EDITORIAL

# The Quality of Caring

No less an authority than the Institute of Medicine (IOM) has declared that quality medical care must include a patient-centered approach.[1] The IOM publication *Crossing the Quality Chasm: A New Health System for the 21st Century* recommends that health care should be based on "continuous healing relationships, … customization based on patient needs and values, … and shared decision-making".[1] However, the great majority of quality improvement efforts are directed toward "harder" or more measurable outcomes, such as medication use, diagnostic testing, hospitalizations, and costs. Medicine is finding it difficult to free itself from tyranny of the objective.

Thus, it is refreshing to see an important qualitative study of the physician-patient relationship such as that by Bendapudi et al[2] in the current issue of *Mayo Clinic Proceedings*. These investigators conducted telephone interviews with 192 Mayo Clinic patients, asking questions such as "Tell me about the best experience that you had with a doctor in the Mayo system" and "Tell me about the worst experience that you had with a doctor in the Mayo system." The researchers compiled patient responses and developed a list of behavioral themes that they believe are 7 ideal physician behaviors: confident, empathetic, humane, personal, forthright, respectful, and thorough.

Although this study is one of the first of its kind, it has limitations. As qualitative research, it might have been more informative if the authors had reported more verbatim patient responses to allow readers to judge whether the authors' identified "ideal physician behaviors" were in fact the best possible classification. For example, other potential categories of physician behavior might include altruism,[3] trustworthiness,[4] and humility.[5]

In addition, it would be informative to know more detail about the interviewed patients. Blanchard and Lurie[6] found that minorities were significantly more likely to report being treated with disrespect or looked down on compared to whites. A meta-analysis by Smith et al found that fear of embarrassment was an important barrier to early cancer diagnosis and that men and women reported different concerns.

From an educational viewpoint, a more important question is whether the 7 ideal physician behaviors in the study by Bendapudi reflect deep-seated character traits of the physician or more superficial "behaviors" or "skills." That is, is it sufficient to "act empathetic" or is it important to "be empathetic"? Is "acting forthright" as good as "being forthright"? Larson and Yao[8] suggest that "surface acting" may be acceptable "without achieving affective and cognitive understanding of the patient." On the other hand, Pellegrino[3] suggests that predictable physician behaviors flow from character traits or "virtues." His virtues of the good physician are summarized in Table 1, listed alongside the ideal physician behaviors from the study by Bendapudi et al.

It is worthwhile to consider the place of the physician-patient relationship in the quality and safety agenda. The IOM has proposed 6 aims for improvement of health care, 1 of which is patient centeredness.[1] These 6 aims have been embraced by most of the health care community and provide guidance for quality and safety improvement efforts. Most improvement efforts target objective, technical, and measurable processes and end points. The explicit goal of most improvement work is the standardization, even the "ultrastandardization," of medicine.[9] This concept derives from quality improvement work in manufacturing and aviation safety.

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There is an important place for standardization and ultrastandardization in medicine. However, the application of standardization and quality improvement methods to the practice of medicine must account for the human activity central to the clinical encounter. Failure to do this reduces the opportunity for real quality improvement and risks dehumanizing both the patient and the physician. In fact, many improvements in aviation safety have centered on communication and teamwork. Placing the 7 ideal physician behaviors[2] alongside the IOM's 6 aims for improvement of health care may be helpful (Table 2). Attention to both relationship and system improvements using appropriate and creative improvement methods may yield better results than focusing on one area alone.

Woolf[10] has proposed that caring is a quality issue. Focusing on patient safety, he describes a hierarchy of lapses in quality. First is the problem of medical errors that lead directly to patient harm, second is the problem of all medical errors, and third is the problem of gaps in quality other than errors. "Lapses in caring" represent the fourth and over-arching deficiency in quality of care. Woolf[10] defines this as follows:

> Unsatisfactory care resulting not only from failure to meet normative benchmarks for quality, … but also from experiences that leave patients feeling uncared for, affecting them in domains that are less easily measured (for example, feeling unheard, rushed,

Address correspondence to James T. C. Li, MD, PhD, Division of Allergic Diseases, Mayo Clinic College of Medicine, 200 First St SW, Rochester, MN 55905 (e-mail: li.james@mayo.edu).

TABLE 1. **Physician Behaviors**

| Seven ideal physician behaviors by Bendapudi et al[2] | Virtues of the good physician by Pellegrino[3] |
|---|---|
| Confident | Benevolence |
| Empathetic | Compassion |
| Forthright | Courage |
| Humane | Fidelity to trust |
| Personal | Intellectual honesty |
| Respectful | Prudence |
| Thorough | Truthfulness |

TABLE 2. **Physician Behaviors**

| Seven ideal physician behaviors by Bendapudi et al[2] | The Institute of Medicine's 6 aims for improvement of health care[1] |
|---|---|
| Confident | Effective |
| Empathetic | Efficient |
| Forthright | Equitable |
| Humane | Patient-centered |
| Personal | Safe |
| Respectful | Timely |
| Thorough | |

inconvenienced or humiliated; or being unable to access desired information, instruction or reassurance)….the extent to which the technical elements of care seem good on the basis of performance indicators but ultimately fail to be *caring* [italics in original] because of deficiencies not captured by these measures. The rudeness or insensitivity that patients encounter or the frustrations they experience in obtaining information and control over treatment decisions illustrate gaps in quality, of deep concern to the public, that often are not measured under normative standards.

These points may be best illustrated by considering those qualities of physician-patient encounters that led to the *worst* experience that patients had with their physicians. Bendapudi et al report that these undesirable physician behaviors are mirror opposites of the 7 ideal physician behaviors; a representation of undesirable physician traits or behaviors is shown in Table 3. Can health care really ever be high quality if the patient-physician interaction is hurried, disrespectful, cold, callous, and uncaring?

This is the challenge of the report by Bendapudi et al: can medicine embrace the physician-patient relationship as essential to health care quality? Is the clinical encounter the "central-defining phenomenon" of medicine[11] or an epiphenomenon unrelated to quality? Are the 7 ideal physician behaviors as important as the 6 aims for improvment of health care?

One of the most important contributions of the quality movement is the emphasis on measurement, systems, and the environment of care. It is time for leaders in health care quality to develop creative ways to improve the quality of caring, starting with an emphasis on measurement, systems, and the environment of care. Relationships in health care can likely be improved, supported, nurtured, taught, modeled, developed, practiced, and measured. We can do better in all these areas. Furthermore, quality in the clinical encounter goes beyond physician virtues and encompasses individualization and attention to the unique circumstances of the clinical encounter.

There are some hopeful signs in this area. The American Board of Medical Specialties (ABMS) and the Accreditation Council of Graduate Medical Education have jointly stated that physicians must "demonstrate caring and respectful behaviors when interacting with patients and their families, … create and sustain a therapeutic and ethically sound relationship with patients, … and demonstrate respect, compassion and integrity."[12] The American Board of Internal Medicine has developed Maintenance of Certification modules that incorporate patient and peer assessment of physician relationship and communication skills. The ABMS is codeveloping a set of validated survey instruments (Consumer Assessment of Healthcare Providers and Systems) that assess the physician-patient relationship and peer relationships. These instruments will be available to all specialty and subspecialty boards and may touch the lives of most physicians. Further development of valid and reliable measures of the physician-patient interactions should lead to more improvement initiatives in health care relationships.

Attention to both the "formal" and "informal" curriculum on relationships and communication is important in improving the quality of the physician-patient encounter. Many health care organizations, including Mayo Clinic, have developed formal curricula on physician-patient communication and relationships. One academic medical center, Indiana University School of Medicine, successfully transformed the social environment of the medical school by addressing the "informal" or "hidden" curriculum on professionalism.[13] This group formed a Relationship-Centered Care Initiative Discovery Team that used a nonlinear, interactive approach to culture change. More such quality initiatives are needed.

Pellegrino[11] wrote that, "Illness remains a universal human experience and its impact on individual human per-

TABLE 3. **Physician Behaviors**

| Seven ideal physician behaviors by Bendapudi et al[2] | Opposites of the 7 ideal physician behaviors |
|---|---|
| Confident | Timid |
| Empathetic | Uncaring |
| Forthright | Misleading |
| Humane | Cold |
| Personal | Callous |
| Respectful | Disrespectful |
| Thorough | Hurried |

sons remains the reason why medicine and physicians exist in the first place." Of the helping and healing professions, of which medicine is the prototype, Pellegrino[11] elaborates as follows:

Each profession deals with humans in vulnerable states; each confronts the most personal, intimate recesses of the lives of other humans; each is permitted access to the inner life of another human being; each promises to help and invites trust; each is judged by the degree to which the good of the person served is attained by their professional activities.

The quality of care and the quality of caring are inseparable. We can hope for a day when medicine is practiced by knowledgeable, competent, and compassionate physicians who create high-quality therapeutic and healing relationships with patients and their families in the setting of safe, effective, and efficient health care systems.

James T. C. Li, MD
Allergic Diseases and Internal Medicine
Mayo Clinic College of Medicine
Rochester, Minn

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