpted from the KPPG/Care Delivery IT Portfolio Advisory Committee (PAC) report KP Care Delivery in 2015—Blue Sky Vision and Implications (June 2003). Reprinted with permission.

In February 2003, a national multidisciplinary, multiregional group met to develop a vision of the Kaiser Permanente (KP) care delivery system in 2015. The intended outcome was to inform near- and long-term recommendations on clinical system investments, in particular, information technology. A consumercentric paradigm emerged. What is unique in this strategic work is that participants created skits to act out in a care delivery setting their vision of the future for members who are healthy, who have an acute medical incident, and who have chronic conditions. These “case vignettes” represent the centerpiece for this three-part series, which will appear in this and in the Winter and Spring 2004 issues. We begin with the most common scenario, the “acute care encounter” and will follow with the “health encounter,” and finally the “chronic care encounter.” The vignettes bring to life future interactions between KP members, clinicians, and health professionals and will be supplemented with perspectives on the market, environment, people, technology, economics, and principles of the consumercentric paradigm. We hope you will enjoy this view of the future of clinical care.

—Tom Janisse, Editor-In-Chief

Introduction

Early in 2003, the Care Delivery IT Portfolio Advisory Committee (PAC) sponsored two working sessions known as Blue Sky Vision Development and Implications. The objective was to develop a vision of Kaiser Permanente’s (KP’s) future care delivery model. In addition, operational implications of the Blue Sky vision were identified. The sponsors (Table 1) strongly believe KP’s future delivery model should drive overall care delivery IT investment and design.

With input from the Regional Presidents and the Executive Medical Directors, the sponsors selected 16 internal KP physicians and staff (Table 2) chosen for their innovative, forward-thinking perspectives and invited seven guests from the industry (Table 3) to provide an external view of the future and KP. These guests represented expertise in technology, health care economics, alternative delivery systems, and self-care education. Participants discussed how our clinicians and staff would communicate with KP members, what external and internal factors might affect KP’s future, and how care and service could be provided a dozen years from today.

The Assignment

The primary objective for the Blue Sky Phase 1 meeting was to create alternative views of KP’s care delivery model in 2015. The sponsors chose the target year of 2015 deliberately. When planning twelve years out, technology readiness concerns and other common short-term barriers to major organizational change can largely be set aside. Conversely, the timeframe is close enough to today so as to ground participants in developing achievable care delivery models.

Table 1. Sponsors

<table>
<thead>
<tr>
<th>Sponsors</th>
<th>Title and Region</th>
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<tr>
<td>Richard D Cordova</td>
<td>President Southern California Regions, KFH/HP</td>
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<tr>
<td>Louise Liang, MD</td>
<td>Senior Vice President, Quality and Clinical Systems Support, KFHP</td>
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<td>Allan Weiland, MD</td>
<td>Regional Medical Director, NWPMG</td>
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<tr>
<td>Andrew M Wiesenthal, MD</td>
<td>Associate Executive Director of the Permanente Federation</td>
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The participants discussed industry-wide trends and internal KP characteristics that set a context for vision development. There was no intent to reach consensus on which health care trends would end, which would gain in influence, nor the set of environmental trends KP would be most likely to face in 2015. The sponsors set forth only two constraints for a future care delivery model:

- KP would be a viable and strong health care provider in 2015,
- Affordability of services had to be a consideration.

It is important to reiterate that the participants were not asked to forecast multiple industry scenarios and create alternative care delivery models that would respond to those scenarios. Participants were asked to consider current trends, to take into account the historical attributes and limitations of KP, and to assume that KP will prevail in the marketplace. The assignment was intended to be target setting not necessarily predictive.

Although the meeting objective was framed to elicit alternative visions of care delivery, a single, dominant model emerged from the group’s work.

**Future Care Delivery Vision**

In 2015, the model of care delivery will be a consumercentric paradigm where the consumer’s demand choice. KP members in 2015 will characterize KP as providing customized and fully integrated and leveraged services with secure and seamless transitions from person to person with many diagnostic and care monitoring events occurring in the convenience of their homes and for a cost that is affordable.

The most effective method to share this vision is through “case vignettes.” To set the stage: It’s April 2, 2015.

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**Table 2. Vision development (Phase 1) participants**

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Virginia Ambrosini, MD</td>
<td>Southern California Permanente Medical Group</td>
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<tr>
<td>James Chang, MD*</td>
<td>The Permanente Medical Group</td>
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<tr>
<td>Michael Chase, MD*</td>
<td>Colorado Permanente Medical Group</td>
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<tr>
<td>Marilyn Chow, DNSc, RN</td>
<td>Program Office, KFHP</td>
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<td>William Cleveenger, MD</td>
<td>Hawaii Permanente Medical Group</td>
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<tr>
<td>Mary Durham, PhD</td>
<td>Center for Health Research, NW &amp; HI</td>
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<tr>
<td>Matthew Gerlach</td>
<td>Southern California, KFHP</td>
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<tr>
<td>Tom Janisse, MD</td>
<td>Northwest Permanente Medical Group</td>
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<td>Timothy Kieschnick*</td>
<td>Internet Services Group, KFHP</td>
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<td>Brent Lowensohn</td>
<td>Information Technology, KFHP</td>
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<tr>
<td>Christine Paige, PhD</td>
<td>Program Office, KFHP</td>
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<tr>
<td>Yancy Phillips, MD</td>
<td>Southeast Permanente Medical Group</td>
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<tr>
<td>David Sobel, MD</td>
<td>TPMG and Permanente Federation</td>
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<tr>
<td>Kurt Van Riper, PharmD</td>
<td>Pharmacy Services, KFHP</td>
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<tr>
<td>Arthur Southam, MD*</td>
<td>Program Office KFHP</td>
</tr>
<tr>
<td>Matthew Handley, MD*</td>
<td>Group Health Cooperative, KP Affiliate</td>
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**Table 3. Industry guests**

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<tr>
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<tr>
<td>Mark Blatt, MD</td>
<td>Intel Corporation</td>
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<tr>
<td>Peter Coughlan</td>
<td>IDEO</td>
</tr>
<tr>
<td>David Gustafson, PhD</td>
<td>University of Wisconsin-Madison</td>
</tr>
<tr>
<td>Ann Hendrich, RN</td>
<td>Consultant, Facility Design</td>
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<tr>
<td>Margaret Jordan, RN, MPH*</td>
<td>Texas Health Resources</td>
</tr>
<tr>
<td>Kate Lorig, DrPH</td>
<td>Stanford School of Medicine</td>
</tr>
<tr>
<td>James Robinson, PhD</td>
<td>UC Berkeley School of Public Health</td>
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“Mom’s out of town!”

A father and son are at home in the kitchen, which has smart technology, including a computerized video system. Dad has been with KP since his birth. The family has been given a Home Testing Kit and has online computer access to KP.

**Son** (moaning): *Obbb Dad, I … don’t … feel … good.*

**Dad:** Geez, Tommy, Mom’s out of town—are you sure you don’t feel okay?**

**Tommy** (whining): *Mom never acts like that when I’m sick.*

**Dad** (whining): *And I’ve got all this stuff to do tonight.*

**Tommy** (moaning): *I … just … don’t feel good, Dad. Mom … usually looks stuff up or makes a call.*

**Dad** (whining): *I hate the telephone. I’m going to sit down and— I don’t know—call someone, I guess. Who should I call?***

**Tommy:** It’s Kaiser, Dad. We got everybody in my preschool to sign up, remember?

**Dad:** (goes over to the computer) *Thank God Mom left a sticker here for me.* (He logs on.) Okay, here’s our personal Web site.
Welcome back. How are you doing? a little bit about what’s up with Tommy.

Tommy: Dad, it’s usually in the medicine cabinet. (Dad finds the test kit.)

Pedi Avatar: Okay, great. It’s turning blue.

Pedi Avatar: Okay, Mike, really good. It looks like you’re doing a really good job so far.

Dad: Thank you.

Pedi Avatar: It looks pretty likely that he has strep throat, so you have a few options. Now, I could give you information on what causes strep throat and other related tidbits, but I know that you usually like to cut straight to your treatment options. Is that what you want to do now?

Dad: Yes, I’d like my options.

Pedi Avatar: Okay. So, probably the thing that most people would recommend here is that you treat it with antibiotics. So, we can send antibiotics to you right away, and you can start him on that, and that will cost about $25. Or, if you want, you could just wait and watch and see if his body heals itself, paying attention to his symptoms and treating him to make him more comfortable. That, of course, is free. Or I could set up an appointment for you right away to see one of your doctor’s team, and there is a $50 charge for that. If you’re having trouble making your decision, I’ll have someone call you, if you like. There’s no charge for that.

Dad: I think I have enough information. I’m going to go ahead and treat Tommy with the antibiotic—can you send it now?

Pedi Avatar: You bet. Oh, I noticed the last time he had a bit of a reaction to the antibiotic we used, so we’ll use a different one. The cost of the antibiotic actually is $100, but your charge is only $25, I’ll go ahead and send that through to your Amex account. And you would prefer to have that delivered to your home, is that right?

Dad: Yes, that would be nice.

Pedi Avatar: Okay, great. And would you like to have some kind of follow-up from Tommy’s pediatrician about this tomorrow?

Dad: I’m sure my wife would love a call tomorrow. No, make that an e-mail, she has her V12 Blackberry with her.

Tommy’s and his Dad’s experience illustrates several characteristics of future care delivery:

- Customization—Cost/service packages that allow members to choose their preferred option—even at an episode-of-care level. Members drive customization, sometimes through specific choices and sometimes through behavior patterns that KP discerns and responds to. The Pedi Avatar “remembered” that Dad normally likes to receive the treatment options without the underlying information on the condition.

- Integration and Leveraging—Technology that leverages scarce and specialized clinical resources by using “intelligent” automated protocols. Tommy’s pediatrician did not have to manage a traditional visit nor did she spend time on a telephone. The pediatrician’s “Web site” and the Pediatric Department’s protocols guided the care provided to Tommy. The automated medical record is the backbone for creating this integration and leveraging capability.
• Seamless Transitions—In the scenario, care delivery (antibiotics) was linked immediately to Health Plan operations (billing and cash management). The follow-up e-mail to Mom will pick up where the Avatar left off.

• Home as the hub—Home Testing Kits were provided to help diagnose initial, acute symptoms. Dad will have authorized automatic access to Tommy’s chart and to the pediatrician’s Web site.

The Blue Sky Phase 1 participants envisioned these characteristics of the future visions:

KP Environment
In addition to discussing external environmental pressures, the group gave examples of KP organizational and cultural characteristics important for setting a context for a future vision. This discussion built upon pre-meeting interviews in which the KP Promise was identified as a cornerstone for any future care delivery model.

Participants provided insight into aspects of KP that needed to end (were unsustainable) or that needed to begin (the coming “big deal”) for the organization to be a viable and strong health care provider in 2015. A few themes generated lively discussion and diverse opinions. The “one size fits all” benefit plan is an example. Participants acknowledged that this mainstay of KP’s historical financial and care delivery models runs against current marketplace trends. Yet many participants believed that to move away from a comprehensive approach to care is ultimately suboptimal by macro-level economic and clinical outcome criteria.

The physician’s role as expert advisor and counselor to member families will grow. For some segments of the future population, a physician’s role as the sole owner of clinical decisions may change. Participants discussed the implications of this shift in social dynamics on our physician culture and how to maintain physicians’ personal relationship with members while technology plays an increasing role in both communication and care delivery.

Our People
The participants recognized the “our people” changes as the most difficult to affect and the most crucial for achieving the future care delivery model. To make significant progress toward the Blue Sky vision, KP will recognize and invest in development of physicians and staff to effectively function in an increasingly consumer-centric, electronic environment for KP’s diverse and involved consumer base.

It is incumbent on KP to ensure that the future model accurately represents the consumer perspective—we must explicitly seek this input into the vision. KP embarks on a cultural paradigm shift to operate in a truly consumer-centric model. For some, the motivation for this transformation will be based on values; for others, this cultural shift represents an essential business strategy. In either instance, leadership will be critical.

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a Participants who created this skit are indicated by * in Tables 2 and 3.
b An avatar typically is a generic picture or animation of a human; in this example, a photograph or caricature of the KP staff member. In the 2003 scenario, an avatar communicates via text boxes. In the 2015 scenario, an avatar communicates verbally.

Acknowledgments
Illustrations created by Tom Bentham. Additional editing and support provided by Eva Eagle.
An Overview of Empathy

Abstract
Empathy is a powerful communication skill that is often misunderstood and underused. Initially, empathy was referred to as “bedside manner”; now, however, authors and educators consider empathetic communication a teachable, learnable skill that has tangible benefits for both clinician and patient: Effective empathetic communication enhances the therapeutic effectiveness of the clinician-patient relationship. Appropriate use of empathy as a communication tool facilitates the clinical interview, increases the efficiency of gathering information, and honors the patient.

Introduction
That the medical care experience is enhanced by effective communication between clinicians and their patients is a well established fact. Byproducts of this enhanced communication include improved health outcomes, better patient compliance, reduction in medical-legal risk, and improved satisfaction of clinicians and patients. Of all the elements involved in effective communication, empathy seems to be the component that is most powerful yet is easily overlooked—and some commentators have asserted that in medical practice the importance of empathy cannot be overemphasized.

What is Empathy?
The origin of the word empathy dates back to the 1880s, when German psychologist Theodore Lipps coined the term “einfühlung” (literally, “in-feeling”) to describe the emotional appreciation of another’s feelings. Empathy has further been described as the process of understanding a person’s subjective experience by vicariously sharing that experience while maintaining an observant stance. Empathy is a balanced curiosity leading to a deeper understanding of another human being; stated another way, empathy is the capacity to understand another person’s experience from within that person’s frame of reference.

Even more simply stated, empathy is the ability to “put oneself in another’s shoes.” In an essay entitled “Some Thoughts on Empathy,” Columbia University psychiatrist Alberta Szalita stated, “I view empathy as one of the important mechanisms through which we bridge the gap between experience and thought.” A few sentences earlier in her essay, she had emphasized that “… [empathy is] consideration of another person’s feelings and readiness to respond to his [or her] needs … without making his [or her] burden one’s own.”

Can Empathy Be Taught?
Unfortunately, many physicians were trained in the world of “Find it and Fix it” medicine, a world where empathetic communication was only an afterthought—if this behavior was considered at all. Empathy was known as “bedside manner,” a quality considered innate and impossible to acquire—either you were born with it or you weren’t. More recently, greater emphasis has been placed on empathy as a communication tool of substantial importance in the medical interview, and many experts now agree that empathy and empathetic communication are teachable, learnable skills.

As we might therefore expect, empathy is the cornerstone of several communication models, including “The Four Habits” model (Invest in the Beginning, Elicit the Patient’s Perspective, Demonstrate Empathy, Invest in the End) developed by The Permanente Medical Group’s Terry Stein with Richard Frankel; the “4 E’s” (Engage, Empathize, Educate, and Enlist) model used by the Bayer Institute for Health Care Communication; the “PEARLS” (Partnership, Empathy, Apology, Respect, Legitimization, Support) framework adopted by the American Academy on Physician and Patient; and other models.

Many medical schools have developed curricula with a strong focus on physician-patient communication and...
empathy. Delivery of these curricula begins early in the students' training. At the University of Colorado Health Sciences Center, this curriculum is known as the “Foundations of Doctoring” program, a curriculum whose teaching staff includes several physicians and trainers from the Colorado Permanente Medical Group (CPMG). CPMG has also developed an eight-hour clinician-patient communication course based on The Four Habits model which is offered to all newly hired physicians in the Kaiser Permanente (KP) Colorado Region. In this course, plenty of time is set aside to explore empathy and to practice empathetic communication with patients selected according to standard criteria.

**Practical Empathetic Communication**

Making practical use of an otherwise esoteric concept such as empathy requires division of the concept into its simplest elements. As outlined by Frederic Platt,19 key steps to effective empathy include:

1. recognizing presence of strong feeling in the clinical setting (ie, fear, anger, grief, disappointment);
2. pausing to imagine how the patient might be feeling;
3. stating our perception of the patient’s feeling (ie, “I can imagine that must be …” or “It sounds like you’re upset about …”);
4. legitimizing that feeling;
5. respecting the patient’s effort to cope with the predicament; and
6. offering support and partnership (ie, “I’m committed to work with you to …” or “Let’s see what we can do together to …”).

Being a psychiatrist or mental health expert is not necessary for using empathetic communication; the only requirement is an awareness of opportunities for empathy as they arise during the interview with a patient. This type of opportunity arises from a patient’s emotion (either directly expressed or implied): This emotion creates the opportunity for an empathetic response by the physician. In a study by Wendy Levinson et al.,20 116 office visits to primary care and surgical physicians were audiotaped and transcribed to look at the frequency of empathy opportunities or “clues.” More than half of visits in each setting included one or more clues. In more than half of cases, patients presented these clues not overtly but in more subtle ways. Unfortunately, physicians responded to those clues in only 38% of surgical cases and in only 21% of primary care cases and frequently missed opportunities to adequately acknowledge a patient’s feelings.21 Clues are often hidden in the fabric of discussion about medical problems and thus may be easily missed by physicians who are busy attending to biomedical details of diagnosis and management. In fact, when opportunities for empathy are missed by physicians, patients tend to offer them again, sometimes repeatedly. This phenomenon can lead to longer, more frustrating interviews, return visits, and “doctor shopping” by patients who feel dismissed or alienated.

After an opportunity for empathy has been presented, the clinician should consider offering a gesture or statement of empathy. Statements that facilitate empathy have been categorized as queries, clarifications, and responses.21 Examples of each are as follows:

- **Queries**
  - “Can you tell me more about that?”
  - “What has this been like for you?”
  - “How has all of this made you feel?”

- **Clarifications**
  - “Let me see if I’ve gotten this right …”
  - “Tell me more about …”
  - “I want to make sure I understand what you’ve said …”

- **Responses**
  - “Sounds like you are …”
  - “I imagine that must be …”
  - “I can understand that must make you feel …”

Ideally, after perceiving the clinician’s statement of empathy, the patient expresses agreement or confirmation (“You got it, Doc!” or “Yeah, that’s exactly how I feel”). When we have not understood the patient’s experience exactly, we must allow the patient to clarify his or her experience and thus allow the physician to restate an empathetic statement that originally missed its mark. The following exchange is an example of this Hypothesis-Test-Feedback Loop used in the doctor-patient encounter:

**Patient:** I am sick and tired of living with these headaches. No one has been able to help me, and none of the medications are working.

**Doctor (stating the hypothesis):** I can see that you are frustrated by the lack of improvement in your symptoms.

**Patient (giving feedback):** Yeah, but I’m really more worried that we’re missing something serious. I’ve got a wife and kids who are depending on me.

**Doctor (correcting the hypothesis):** So, it sounds like you’re really more concerned that something...
serious could be going on that is causing these headaches.

Patient (closing the empathy loop): Yes, exactly.

In this example, the physician makes an empathetic statement (hypothesis) about what he or she surmises is the chief aspect of the patient's experience: frustration about an unrelenting headache. When the hypothesis is tested, the patient clarifies that although frustrated, he is mainly experiencing worry about the situation. Armed with this feedback, the physician restates the hypothesis back to the patient, who lets the physician know that he or she “got it exactly right.”

**Barriers to Giving Empathy**

Because empathy is such a powerful communication skill, we might suppose that clinicians would scramble to learn about and use it at every available opportunity. However, this is not necessarily the case. Clinicians have many reasons for not offering empathy to patients. An informal survey of practicing clinicians participating in a recent clinician-patient communication course revealed misgivings (and misconceptions) about empathetic communication. Concerns mentioned included:

- “There is not enough time during the visit to give empathy.”
- “It is not relevant, and I'm too busy focusing on the acute medical problem.”
- “Giving empathy is emotionally exhausting for me.”
- “I don’t want to open that Pandora's box.”
- “I haven't had enough training in empathetic communication.”
- “I'm concerned that if I use up all my empathy at work I won't have anything left for my family.”

In our experience, empathy facilitates the clinical interview, increases efficiency of gathering information, and honors the patient. Empathy need not be awkward nor emotionally exhausting; unlike sympathy, empathy does not require emotional effort on the part of the physician. An appropriate statement or gesture of empathy takes only a moment and can go a long way to enhance rapport, build positive relationships, and even improve difficult ones. Studies have shown that when opportunities for empathy were repeatedly missed, visits tended to be longer and more frustrating for both physician and patient. Conversely, empathy may save time and expense and often is a cost-effective method of facilitating early diagnosis and proper treatment.

**Empathy Versus Sympathy (and Versus Pity)**

Despite some divergent opinion on the matter, we may propose a subtle but important distinction between empathy and sympathy. Whereas empathy is used by skilled clinicians to enhance communication and delivery of care, sympathy can be burdensome and emotionally exhausting and can lead to burnout. Sympathy implies feeling shared with the sufferer as if the pain belonged to both persons: We sympathize with other human beings when we share and suffer with them. It would stand to reason, therefore, that completely shared suffering can never exist between physician and patient; otherwise, the physician would share the patient's plight and would therefore be unable to help.

Empathy is concerned with a much higher order of human relationship and understanding: engaged detachment. In empathy, we “borrow” another's feelings to observe, feel, and understand them—but not to take them onto ourselves. By being a participant-observer, we come to understand how the other person feels. An empathetic observer enters into the equation and then is removed.

Harry Wilmer summarizes these three emotions—Empathy, Sympathy, and Pity—as follows:

- Pity describes a relationship which separates physician and patient. Pity is often condescending and may entail feelings of contempt and rejection.
- Sympathy is when the physician experiences feelings as if he or she were the sufferer. Sympathy is thus shared suffering.
- Empathy is the feeling relationship in which the physician understands the patient's plight as if the physician were the patient. The physician identifies with the patient and at the same time maintains a distance. Empathetic communication enhances the therapeutic effectiveness of the clinician-patient relationship.

**Conclusion**

Empathy is a powerful, efficient communication tool when used appropriately during a medical interview. Empathy extends understanding of the patient beyond the history and symptoms to include values, ideas, and feelings. Benefits of improved empathetic communication are tangible for both physician and patient.

**Acknowledgments**

Ilene Kasper, MS, and Andrew M Lum, MD of Kaiser Permanente Colorado; and Brian Dwinnell, MD, and Frederic W Platt, MD, FACP, of the University of Colorado Health Sciences Center, reviewed the article.

**References**


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Two Things Stand

Life is mostly froth and bubble,
Two things stand like stone,
Kindness in another’s trouble,
Courage in your own.

*Adam Lindsay Gordon, 1833-1870, poet*
Introduction

What’s in it for me? Every physician is a leader, and all physicians have direct influence on their work environment. Whether in a formal leadership role or not, physicians greatly influence the work environment. Physicians are leaders in their health care teams because of training as well as from a legal perspective. The way you conduct yourself and your relationships with others can either lead to, or detract from, a work culture that supports patient care and service. Research suggests a relation between physician behaviors that create a work environment of teamwork, collaboration and support, and the ability of all health care team members to provide patients with a high-quality care experience.

Your Role as Patient Advocate

This section focuses on behaviors you can adopt to influence patient satisfaction and promote service and health care quality. These behaviors help you promote a service culture through words, actions, systems, and processes.

As you know, your primary responsibility as a physician is the well-being of your patient. Because of your deep understanding of your patients’ needs, you are the perfect advocate to lead changes to health care systems and processes. To successfully lead change as a patient advocate and as leader of the health care team, you are in a perfect position to determine what is important to your patients. By spending time inquiring about their needs and their experiences with the health care system, you can assess how well your care processes perform against those stated patient needs. You will then be in a position to advocate for changes that really matter to your patients—changes that will improve their care experience.

Patient Needs—Obtaining Important Feedback

First, you can use opportunities to obtain patient feedback. Here are some specific questions you can use to obtain a better understanding of your patients’ needs, as well as questions to assess how these expressed needs are being addressed by you and your team.

- Ask questions about their needs:
  - How would you define high-quality service? High-quality care?
  - What is most important to you when you visit your doctor?
- Talk to your patients about the service they receive:
  - How are we serving your needs?

The best physician-leaders always behave as if they have a patient at their elbow, and they bring the patient’s perspective into every conversation.

James Reinertsen, MD, “Physicians as leaders in the improvement of health care systems”
- What do you like and dislike about our service and care?
- How can we improve our service?
- What are we not providing that you feel we should provide?

- Observe interactions between staff and patients.
  - What processes (for example, scheduling appointments or check-in) work smoothly from the perspective of both patient and staff?
  - What processes require unnecessary multiple steps or potential rework?
  - What barriers do staff encounter as they try to serve the patient?
- Encourage staff to be “listening outposts” to obtain information about members.
  - What has staff learned from patients about what helps or hinders meeting patient needs?
  - What complaints are heard from patients about services or processes?

Tell your patients that their feedback to you about the care and service they receive is highly valued and will be used to make service improvements.

**How To Use The Information**

**Personal Application**

Use this knowledge to better serve your patients. Commit to quality through your actions and words.

- Set the tone for your team by modeling excellent service to patients and letting your staff know that the same sort of behavior is expected from them.
- Understand the unique needs of your patients based on differences in background and culture.
- Participate in improvement efforts when asked.
- Talk about issues of quality honestly and openly. Work with your team to create a “blame-free” environment so issues of quality can be discussed.

**Checklist for Focus on the Patient**

- I talk to patients about how well their health care needs are being met.
- I participate in discussions regarding patient feedback and performance data with my team.
- I identify barriers to service and quality and encourage others to do so.
- I get involved in fixing problems and encourage others to do so.
- I model high-quality service behavior for my team members.
- I demonstrate my commitment to quality through my actions and words.

**Share Information**

It will be important to then share what you know about member and patient needs. Communicate to your team the importance of good patient service and its place in the delivery of quality care. Ask team members to contribute their knowledge of members’ needs. Encourage discussions of patient feedback at team or department meetings.

- Repeatedly communicate to all team members the importance of service quality in your team.
- Discuss how your team is an important link in the chain of meeting patient needs.
- Communicate that the contributions of all team members are valued and important to fulfilling the team’s patient satisfaction goals.
- Before your team makes a decision that may affect your patients, ask “Does this solution contribute to meeting our patients’ needs?” “Is this really patient-centered care?”
- If patient satisfaction data are available for your department or team, use these results to improve service.
- Support, encourage, and empower team members to solve member problems on the spot.
- Examine from the patient’s perspective the systems and processes of your department to identify barriers to service.
- Ask staff for their ideas on ways to improve. Work as a group to implement solutions.
- Make a point of drawing together diverse groups when

The ability to understand the customer’s needs and wants can be summed up in a simple phrase:

“Always be Learning.”

— Karl Albrecht and Ron Zemke, *Service America!: doing business in the new economy*

“Quality service is a top down affair. It starts at the top or it doesn’t start.”

— Karl Albrecht and Ron Zemke, *Service America!: doing business in the new economy*
discussing issues or solving problems to fully consider different points of view.

- Always ask your team as well as your patients the question, “How can we improve?”

**Summary**

As physicians take the lead in creating patient-centered care, the ability to understand patient needs and translate those needs into meaningful improvement in the health care environment will require a new set of skills. Understanding patients’ experiences outside your exam room, leveraging staff to work as a team, serving as a role model for service behavior, and sharing your knowledge are different from what makes the solo practitioner successful. These are the behaviors that make leaders successful. You can begin the process by slowly adopting the behavior mentioned in this article in a manner that fits your style. Small changes in behavior can reap big rewards. It is important to take the first step.

**References**


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**Quality Improvement**

Quality improvement has little chance of success in health care organizations without the understanding, the participation, and in many cases the leadership of individual doctors.

“Country Road”
color photograph
By Alan D Fremland, MD

This country road was met on a relaxed drive through rural Southern California. More of Dr Fremland’s art can be found on the cover and on page 22.
Transitions of Clinical Information Systems

In early February 2003, George Halvorson, Chairman and CEO of Kaiser Foundation Health Plan and Hospitals, Inc, and Jay Crosson, Executive Director of the Permanente Federation, announced that Kaiser Permanente (KP) was purchasing an integrated suite of electronic health record and related applications from Epic Systems (Madison, WI) to deploy programwide. The decision to purchase the Epic products changed the direction set four years earlier for development of an electronic health record system at KP. The decision to change direction in 2003 was made after months of careful analysis and is best considered in the context of KP’s previous work to develop electronic health records.

History of KP Regional Electronic Health Record Systems

More than a decade ago, leadership of most KP regions recognized the need for electronic health records. Every region—including some that no longer exist—invested time and money to collect information relevant to patient care and to display that information at the location where care was provided (the “point of care”), usually clinician offices. Each region had episodes of success and failure in these efforts and attempted to learn from these experiences.

Some effort was made in the early 1990s to coordinate these projects. First—and true to the KP culture—each Permanente Medical Group (PMG) needed to define its goals and find the most direct path to those goals. We describe the results of these efforts, most of which remain in use today.

In the KP Ohio Region, Allan Khoury, MD, led development of an operational data store (ODS) of information derived from ancillary systems (eg, for storing pharmacy orders and laboratory results). These data were combined with data extracted from progress notes written after each outpatient encounter and then scanned into the computer system. The ODS is used to generate point-of-care alerts and reminders, which have been extremely effective in helping Ohio PMG clinicians to improve care. This highly successful medical automated record system (MARS) was recognized with the Nicholas E. Davies Award for Excellence, a national award granted (formerly by the Computer-Based Patient Record Institute and currently by the Healthcare Information and Management Systems Society) to promote adoption of the electronic medical record throughout the United States.

In the KP Mid-Atlantic Region, development of the PACE system was led first by Andrew Barbash, MD, and more recently by Mark Snyder, MD. PACE, too, is based on an ODS, and PMG clinicians in the KP Mid-Atlantic Region type their progress notes into the system.

In Southern California, John Mattison, MD, led development and implementation of a highly innovative process: entering structured data (as distinguished from free text) as progress notes. This effort advanced development of a structured vocabulary for clinical data that is rapidly becoming an international standard. This clinical data vocabulary formed the heart of SCPMG’s WAVE application used in clinical settings in the KP Southern California and Hawaii Regions. WAVE was the core documentation tool in KP’s first effort to collectively develop an electronic health record, the National Clinical Information System (NCIS). The key lessons learned during development of NCIS still apply as KP continues to develop tools and templates for charting that will both speed entry and foster the collection of clinical data that can be used by many different computer systems.

The KP Northern California Region developed an effective, widely accessible repository of clinical data and a system to present it, the Clinical Information Presentation System (CIPS), on which all clinicians in the region rely. The project has been led by several clinicians over the years, including George Peredy, MD, and Steve Bornstein, MD. CIPS contains data from key ancillary systems and problem lists; summary data related to outpatient visits, hospitalizations, and emergency department visits; transcribed reports; preventive health services information and prompts; and much more. The repository is used by another application,
Preventive Health Prompts (PHP), to display and print point-of-care alerts about preventive health and chronic disease management. Clinical outcomes have clearly improved as a result of these reminders.

In the KP Northwest Region, Homer Chin, MD, led internal development of an electronic health record. In 1992, the KP Northwest Region purchased Epic’s ambulatory health record product (EpicCare) and integrated it with the region’s existing ODS and results-reporting system. Implementation was complete by 1997, and the system won the Nicholas E Davies Award.

In the KP Colorado Region, Jeff Rose, MD, and (more recently) Andrew Lum, MD, led development and implementation of the Clinical Information System (CIS) in partnership with IBM (White Plains, NY). By the end of 1998, all outpatient encounters were documented using CIS and the structured clinical data vocabulary developed in conjunction with the work being done by SCPMG. Most data entry occurred in examination rooms, a process resulting in the first large-scale KP experience with examination room computing. The KP Colorado Region stopped using paper health records six months after the last clinician’s office was connected to CIS; the KP Colorado Region has since been essentially paperless. The KP Colorado’s CIS also won the Nicholas E Davies Award. This was the third time KP had won this award; no other organization had received this award more than once.

Creating a Programwide Standard

In 1999, leadership in the national KP organization decided to stop internal development of NCIS except for the population care registry application, forms of which are still used by the KP Hawaii, Northern California, and Georgia Regions. KP management assessed two existing examples of ambulatory electronic health record systems used in the KP Colorado Region (CIS) and in the KP Northwest Region (EpicCare). After intense analysis and discussion, the decision was made to alter CIS for programwide deployment.

Although the effort to alter CIS proved considerable, it led to implementation of CIS in parts of Hawaii and in building infrastructure to interface to all of the ancillary systems in use programwide—185 at last count. In addition, the structured clinical vocabulary that originated in the KP Southern California and Colorado Regions was expanded, and the PMGs made important collaborative efforts to develop content (eg, templates for documentation, for order sets, and for decision support). The Interregional Clinical Content Team (IR CCT) of the Care Management Institute is now responsible for ongoing content development. In the summer of 2002, when George Halvorson requested reassessment of KP’s approach to development of an electronic health record system, the CIS implementation team had already prepared to upgrade the version used in KP Hawaii, to implement CIS in KP Southern California, and to replace the outdated version used in KP Colorado.

Reassessment Leads to New Programwide Standard

The software reassessment showed that several vendors—most notably, Cerner Corporation (Kansas City, MO) and Epic Systems Corporation—had dramatically improved the functionality and breadth of their products since 1999, when KP last evaluated them. Further, these products were integrated into suites of applications: Data from a database or other data repository could be transferred easily between applications in the suite without requiring interface development.

Evaluations of Cerner’s and Epic’s products by potential users at KP clearly showed that these products had surpassed the CIS products developed jointly by KP and IBM and that the rapid pace of product evolution was likely to continue. Consequently, although KP’s potential users concluded that either Cerner’s or Epic’s software could be used effectively at KP, these users clearly and consistently preferred Epic’s products. This preference was seen among all categories of users and for all products that might be used at KP. The KP Northwest Region had adopted EpicCare, Epic’s ambulatory health record product, early; the region’s influence on improvement in quality and features of Epic’s products was clearly substantial.

The assessment team concluded that the underlying architecture of Epic’s products and proposed technical solutions were sound and that adopting Epic’s applications would have several important advantages resulting from Epic’s extensive, well-codified implementation experience. On the basis of Epic’s experience with organizations like KP (and with KP directly, ie, through Epic’s long association with the KP Northwest Region), Epic’s staff concluded that KP could rapidly implement much of Epic’s product suite if KP staff collaborated on basic configuration tasks across regions.

The CIS implementation team had projected programwide deployment of the ambulatory electronic health record system within seven years; instead, Mr
Halvorson is challenging the organization to achieve four major goals within three years:

- programwide deployment of the ambulatory electronic health record system;
- deployment of hospital information systems in regions where these systems are needed;
- creation of a Web presence for clinicians and another for members;
- implementation of integrated electronic patient registration, billing, and appointment scheduling systems.

The three-year goal will probably be accomplished fully throughout KP (except, perhaps, in California, where great progress toward the goal will have been made nonetheless). Potential impediments—in particular, the need to coordinate implementation of the hospital information systems and mandatory seismic retrofitting—may keep California from fully realizing the goal within three years.

In addition to their speed and breadth, the functions inherent in Epic’s software products are more extensive than would have been possible after three years with CIS, particularly with regard to decision support for clinicians and Health Plan members. Preprogrammed rules and templates created by KP for charting and ordering will trigger this decision-support mechanism. All KP regions will benefit from the KP Northwest Region’s experience with the decision-support features of EpicCare, and KP will reuse the CIS work done previously by KP in preparation for EpicCare deployment. Because Epic’s clients routinely share this work among themselves, KP will not need to reinvent decision-support rules and templates already built elsewhere.

In the end, the decision to change from CIS to Epic products was easy, even for those of us who had invested substantial personal energy making the CIS project successful and who were proud of what had been accomplished. In 2003, KP negotiated a contract with Epic Systems that took into account the increased risk and difficulty of implementation created by KP’s size and organizational complexity.

Because Epic continues to develop its suite of products, our contract includes the rights to annual updates for products currently licensed to us. Our agreement also includes a favorable pricing structure for any new Epic products that KP acquires. On a formal, regular basis, Epic will solicit KP’s input about possible modifications or additions to Epic’s products. This contract structure and solicitation of feedback are routine for Epic’s clients, who uniformly view Epic as a good organization to conduct business with. The entire project team sees Epic as a capable partner for KP.

Looking Toward the Future

What advantages will KP reap from this partnership with Epic? The practical answer is contained in the catalog of products posted on KP’s Intranet site:

From the intranet home page, http://kpnet.kp.org, click on “Use Technology” in the left navigation bar; click on the “Kaiser Permanente HealthConnect” link; and click on the “Epic Product Catalog” or the “Epic Product Documentation” link. Epic’s products and services are also shown on the Epic Systems Corporation Web site, www.epicsystems.com. In general, KP will benefit from having a proven, highly functional, computerized system for gathering, storing, and presenting clinical, operational, and business data that supports clinical and administrative operations and serves our members well. Most observers feel that the system is user-friendly and fits well with the way people think and practice.

Once fully deployed, an integrated information technology support system within an integrated health care delivery system has many transformational possibilities. The basic reason for using an electronic health record system applies also to using an integrated information technology system; to have complete, accurate clinical data immediately available for use in patient care. The greater challenge, however, will be to use this integrated information technology system and integrated health care delivery system to improve patient care in ways we cannot yet foresee.

Implementing the entire suite of Epic’s products licensed to KP will be challenging, but changing our processes of patient care to take full advantage of these products will be even more challenging. If we do it, given the inherent advantages of Permanente Medicine and its integrated health care model, the result should be extraordinary. To paraphrase the motto of the medical unit depicted in the hit movie and television show, M*A*S*H, our Health Plan members will get “the best care anywhere.”

Acknowledgment

George Peredy, MD, of The Permanente Medical Group, reviewed the article.
On July 9, 2002, the National Heart, Lung, and Blood Institute of the National Institutes of Health announced premature termination of one component of the Women’s Health Initiative (WHI). This component was designed to assess risks and benefits of hormone therapy (HT) combining estrogen with progestin in healthy postmenopausal women. The WHI data and safety monitoring board concluded that despite noteworthy benefits, the risks of this combined HT outweighed the benefits in this study population.

The impact of the announcement was immediate and profound: These results not only contradicted the medical community’s previous understanding of combined HT but also received much attention in the press. Millions of women suddenly felt compelled to reassess their decision to continue HT, and health care providers mobilized to address the flood of questions and requests for counseling that continue to this day.

As recently as 2002, overwhelming observational data and expert opinion led to the conclusion that for most women, benefits of HT far outweighed its risks. The clear benefits of HT included relief of vaso-motor symptoms as well as prevention of osteoporosis and heart disease. Potential benefits of HT included improved quality of life (including, for example, improved sexual function), prevention of colon cancer, and protection from Alzheimer’s disease. Consequently, the WHI results stunned the medical community, and in the months after the July 2002 announcement, many major medical organizations scrambled to prepare responses and to revise guidelines.

We health care providers in the KP Northern California Region are fortunate: Within hours after reading the press release, the KP Women’s Health Care leadership began preparing an educational response for prompt transmission to more than 90,000 female Health Plan members aged 45 or older who were receiving HT. Today, our regional Clinical Guidelines (revised in October 2002) succinctly state: “The sole indication for hormone therapy (HT) is for the treatment of menopausal symptoms. When HT is elected for symptom relief, prescribe the lowest effective dose for the shortest possible time (1-5 years).”

Women’s Health Initiative Results: Details to Date

Health care practitioners must clearly understand this WHI study in detail if they are to apply its results to individual perimenopausal patients. Although absolute risk and calculated relative risk are difficult for many patients to understand, clinicians must be able to explain these risks as calculated for the treatment groups in the WHI study.

The estrogen-plus-progestin (E+P) arm of the postmenopausal HT component of the WHI was designed to end in 2005 after a mean follow-up of 8.5 years but was stopped in May 2002 after a mean follow-up of 5.2 years. The 16,608 women eligible for the study had an intact uterus and were randomized to treatment groups who received either a tablet containing 0.625 mg conjugated equine estrogen combined with 2.5 mg medroxyprogesterone acetate (PremPro) or a placebo tablet. Primary outcomes were coronary heart disease (CHD) and breast cancer. Secondary outcomes were stroke, pulmonary embolism, endometrial cancer, colorectal cancer, hip fracture, and death from other causes.

Results of comparing health benefits and risks were summarized by using a global index, defined as the earliest occurrence of any study outcome (giving extra statistical weight to the seven listed diseases). Randomized participants in both groups had these baseline characteristics: mean age 63 years; race/ethnicity 84% white, 7% black, 5% Hispanic; 74% had never used HT; mean BMI 28.5; mean blood pressure 128/76 mmHg; 50% had never smoked; 90% had at least one term pregnancy; 87% had normal serum cholesterol levels; and few had clinically significant chronic medical conditions.

At the tenth interim analysis of the
study data, the data and safety monitoring board recommended that the E+P arm of the trial be stopped because predetermined limits for increased risk of breast cancer and for the global index had been exceeded. The study found that use of E+P was associated with increased risk of CHD, breast cancer, stroke, and pulmonary embolism and with decreased risk of colorectal cancer and hip fracture. No difference in mortality was seen between groups, but overall health risks exceeded benefits for the group using E+P.

Table 1 summarizes key study findings and may be useful for showing patients alternative perspectives on the same data. This tabular summation can facilitate patient counseling and can help us to tailor treatment to the needs of individual patients.

For example, annualized absolute risk of stroke (i.e., the percentage of group participants who had a stroke during each study year) was 0.21% for the placebo group and was 0.29% for the E+P group. Thus, the projected ten-year risk of stroke is 2.1% for the placebo group and is 2.9% for the E+P group; in contrast, the projected 10-year risk of no stroke is 97.9% for the placebo group and is 97.1% for the E+P group. An alternative perspective would compare the 21 cases of stroke expected per 10,000 person-year in the placebo group with the 29 cases expected per 10,000 person-year in the E+P group; thus, a group of 10,000 women who take E+P for one year might have eight more cases of stroke than if they took a placebo. This comparison would show a 41% increased risk of stroke in the E+P group, who would be 1.29 times more likely to have a stroke than the placebo group (RR=1.29).

Asymptomatic perimenopausal women balancing the potential benefit and risk of HT might weigh “a 41% increased risk of stroke after one year of using E+P” or “1.29 times more likely to have a stroke” differently than “a 97.1% chance (risk) of not having a stroke after 10 years of using E+P.” Our challenge as clinicians is to interpret findings for patients in an unbiased, easily understood way so that our patients can be better informed when making decisions about their health care.

The WHI is more than a single study—it is a large, 15-year research program based in the United States and designed to study major causes of death, disability, and frailty in postmenopausal women. The goal of the WHI is to use prevention and intervention strategies and risk factor identification to reduce incidence of CHD, breast and colorectal cancer, and osteoporotic fracture in women.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Placebo (n = 8506)</th>
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<th>Estrogen plus progestin versus placebo</th>
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<td>Event (%)</td>
<td>No event (%)</td>
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<td>VTE§</td>
<td>1.6</td>
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<td>1.0</td>
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<td>Colon cancer§</td>
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<td>Overall risk versus benefit:</td>
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<tr>
<td>Global index (any event)</td>
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<td>84.9</td>
<td>151</td>
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</tbody>
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‡CHD = coronary heart disease, including death from CHD and nonfatal myocardial infarct;
§VTE = venous thromboembolism, including deep vein thrombosis and pulmonary embolism; RR = relative risk.
b 10-year projected event risk calculated as annualized event rate x 10.

Results evident during first trial year.
§Results evident after first trial year.
#Results evident after fourth trial year.
†Results evident after third trial year.
women. Major components of the WHI include three clinical trials evaluating promising-but-unproven approaches to prevention; an observational study identifying predictors of disease; and a study evaluating community-based approaches to adopting healthful behavior. Results of major WHI studies on effects of E+P use on health-related quality of life, global cognitive function, and dementia and mild cognitive impairment were published in the first half of 2003. We can expect many more such publications in the future. Often, more questions than answers will result from these studies; health care practitioners will need not only to critically assess the clinical significance, scope, and magnitude of study findings but also to develop tools that will enable our patients to do the same.

Acknowledgment
Ruth E Shaber, MD, reviewed the article.

References

The Obvious
Everything you’ve learned in school as ‘obvious’ becomes less and less obvious as you begin to study the universe. For example, there are no solids in the universe. There’s not even a suggestion of a solid. There are no absolute continuums. There are no surfaces. There are no straight lines.

R Buckminster Fuller, 1895-1983, engineer, designer, and architect
Why do you do, What you do,  
When you do, What you do

By Calvin Weisberger, MD

I’m getting older. I’m physically slower; my reflexes are not what they used to be. My eyes are worse, my hearing is diminished, my hair is graying, my joints ache sometimes, and I’m not as quick or precise at remembering as I once was. As great as the gradual changes in my physical performance are, my personality changes are perhaps more significant. My type A, aggressive personality has mellowed. Time has been a great teacher. Experience has been a great teacher. Success and failure have taught invaluable lessons.

Once quick to argue, firm in my intellectual stances and convinced of the correctness of my position, I’m different. After overwhelming others with “forceful” arguments and later being proven wrong, “I know that I don’t know what I know.” “Today’s truth is tomorrow’s error,” is a mantra. Tolerance of other viewpoints and intellectual stances has evolved. Having made many thoughtless or careless mistakes myself, the willingness to forgive has appeared. I try to lead by facilitation. One doesn’t need to have the answers as leader, but one must allow them to come from others. Even when a solution seems obvious, it’s good to let someone else suggest it. When solutions come from the group rather than from the leader, the solutions are more readily accepted.

Having the brightest light in the fixture may unbalance the total illumination. Historically impatient, a certain phlegmatism has evolved in me. Suppressing colleagues when chairing a meeting causes serious conscious and subconscious resentment. Once quick to rush to combat, I pick the battles that can be won, avoiding the battles that will inevitably be lost. The wisdom of the “win-win” scenario seems powerful. When you create a loser, you fertilize the field of revolution. Sharing victory encourages the growth of comradeship. Somehow the “team triumph” seems to produce longer-lasting joy than the individual achievement. Whatever team I have been associated with, the successes always seem to live on in the members.

My youth’s compulsion to always be right has morphed to the acceptance of personal fallibility. I am quick to apologize. Although cavalry Captain Nathan Brittles in a John Wayne movie1 said “Never apologize, Mister. It’s a sign of weakness!” I don’t ascribe to that belief.

Though capable of inflicting pain, I do so most often inadvertently. When guilty, I apologize profusely and sincerely and try to make amends. Earlier in life, I lacked the courage to be wrong or to admit the error. There was fear that either would diminish me. Time and pain have corrected that misconception.

Without wishing it, there is less sensitivity to others’ feelings than I might desire. I’ve learned to compensate by observation but understand that observation is a poor substitute for true empathy. Having become more sensitive to my own failings, I am better able to see when I’m tiresome to others. I’ve seen my arrival put disappointment on faces. This has made me willing to walk away rather than to inflict myself on others.

I am quick with a complement when it is deserved. I am slower to criticize, perhaps not as slow as I should be but better than I once was. After a leadership course, I spent a lot of time distributing compliments to colleagues. This was met with suspicion. I persevered. What once was met with mistrust is now met with appreciation.

I’ve learned to value friends and to mourn the acquisition of enemies. It is said that one can never have enough friends but that one enemy is too many. I adhere to that belief, though I remain too adept at antagonizing others and producing animus.

Patience has evolved. I have learned to plant the seeds of progress and fertilize them for years until they are ready to germinate and grow. Sometimes when they grow, no one remembers who did the planting. This omission no longer bothers me, as the fruit of the progress feeds my hunger for recognition. I accept both compliments and criticism with grace. Both once embarrassed me, but that too has passed with advancing time.

I’ve learned the value of communication. Missed communication, late communication, inaccurate communication—these are root causes of many of the problems we face daily. The ability to communicate truth and to avoid communicating untruth must be constantly regenerated. We are constantly tempted by the power of the lie. It is like the “power of the dark side.” I am as prone to “spin a tale” as the next person, but generally succumb reluctantly and with remorse afterward.

All these things and more contribute to my behavior. My personal evolution is a daily ebb and flow of experience. Why do I do what I do when I do what I do? I do what I do when I do what I do, because I am still learning.

Reference
1. She Wore a Yellow Ribbon. RKO/Warner Bros Video 1949.

Calvin Weisberger, MD, is Regional Coordinating Chief of Cardiology for Southern California. He is co-author of the book Practical Nuclear Cardiology. He has written other pieces in various venues. E-mail: calvin.l.weisberger@kp.org.
SCPMG Celebrates Its “First 50 Years”

By Chad Fifer

Although the Southern California Permanente Medical Group (SCPMG) was officially “born” on January 1, 1953, it did not spring to life in a single day. The guiding principles of the organization took decades to develop—decades of stops and starts, of successes and failures. Above all, it took the persistence, extraordinary vision, and dreams of two men: Sidney Garfield, MD, and Raymond Kay, MD.

Drs Garfield and Kay were just beginning their medical careers when they met in the early 1930s at Los Angeles County General Hospital (now the Los Angeles County/USC Medical Center). The origins of SCPMG may well have been right then and there. As Dr Kay would later say, “Many fundamental concepts of the Southern California Permanente Medical Group stem from the early experience and reactions some of us had while young physicians in training at the Los Angeles County General Hospital.” Dr Garfield pioneered the health care delivery system we now know as Kaiser Permanente, while Dr Kay became the driving force behind the formation of SCPMG. (Excerpted from “SCPMG . . . The First 50 Years,” a historical account of the Medical Group by Teri Allen, to be printed later this year.)

It was 1949 when Ray Kay, MD, left his job at Los Angeles County General Hospital, moved to Fontana, and became the Medical Director of the Kaiser Permanente Southern California Region. A mere four years later, the small group of Fontana physicians employed by Sidney R Garfield, MD, and Associates became the partnership of physicians known as SCPMG. On January 1, 1953, 13 physicians signed the first SCPMG Partnership Agreement, creating an organization of partners who co-owned and governed the medical group. During the early years, Dr Kay said, “We dreamed of a form of practice that we hoped would meet the needs of both patients and physicians.”

SCPMG has grown into an organization of approximately 3700 partners and associate physicians working at 12 medical centers and more than 100 medical offices in the KP Southern California Region. The organization and its leadership have proved remarkably resilient during the last 50 years by continuing to provide high-quality, convenient, and affordable health care in spite of various internal and external challenges.

In the 1950s, SCPMG’s leaders took on the challenge of launching a new, innovative organization in a less-than-favorable health care environment. They faced bashing from the “established” medical community as well as pressure from unions and the KP organization itself. In 1956, SCPMG became the first medical group within KP to sign a medical service agreement, establishing a contractual partnership with the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals. This agreement cemented a healthy relationship between the medical group and the Health Plan that both still enjoy.

The 1960s saw SCPMG dealing with the pressures of growth and expansion, as KP’s Panorama City and Bellflower medical centers opened and construction began on KP West Los Angeles. In the 1970s, this expansion continued—SCPMG began serving members in San Diego and Orange County while coping with the emergence of government regulation and managed care competition.

Increased competition from these managed care companies, coupled with escalating health care costs, threatened the stability of SCPMG in the ’80s and ’90s, but the organization weathered the storm. By
improving its access, service, and efficiency, SCPMG separated itself from the pack and outlasted many of its rivals, to become the successful medical group that KP members continue to rely on today.

“Over the last 50 years, SCPMG has proven to be a very durable organization of physicians; and we are an important part of the infrastructure of Southern California health care,” said Oliver Goldsmith, MD, SCPMG Medical Director. “I’d be hard pressed to find a group of physicians more singularly committed to their program and the patients they serve.”

This year marks SCPMG’s 50th Anniversary—a time to celebrate the history of its partnership, longevity of its mission, dedication to its patients, and the strength of group practice. Several activities are taking place throughout the rest of the year to commemorate the anniversary and to thank physicians, providers, and employees for their commitment to medical excellence.

SCPMG “The First 50 Years” Celebration

This regionwide anniversary celebration for SCPMG Partner and Associate Physicians as well as retired partner physicians will feature guest speaker Jerome Groopman, MD. Dr. Groopman is an esteemed physician and writer on doctor-patient relationships for The New Yorker and author of The Measure of Our Days, which inspired the critically acclaimed TV series Gideon’s Crossing. The program, followed by a reception, will have been held on Sunday, October 26, 2003, at the Pasadena Civic Auditorium.

50th Anniversary Web Site

The 50th anniversary is also being commemorated within the pages of the SCPMG Physician Intranet portal (http://scpmgphysician.kp.org). This site features:

- historical accounts of the people and places that shaped the history of SCPMG;
- anniversary messages from Oliver Goldsmith, MD, SCPMG Medical Director, and Jeffrey Weisz, MD, SCPMG Medical Director-elect;
- an SCPMG Anniversary Events Calendar which includes KP Southern California regional and local celebrations; and
- a “Tell Your SCPMG Story” section which enables physicians and staff members to submit stories of their personal experiences in SCPMG, for example, why they joined the medical group, important milestones, proudest moments, working wisdom gained, unforgettable faces, and more.

“As we move forward into our next 50 years, the medical group will continue to operate on its core principles: Permanente Medicine and a sense of compassion and of caring for our patients,” said Dr. Weisz. “We are responsible for putting the KP Promise into action every day in our medical facilities and administrative offices. I would like to thank the SCPMG people of yesteryear and those of today for working diligently to carry out our tradition of quality medical care.”

Reference

## Physician News Roundup

### Mid-Atlantic Permanente Medical Group (MAPMG)

**MAPMG Names Philip S Carney, Jr, MD, as New President and Medical Director**

On June 19, 2003, the MAPMG shareholder physicians ratified the election of Philip S Carney, Jr, MD, as president and medical director of the Mid-Atlantic Permanente Medical Group. Dr Carney is board-certified in emergency medicine, family practice, and geriatrics. In addition, he earned both a Masters of Public Health and an executive MBA. He has been Area Medical Director in the Southern California Permanente Medical Group (SCPMG) and Chief of Staff at the Kaiser Foundation Hospital in Fontana, Kaiser Permanente’s birthplace in Southern California.

Shortly after taking office, Dr Carney announced the appointment of Yancy Phillips, MD, as MAPMG Chief Operating Officer. Dr Phillips served as Associate Medical Director for Clinical Affairs of The Southeast Permanente Medical Group (TSPMG), which he joined in 2000, following a 20-year career in a variety of leadership positions at the Walter Reed Army Medical Center in Washington, DC.

![Philip S Carney, Jr, MD](image_url)

### Southern California Permanente Medical Group (SCPMG)

**SCPMG Leadership Team Appointments**

Jeffrey Weisz, MD, SCPMG Medical Director-Elect, who will take office on January 1, 2004, announced in May the partnership ratification of the following SCPMG leadership team, also effective January 1: Michael Kanter, MD, Associate Medical Director of Quality and Clinical Analysis; Paul Minardi, MD, Associate Medical Director of Operations; and Jeffrey Selevan, MD, Associate Medical Director of Business Management.

**Kidney Disease Patients Do Better at KP**

The results of a Medicare demonstration project recently released to Congress by the US Department of Health and Human Services show that dialysis and kidney transplant patients can receive high-quality, affordable care in a managed care setting. KP Southern California was one of four health plans in the country chosen by Medicare to participate in the three-year demonstration project.

The goal of the demonstration project was to determine the medical outcomes and costs when fee-for-service patients with end-stage renal disease (ESRD) join a managed health care program.

“The independent scientific evaluation is clear. Medicare ESRD patients who joined KP showed a 31% reduction in mortality rates,” said Peter Crooks, MD, Physician Director for the Southern California KP site. “We have believed for a long time that our medical care program provided very good outcomes for ESRD patients, and it is nice to have validation and confirmation from Medicare.”

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Southern California Permanente Medical Group (SCPMG) continued

KP School of Anesthesia/CSU Fullerton Named One of the Top Programs in the US

US News and World Report, in its directory America’s Best Graduate Schools, 2004 Edition, has named the Kaiser Permanente School of Anesthesia/California State University Fullerton as one of the top ten anesthesia training programs in the country. The US News rankings spotlight the country’s academically excellent graduate programs. John Nagelhout, CRNA, PhD, Program Director, noted, “The high-quality anesthesia education afforded our nurses is a reflection of the excellent health care provided by the Kaiser Permanente system and by our continued partnership with California State University Fullerton.” The KP School of Anesthesia is affiliated with 16 KP and community hospitals throughout the KP Southern California Region.

Fred Ziel, MD, Receives CMI’s “Lifetime” Diabetes Achievement Award

Fred Ziel, MD, KP Woodland Hills, has received the Care Management Institute’s (CMI) 2003 Honorary Achievement Award for his outstanding commitment to improving outcomes and care for KP members with diabetes. As Director of the KP Woodland Hills Diabetes Program, SCPMG Regional Coordinator for diabetes outcomes, and SCPMG Chairman of Regional Endocrinology, Dr Ziel has been an innovator and a motivator in his efforts to improve standards of care. His accomplishments for the diabetes program include: improving testing outcomes from 25% to 80% through use of the “point-of-service fax,” which was conceived by his regional team; sending letters to patients; creating quarterly physician reports; publishing eye data (photos) in a leading diabetes journal, thus setting a national standard for practical, accurate assessment of eye health in diabetic patients; and developing telephone outreach.

The Permanente Medical Group (TPMG)

First Honorees of New Morris F Collen Research Award Announced

In July, TPMG Executive Director/CEO Robert Pearl, MD, announced the first honorees of the new annual Morris F Collen Research Award, named for the TPMG physician who pioneered the field of medical informatics in the 1950s and started what is now the Division of Research. The honorees are William Durston, MD, whose research has focused on the role of ultrasound in the emergency department; and Barry Rasgon, MD, Research Director of the KP Oakland Head and Neck Surgery Residency Program.

Domestic Violence Prevention Program Receives National Award

The American Association of Health Plans (AAHP) honored Kaiser Permanente Northern California for its Family Violence Prevention Program with the AAHP/Wyeth Gold HERA Award. The HERA Awards recognize programs that have made a measurable difference in the lives of women and children.

The Family Violence Prevention Program, a comprehensive program to prevent and reduce domestic violence, began at the KP Richmond Medical Center in 1998. Conceived and directed by Brigid McCaw, MD, MPH, the program has four components: a screening and referral system, a supportive environment, on-site resources, and community linkages. “Clinicians have been trained to screen, identify, and support women who are at risk for abuse,” said Dr McCaw. “Part of this support may be referral to an on-site social worker, participation in a support group, or contacting a community advocacy agency. Community resources include 24-hour crisis hotlines, emergency housing, and legal services.”
NCQA Reports Cardiovascular Disease Has Met its Match in KP Northern California

The 2003 annual report of the National Committee for Quality Assurance (NCQA) pays tribute to KP Northern California’s cardiovascular care programs with a special section titled “Doing Cardiovascular Care Right.” Stating that “The Nation’s Number One Killer—Cardiovascular Disease—Has Met its Match in Northern California,” the four-page feature describes how health care professionals at KP Northern California have accomplished the remarkable: They have reduced death from heart disease among its three million members so significantly that it is no longer the leading cause of death in the KP Northern California population, despite remaining so in the general population.

Barbara Caruso compiled this material from California Wire, Partner News, and other PMG newsletters and sources. To submit news of physician or PMG awards and recognitions, contact Ms Caruso at barbara.caruso@kp.org.

Competition

[Permanente] Doctors compete with each other, not in the economic sense but in the realm of professional excellence.

Herman Weiner, MD, second Medical Director of SCPMG, describing the advantages of group practice in general and Permanente in particular.

This “Moment in History” quote collected by Steve Gilford, KP Historian

KNPW Ranked #1 HMO in Nation

Results of a national consumer magazine’s 2002 annual survey published in October 2003 ranked Kaiser Permanente Northwest as the #1 HMO in the nation. The rankings were based on the responses of more than 42,000 readers. HMOs and PPOs were ranked according to ease of getting needed care, choice of doctors, customer support, billing problems, access to doctors, and satisfaction with primary care doctors. Four other KP Regions and the Group Health Cooperative also ranked among the top 15 HMOs nationwide.
Celebrating a Medical Center’s Anniversary and an Emotional Reunion

The rapid growth of defense industries on the West Coast following the attack on Pearl Harbor in December of 1941, set off one of the largest migrations in American history. Eager to fill a need for labor that had outgrown the local labor pool, tens of thousands who had struggled through the Depression years flooded into the states of Washington, Oregon, and California. Each person had his or her own story. One story helps illuminate the time and place when Kaiser Permanente was being born. Although the story began on a Texas sharecropper’s farm 75 years ago, the final chapter was not written until the 60th Anniversary celebration, held last year, of the first Kaiser Permanente hospital.

Alfonzo Smith was born in Texarkana, Texas, and raised by his grandparents on a sharecropped farm. When Mr Smith was about ten years old, he was playing on his grandfather’s mule wagon and slipped down into the traces. As he fell, he gashed his leg on a piece of steel used to hold the mules in place, thus ripping a piece of flesh from the leg.

Even though the wound wouldn’t heal, seeing a doctor was out of the question; even if his family could afford the fee, there were no doctors around. Leaving the farm and through a succession of jobs, he continued to bandage his leg to keep it clean and always had to live with the pain.

In early 1940, he left Fort Worth and joined what was already a growing flow of emigrants from parts of America with high unemployment to “The Golden State,” where the jobs were. Although he had been doing heavy work for more than ten years, the Army looked at the ulcer on his leg and classified him as 4-F, the lowest rating. He was able to get a job on a railroad track maintenance crew, working for the Western Pacific Railway in the Sacramento area, despite his weakened leg and the pain. Even in the hot California Central Valley summer, few knew of the constant throbbing pain from the ulcer he kept hidden under homemade bandages.

Cooler weather and the chance for better pay drew Mr Smith to the San Francisco Bay Area. He’d heard that the Kaiser Shipyards were hiring and that African Americans could get jobs there.

After Mr Smith had established himself in his new job on a cleanup crew in Yard Two, he decided to see if the Permanente Health Plan could do anything for his ulcerated leg. He was referred

Steve Gilford is a filmmaker, writer and historian who specializes in the history of Kaiser Permanente as well as in the life and times of Henry Kaiser. E-mail: Sageprod@aya.yale.edu.
to a dermatologist at the Oakland hospital who sent him to a surgeon. “My eyes opened wide when he said he could take care of it, because it had been a problem for such a long time.” With the newly improved blood supply, the ulcer that hadn’t healed in all those years soon vanished.

I asked Mr Smith if he remembered the name of the doctor who had done the surgery. Without the slightest hesitation he answered, “Dr Grant.” When I was surprised that he remembered the name so clearly, Mr Smith explained, “He was such a wonderful person. I had never really seen a white person treat a black person so well.”

Mr Smith regretted that he had never had the opportunity to tell Dr Grant how much he appreciated the treatment he’d received and what a difference it had made in his life.

In late September in a park across from the Oakland medical center, in a large tent filled with music, good food, and a crowd of past and present Kaiser Permanente employees celebrating 60 years of medical care, the two men were reunited. They hugged and laughed together. That day, Mr Smith also met and shared his story with another surgeon, Robert Pearl, MD, now TPMG Medical Director. As they looked at photographs of the original hospital, Mr Smith pointed to a window on the first floor and said to Dr Grant, “Your office was right there.” “You’re right,” said Dr Grant, smiling broadly, “That was it.”

Another Permanente physician standing nearby said incredulously, “You can remember where your office was?” “I ought to,” Dr Grant replied, “I was there for 40 years.”

Meeting again brought up so many pleasant memories for both men that they found themselves holding onto each other’s hands as they reminisced about their shared experiences nearly 60 years before. At that time, Dr Sidney Garfield had just founded the medical care program and was determined to make the care as personal as possible. The story of Donald Grant, MD, and Al Smith is an indication that he succeeded.

A Thankful Heart

A thankful heart is the parent of all virtues.

Cicero, c 106-43 BC, orator, lawyer, politician, and philosopher

Celebrating a Medical Center’s Anniversary and an Emotional Reunion
“Honu” has the right of way
watercolor
By Patty Stelz, RN

More of Ms Stelz's art can be found on page 9.
**announcements**

**Primary Care 2004**
April 5-9, 2004
Wailea Marriott, Maui, Hawaii

**Conference sessions for 2004 are:**
- Practical Primary Care Skills
- Women’s Health
- Musculoskeletal Medicine Skills
- Improving Skills with Occupation-Related Medical Problems

For registration or program information:
visit www.kpprimarycareconference.org
or call 510-625-6374 • Fax: 510-625-3037
E-mail: primary.care.conference@kp.org

The Kaiser Permanente National CME Program designates this educational activity for up to 20 hours in Category 1 credit toward the AMA Physician’s Recognition Award. Each physician should claim only those hours of credit that s/he actually spent in the educational activity.

**Calling All Artists …**
Join in a medical artistic tradition of seven years

The Permanente Journal is always interested in considering artwork by Kaiser Permanente clinicians and employees. Submit a sample of your artwork today.
To submit art for consideration for the cover or interior pages of The Permanente Journal, please use the following guidelines: Send us a high-quality color photograph of your artwork no smaller than 4”x5” and no larger than 8”x10”. Slides and digital images may also be submitted. Include a cover letter explaining your KP association, art background, medium, and a brief statement about the artwork (description, inspiration, etc).

Send artwork samples to:
Managing Editor, The Permanente Journal,
500 NE Multnomah St, Suite 100,
Portland, Oregon 97232
E-mail: permanente.journal@kp.org

**the lighter side of medicine**

**THE HUMERUS ZONE**

Cartoon submitted by Don Wissusik, MA, MS, inspired by a joke told by John Gale, MD. Mr Wissusik is a Clinical Services Manager for the Department of Addiction Medicine at the Tualatin, Beaverton and Sunset Clinics. Dr Gale is a psychiatrist at the Beaverton Mental Health Department, where he is known as the “joke historian.”
In 1913, Arthur Wynne, a British born journalist, created the first crossword puzzle for an American newspaper called the New York World. It was called a “word-cross.” It was based on a similar, much older game, played in ancient Pompeii, called Magic Squares or word square. The word square: “Sator Acrostic” was possibly used during Roman times as a secret sign to indicate the home or place of a Christian family or safe house.

The first crossword puzzles were primarily published for children but developed into an adult pastime when, in the 1920s, it was realized that they could sell newspapers. It was during this time that crossword puzzles attained the familiar appearance they have today.

Across
1 Flip-___
5 Venerable cancer test
8 Bridge section
12 Places
13 Bit of info
15 Guthrie
16 Dull pain
17 Doolittle
18 Mrs Kaiser
19 One way to a man’s heart
22 Famed short-story writer
23 The South, once (abbr)
24 ___ Camera (movie title, 3 wds)
26 Asparagus pieces
29 Mr Kaiser
31 The “p” in po or pr
32 Beginner at West Point
34 Turkish leader Ataturk
36 Totally amazed
38 Gems
40 C2 structure
41 Satan
43 Finnish architect Alvar
45 Beaty or Rorem
46 Psychologic coping mechanism
48 Facial regions
50 Verne protagonist
51 German one
52 Petechia, for example
54 Doctor who sets you straight
61 Take ___ (get an admission while on call, 2 wds)
63 Administer therapy
64 Hebrew month
65 Biblical destination for San Diego KP members?
66 Intend (2 wds)
67 Large truck
68 Really long times
69 Surgeries or detectives, for short
70 Padlock’s partner

Down
1 Lacking energy
2 Scottish lake
3 ___ Rios (Jamaican resort)
4 Prepare to wear rings
5 ___ Alto
6 Keep ___ (continue, 2 wds)
7 Writer Mario
8 Miscarrage (abbr)
9 KP’s pioneering business method
10 Furthermore
11 Body part frequently wiped
13 Actress Yvonne
14 Ike’s wife
21 Pull quickly
25 Four-footed TV star (2 wds)
26 Sutured
27 KP practice hallmark
28 Part of a flower
29 “Are you there?”
30 Doe and Eyre
31 Note-taker’s aid
33 Pastoral sound
35 Hallucinogen
37 Eat
39 Microbial prefix
40 C2 structure
41 Satan
42 Classy way to travel
44 Off-Broadway award
47 The mother of all arteries
49 Certain car stereos
52 State of altered consciousness
53 KP region
55 Moe, Larry, and Curly (for instance)
56 Rope precursor
57 Grains that you might feel or sow
58 Opinion
59 Former TPMG leader Bruce
60 35-Down experience
62 Heavy weights (abbr)

Visit TPJ on the Web for answers to this puzzle: www.kp.org/permantejournal
Prescriber’s Letter

Prescriber’s Letter is a concise monthly newsletter that provides large amounts of information about drug therapy. Perhaps most importantly, this newsletter presents the information in an interesting and helpful manner that is well matched to the needs of practitioners. Each time I have received a sample copy in the mail, I’ve ended up reading more than I would have anticipated; the information is presented in an engaging, telegraphic style. In addition to the six-page monthly hard copy of Prescriber’s Letter, the publication has excellent associated Web-based features, including online access to previous issues.

The drug information in Prescriber’s Letter is divided into specialties and disease states. Comparisons between related drugs are brief and to the point; drug costs and marketing approaches are mentioned when relevant. Detailed supporting information is referenced by code number at the end of each Prescriber’s Letter “note” and is easily found on the Web site. The newsletter consistently maintains this pattern of providing interesting, concise, initial information in hard copy along with detailed supporting information on the Prescriber’s Letter Web site.

For instance, a recent issue included a short note on the generally beneficial use of statin drugs in diabetic patients regardless of their cholesterol level. This segment closed with a reference number link which, when accessed, presents a longer, well-documented, comprehensive discussion of the evidence underlying the statements in the newsletter. Another example of the newsletter’s useful, easily accessed information is the brief mention given to recent information that St John’s wort sometimes blocks the effect of oral contraceptives and allows pregnancy. The evidence for this claim is well documented on the Prescriber’s Letter Web site.

This Web site has other helpful, interesting features. Rumor vs Truth explores the validity of current assertions regarding clinical practice; a chatroom function invites reader commentary about these beliefs and enables readers to question the validity of statements overhead. New Drugs lists and discusses drugs recently released into commerce. Recent listings range from the new, nasally administered influenza vaccine to a new drug for Fabry’s disease. Useful Charts is another helpful Web site feature in which I immediately found items of interest, for example, a list of drugs to avoid prescribing to patients with dementia; a chart comparing statin drugs; and a surprisingly long list of drugs that interact with grapefruit. Additional Web site functions are included, and CME credit also is available. Subscription to Prescriber’s Letter includes 24-hour-per-day access to a fax service which provides detailed information that cannot be located on the Web site, www.prescribersletter.com.

An obvious comparison with Prescriber’s Letter is the Medical Letter: 1 Both are high-quality publications. Of the two, however, I found Prescriber’s Letter far more interesting to read. In addition, the subscription fee is fully refundable at any time. After reviewing four issues of Prescriber’s Letter, I decided to subscribe to it.

Reference

Growing Up Fast
By Joanne Lipper

On the subject of teenage pregnancy, we might suppose that the right combination of parental supervision, community support, personal values, and education would effectively neutralize the impulsivity and hormonal surges of adolescence. Written for a general audience, this book examines these opposing forces by presenting in-depth stories distilled from conversations between Joanne Lipper and six teen-aged mothers. The introductory chapter sets the stage effectively, but the closing chapter does not summarize as well as the reader might hope.

The setting for these stories is Pittsfield, a small city in western Massachusetts in the Berkshire Mountains. This area boasts many cultural offerings—Tanglewood and Jacob's Pillow are among the better-known attractions. Pittsfield has benefited from this environment but even more so from its long relationship with the General Electric Corporation (GE), the area’s main employer for decades. This situation changed in 1986, when GE decided to shift many of its operations abroad; this action greatly disrupted the Pittsfield economy and combined with an earlier crisis—toxic waste disposal into the local river—to set the city on a prolonged course of decline.

This decline occurred at a time of plentiful coverage for inpatient treatment for substance abuse, and a local hospital contracted with Medicaid to provide such treatment for New York beneficiaries. Consequently, Pittsfield became a hub for drug dealers and drug abuse. The impact of this phenomenon on a poor community is the powerful theme of this book and illuminates the social, economic, familial, and psychological factors which lead to early sexual activity and pregnancy.

Ms Lipper cites a study¹ coauthored by Vincent Felitti, MD, of SCPMG in San Diego (and Book Review Editor of The Permanente Journal) which found that girls younger than 15 years of age are more likely to engage in sexual behavior if they have been subjected to emotional, physical, or sexual abuse; have witnessed domestic violence; live with an adult who has a history of substance abuse, mental illness, or a prison record; or has experienced a combination of these factors, which fill each chapter of the book. Readers must try to imagine how a teenage girl could cope with the deprivations caused by these factors. Most of the girls are themselves children of teenage mothers—mothers so entrapped by their own problems that they cannot provide the basic necessities for their children. These children naturally continue to seek security—no matter how illusory or temporary—whenever possible. The immensity of the problems seems insurmountable.

But perhaps they are not insurmountable. A community resource such as the Teen Parent Program can become a lifeline for pregnant adolescents in Pittsfield. This program (a day school housed in a church building) offers counseling, daycare, tutoring, and—perhaps most important—caring adults who help these girls through family turmoil, medical needs, and the public welfare system. The program is no panacea but is a beginning.

We would hope for happy resolutions for all the girls described in the book. Instead, however, the book describes heroic victories—a high school graduation and ending the need for public welfare assistance—as well as horrendously bad choices such as returning to a physically abusive boyfriend or selling drugs. The reader is left to worry about the kind of parents the babies will become—and how soon.

Ms Lipper largely allows the stories to speak for themselves but does offer some psychological and sociological insight into these teens. Given how well she has come to know these young mothers, her insights ring true. The final chapter, “Community,” attempts to synthesize what Ms Lipper has learned from the girls (and from others) about

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The book forcefully reminds those who interact with pregnant teenagers that these girls are usually the victims of deeply troubled families. More awareness of the predictors of teenage sexual activity and pregnancy may provide an opportunity for health care professionals to make appropriate referrals, offer counseling, and provide medical information to such children, who must be considered at high risk for a life of extraordinary challenges.

Reference

Words
Words are things; and a small drop of ink
Falling like dew upon a thought, produces
That which makes thousands, perhaps millions, think.

Lord Byron, 1788-1824, poet
Your Breast Cancer Treatment Handbook: Your Guide to Understanding the Disease, Treatments, Emotions and Recovery From Breast Cancer
By Judy C Kneece, RN, OCN

Review by Carol Redding

Handbook is an appropriate description of this concise, practical work, which is clearly and sensitively written. Ms Kneece combines her credentials—registered nurse, certified oncology nurse, MammaCare® Specialist, and trainee at the Mind and Body Institute of Harvard Medical School—with an empathetic understanding of her patients’ needs. This combination offers readers a high level of psychological and emotional comfort with this handbook—both as a resource and as a starting point for building a better understanding of what it is like to have breast cancer.

The practical nature of the book is invaluable in its simple, thorough explanation of different types of breast cancer, the role of the lymphatic system, surgical and reconstructive procedures, and general medical terminology likely to be encountered by patients with breast cancer. In short, the author provides patients with the tools they need to become well-informed, fully participative members of the health care team. At the same time, the author spares the reader the research efforts that would be required if such a handbook were not readily available.

Kneece also addresses the needs of a patient’s family and friends and offers brief, sound advice on how to convey information, what sort of reactions to expect, and how to prepare for them. Of particular use is her advice on how to talk with children about breast cancer: This advice prepares patients for the possibility that their children may express anger or fear or may believe that they somehow caused the disease.1 As part of her overall experience of having breast cancer, every mother with this disease must be prepared to face these issues. The author also helps patients understand the importance of including children in the care experience and guides patients on how to do this in a way appropriate for each child’s age.

Kneece reminds the patient—whose normal reaction to the diagnosis might be self-absorption, distress, and withdrawal—that her mate is also suffering because of the breast cancer diagnosis. The author speaks frankly about effective steps that a couple can take to maximize communication and sensuality, thereby using their shared experience of breast cancer to strengthen their relationship instead of being driven apart.

The visual layout of this book is especially helpful. A combination of tables, charts, bulleted lists, and clearly illustrated images is used to clarify concepts, surgical procedures, cellular structures, metastatic pathways, postoperative exercises, and techniques for breast self-examination. The book includes a set of tear-out pages useful to patients for maintaining records of medical contacts, treatment records, bulb drain records, and sets of predefined questions for the health care teams with whom patients are likely to interact.

Your Breast Cancer Treatment Handbook is an affordable, comprehensive resource for any family coping with a breast cancer diagnosis and its aftermath. The book is an equally appropriate and meaningful gift to give to a friend or family member during any stage of breast cancer treatment or recovery.

If this publication has any drawback, it is its cover design—ironically, one aspect of the book that could encourage many women to pick it up for a closer look. Its depiction of a delicate pink rose accompanied by gold-embossed script will probably make the book visually appealing to most women but might cause some men to overlook it as merely “girls’ stuff” or “feminine fluff.” Physicians and other health care practitioners who interact with the male partners of women with breast cancer should encourage these men to read this book cover to cover, because the content is as much for them as for the women they hold dear.

Carol Redding, a writer, is also an Information Technology Consultant and Customer Service Manager at San Diego State University; a California-licensed Private Investigator; a grant writer for the California Institutes of Preventive Medicine; an authentic voice in the National Call to Action, a movement to end child abuse and neglect; a Fellow of the Association of Teachers of Preventive Medicine; a cancer survivor; and a patient who recently embarked on her own breast cancer journey.
Another reason for men to read this book applies to them even more directly: The American Cancer Society estimates that in 2003, about 1300 new cases of invasive breast cancer will be diagnosed among men in the United States. Breast cancer is about 100 times more common among women, but we would be doing men a grave injustice by ignoring the possibility that they, too, may someday be diagnosed with this disease.

In Kneece’s own words, “Breast cancer is more than scars on the breast; it can also scar the heart. We must address the psychological and social issues breast cancer brings if a woman is to master the disease. … Getting well is more than surgery and treatments; it is a woman understanding the vital role she can play in managing her own physical and emotional recovery.”

Interspersed throughout the book are quotations from breast cancer survivors, whose poignant words offer readers a profound sense of community—membership in a club to which they would rather not belong but in which they might nonetheless find comfort.

*MammaCare® is a breast examination certification program, which purports to be “The only scientifically validated system for teaching physical examination of the breast.” Their Web site offers a full description of their program: www.mammacare.com.

References

Strength

Strength does not come from winning. Your struggles develop your strengths. When you go through hardships and decide not to surrender, that is strength.

Arnold Schwarzenegger, b 1947, weightlifter, bodybuilder, actor, and politician
Epidemic of Care: A Call For Safer, Better, and More Accountable Health Care
By George C Halvorson and George J Isham, MD

Review by Vincent J Felitti, MD


Epidemic of Care is an important book for Permanente physicians to read because it provides insight into the thinking of George Halvorson, the new CEO of Kaiser Foundation Health Plan. The book is a simple, clearly written treatise on the complex subject of delivering and paying for medical care in the United States. The tone of the writing is encouraging and suggests that the Health Plan may have its most forceful and outspoken leader of the past 35 years. George Isham, MD, the book’s coauthor, is medical director of HealthPartners in Minnesota.

Epidemic of Care is basic in its approach to the problems of delivering medical care in the United States. The authors’ medical economics methodology is helpful because insofar as medicine is a metaphor for human concern, economics can be viewed as social psychology in which the units of measurement are dollars. Halvorson and Isham are excellent guides through the complex issues underlying our current problems with delivering medical care as well as how those problems came about. The authors suggest possibilities for change and explain current resistance to change. The problems described are not intellectually complex but are emotionally disturbing and thus are often misinterpreted and misunderstood.

In some ways, the authors have written a modern version of Victor Fuchs’ fine old book, Who Shall Live. This update was needed because in the 30 intervening years since the Fuchs book first appeared, total annual US expenditures for medical care have risen from $450 per American to $4930, and medicine’s portion of the gross national product has risen from 8% in 1973 to 14% more recently. With the book’s title, the authors make the point that the quantity of health care delivered has become a major problem—especially because no equivalent increase exists either in the quality of care or in its outcome. Rene Dubos’ comment is particularly relevant: “To ward off disease or recover health, men as a rule find it easier to depend on healers than to attempt the more difficult task of living wisely.”

Most of us in The Permanente Medical Groups have been shielded from the realities of community medical practice; indeed, we usually are even unaware of the extent of that shielding. This book provides needed understanding of medical care issues extending far beyond our own specialized areas of practice. Much to their credit, the authors provide this understanding clearly and interestingly while presenting an intelligent, perceptive analysis of a major political problem facing our country generally and Permanente physicians specifically. This problem—how to deliver high-quality medical care consistently, efficiently, and affordably—confronts us whether or not we choose to pay attention to it.

The book begins by outlining our expectations for medical care and how our sense of entitlement developed: “We get what we pay for. There are over eight thousand billing codes set up for various units of care. There isn’t one single billing code set up for a cure. There is no fee for preventing a disease. The system does what it is paid to do. That really shouldn’t surprise anyone.” We are also given an interesting, necessary description of insurance processes—how insurance works—and of the implications of those processes for various proposals aiming to change the way medical care is paid for and delivered. The authors make helpful comparisons with medical care, expectations of it, and its costs in Britain, Canada, and Germany.

Because Permanente physicians experience relatively little fallout from the complicated issue of community competition, they will be particularly interested by the discussion of the usual competition between hospitals, insurers, and physicians. The discussion suggests that the Health Plan under Halvorson may expect The Permanente Medical Groups to actively partner with the Health Plan to solve these problems. That increased expectation would be a profound and probably healthy change in the relationship between Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and The Permanente Medical Groups. (Did you know that no entity exists called Kaiser Permanente? “Kaiser Permanente” is not the name of an organization

Vincent J Felitti, MD, has been with the Southern California Permanente Medical Group since its opening in San Diego in the late 1960s.
but is instead the name applied to a function contracted yearly between three legally distinct organizations: Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and The Permanente Medical Groups.)

Halvorson and Isham emphasize the importance of an emerging application of technology: the electronic medical record. By his recent actions, Halvorson has made clear that he expects rapid arrival of the electronic medical record at Kaiser Permanente facilities. The rumor that $1 billion has been spent on this project during the past 17 years or so is not an encouraging piece of our history.

The authors point out that we absolutely must retain Health Plan members who use little or no care, because these least frequent users are the economic motor driving the entire operation; by contrast, 5% of our member population uses 50% of the medical care. By dismissively referring to these low-utilizing patients as “the worried well,” we often fail to do them justice. Drug costs and the subtle forces supporting increased prices also are perceptively discussed. So too are the developing shortages in support personnel, the expanding role of the Internet in medical practice, and the problem of providing insurance coverage for experimental medical treatment.

Epidemic of Care openly addresses many impending realities from which we have been largely shielded thus far by the protective nature and size of our organization. For this reason—among the others given here—this small, excellent book deserves to be read by all Permanente physicians and indeed by all people working within the Program.

References

Through Books
It is chiefly through books that we enjoy intercourse with superior minds.

William Ellery Channing, 1780-1842, clergyman and writer
CME Evaluation Form

All PMG physicians and those clinicians eligible to do so may earn up to two hours of Category 1 credit for reading and analyzing the four designated CME articles, by selecting the most appropriate answer to the questions below, and by successfully completing the evaluation form. Please return (fax or mail to the address listed on the back of this form) to The Permanente Journal by January 15, 2004. You must complete all sections to receive credit. (Completed forms will be accepted until January 2005. Acknowledgment will be mailed within two months after receipt of form.)

The Permanente Journal has been approved by the American Academy of Family Physicians as having educational content acceptable for Prescribed credit hours. Term of approval covers issues published within one year from the distribution date of November 2003. This Fall 2003 issue has been reviewed and is acceptable for up to two Prescribed credit hours. Credit may be claimed for one year from the date of this issue.

Section A.

page 13
Article 1. A Case Study of Cauda Equina Syndrome

A 53-year-old overweight male forklift operator presents with three days of low back pain which started at work. Initially it was nonradiating, but over the last 24 hours, he noted numbness in both buttocks and increasing severity of pain. Straight leg raising at 45 degrees in both the right and left leg causes radiating numbness in the right leg and foot. Right patellar reflex is decreased, and there is weakness of right knee extension and right ankle dorsiflexion. Lumbar x-ray films are normal. An MRI would probably show involvement of which nerve root?

a. L3
b. L4
c. L5
d. S1
e. S2

Cauda equina syndrome (more than one answer may be correct):

a. Most commonly has a gradual onset over days or weeks in patients with chronic back pain
b. Is usually caused by fracture
c. Can be diagnosed by plain radiographs in most cases
d. Is treated with surgical decompression

(Continued on next page)

page 26
Article 2. Patient-Centered Care in the Exam Room at Warp Speed

Which of the following is not a component of the “Four Habits” model?

a. Investing in the end
b. Investing in the beginning
c. Eliciting the perspective of the patient’s family
d. Empathy

According to the panel, which of the following are not patient-centered care skills? (more than one answer may be correct)

a. Sympathy
b. Clinicians making decisions on behalf of patients
c. Making at least one nonmedical statement
d. Listening

Section B.

Referring to the CME articles and to the stated objectives, please check the box next to each statement as appropriate.

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<th>Article 1</th>
<th>Article 2</th>
<th>Article 3</th>
<th>Article 4</th>
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<tbody>
<tr>
<td>The article covered the stated objectives.</td>
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<tr>
<td>I learned something new that was important.</td>
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<tr>
<td>I plan to use this information as appropriate.</td>
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<tr>
<td>I plan to seek more information on this topic.</td>
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<tr>
<td>I understood what the author was trying to say.</td>
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Section C.

What change(s), if any, do you plan to make in your practice as a result of reading these articles?

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Section D. (Please print)

Name: ______________________________________________

E-mail: ______________________________________________

Address: ______________________________________________

______________________________________________

Signature: ______________________________________________

Date: ______________________________________________

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Tom Janisse, MD, Editor-In-Chief

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18 Understanding Noncompliant Behavior: Definitions and Causes.  
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This article describes noncompliant behavior, discusses its common reasons, and provides insight into the behavior while offering strategies for coping with noncompliant patients.

23 Corridor Consult: How Can Busy Physicians Better Manage Laboratory Results?  
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26 Patient-Centered Care in the Exam Room at Warp Speed.  
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