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Radical Reorientation of the US Health Care System Around Relationships: Rebalancing the Transactional Model

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"Dr Serra's last urgent appointment for today just filled, but Dr Breznik can see you at 1 PM." Same-day service. All is good, right? No. The work of managing this patient more than doubled, the patient was needlessly inconvenienced, potentially unnecessary tests were ordered, and hazards were introduced into his care. This patient has a complex medical and surgical history which Dr Serra has managed over several years. When the patient is seen, Dr Breznik labors to get modestly up to speed, applies some temporizing measures, and schedules an appointment 3 days hence with Dr Serra, who currently is standing down the hall, between seeing other patients, documenting.

Over the past several decades, health care has increasingly been conceptualized as a series of independent encounters (ie, transactions) that can be distributed nearly randomly among health care workers: any physician can round on the patient, any clinician can be on the other side of the telemedicine screen, any resident can cover "continuity clinic." Although this is a factor in almost all specialties, this transactional mindset that treats physicians as interchangeable parts is particularly problematic in specialties where continuity and longitudinal care play a critical role (eg, primary care disciplines, neurology, oncology, and psychiatry). We believe that this industrial-based conceptualization has been harmful to health care and has impeded progress toward quadruple-aim[1] outcomes. Yet, such fragmentation of care is ubiquitous.

We acknowledge the variety of countervailing forces that have brought us to this very transactional model, including the corporatization and commodification of health care;[2-4] the consumer movement;[5,6] the revenue-driven focus of many delivery institutions; electronic health records designed for individual transactions more than for longitudinal care; the increasingly narrow subspecialization of many physicians; and the increasing involvement of private equity investors in health care delivery.[7]

Examples of structural pressures that deprioritize relationships abound: adoption of models where care is provided separately by inpatient and outpatient physicians without creating time or incentives for these physicians to coordinate with each other; scheduling approaches that result in a surgeon working with a different scrub team and anesthesiologist each day; transitions clinics where patients are seen after hospitalization, not by a physician who participated in their inpatient care, nor by the physician who will manage their care as an outpatient, but rather by a physician they have never seen before and will likely never see again.

Evidence suggests that being cared for by the same physician over time — whether for a week in the hospital, a year in the ambulatory clinic, or over a lifetime across settings — is associated with a host of benefits including improved diagnostic accuracy,[8] care coordination, patient satisfaction, and trust[9-12]; fewer emergency room visits,[13,14] hospital admissions,[9,10,13,15-18] and readmissions[19,20]; and higher quality[12,21-25]; lower costs[12,15-17,19,22,26-36]; and reduced mortality.[15,24-35,37-39] Stable team composition also contributes to positive outcomes for patients and clinicians.[40-47]

How would health care differ if the infrastructures, policies, and technologies upon

which care delivery is based were reoriented to prioritize relationships at every level? Not just on the surface, such as turning the monitor so the patient can watch the clinician type, nor a romanticized "Marcus Welby" notion from the past, but deep within the structures, processes, and assumptions of modern health care. This vision, informed by one of the author's 3 decades of experience in a setting that prioritized relationships,[46,47] goes beyond relationship-centered care, which focuses on what the physician as an individual actor should do to maintain relationships[48-50] and extends to whether the health system itself is constructed to appropriately value clinician-patient and clinician-clinician relationships.

We believe that intentionally reshaping operations, culture, technology, and financial incentives to prioritize relationships will benefit patients, the health care workers and delivery systems that serve them, the payers who share in the costs of their care, and other stakeholders who care about quality, equity, and access.

So, how can system transformation centered on relationships be accomplished? In this commentary we present three foundational actions that must be advanced to reorient the care delivery system: structurally prioritize continuity of relationships, make room for relationships by removing sludge[51] from the system, and realign reimbursement and incentives at the delivery-system level (Figure). We present examples of implementation strategies and tactics in each of these three domains to guide organizational leaders, policy makers, technology vendors, and other interested stakeholders.
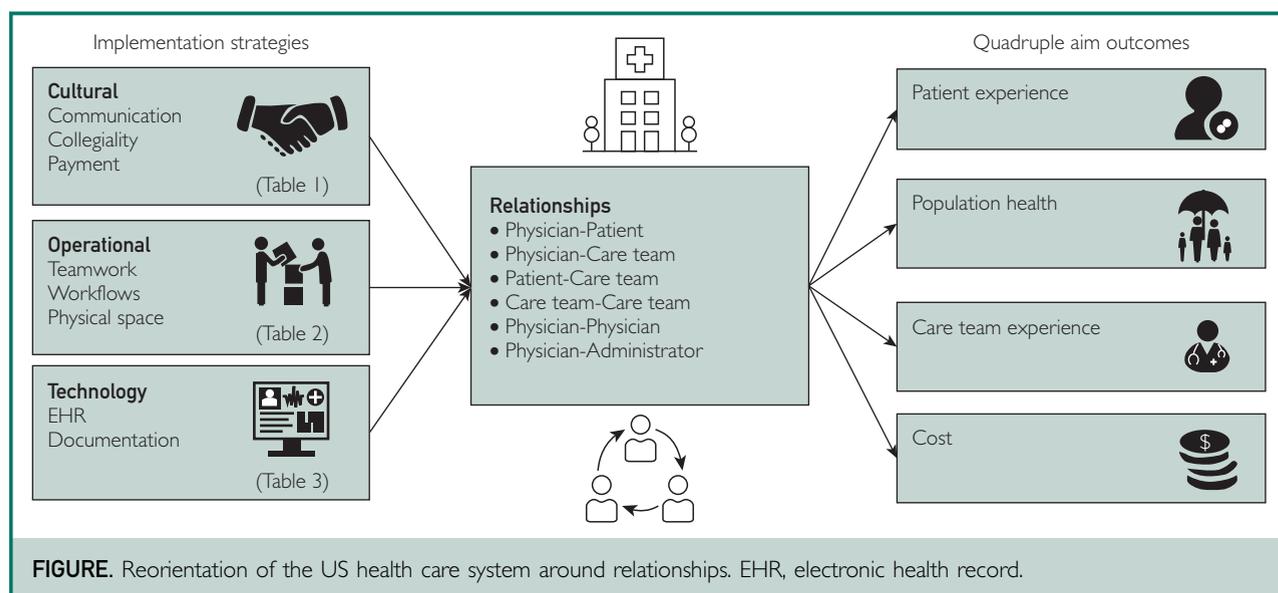
Prioritize Continuity of Relationships

What if clinical care was restructured around relationships? Such a framework must attend to multiple relationships: physician-patient; physician–team members; team member–team member (such as nurse-scheduler); clinician-colleagues, and also relationships and communication channels between institutions, such as between a hospital and an ambulatory clinic. Although the patient example used in the introduction highlighted the ambulatory environment, continuity is also important in the inpatient setting. For example, the Cleveland Clinic Department of Infectious Disease has pioneered a "one-attending" policy where hospitalized patients are followed by the same consultant until discharge even if new attendings rotate on service. Much clinical knowledge is housed in the relationship, and this continuity throughout the course of the hospitalization allows that deeper knowledge to inform the care. To avoid unrealistic work expectations, this model requires adapting ambulatory clinic hours to accommodate this tail of hospital rounding responsibilities, yet, as one physician reflects, "for those who find joy and meaning in developing meaningful relationships with patients and their families, it can be deeply fulfilling" (personal communication, Susan Rehm, MD, June 8, 2022).

Systems that promote continuity must also be balanced with mechanisms of cross coverage to permit physicians time to recharge. For example, some physicians pair with another physician and design complementary office and vacation schedules. When a physician is unable to provide continuity for their patients, a back-up level of continuity occurs with their partner. Given their close working relationship, the partnering physicians can share knowledge with each other about their patients. These partnering physicians also benefit from the stronger collegial bond in caring for patients as a team and providing coverage that allows each to have meaningful time away.

Continuity is more efficient for the system, decreasing the total volume of work. It takes less time and fewer resources to evaluate a patient the physician knows well; the diagnostic workup can be more targeted, and the therapies more easily aligned with the patient's preferences and other conditions. As the Cleveland Clinic infectious disease physician notes: "One could also argue that it reduces burnout among the group as a whole. Picking up a patient who has been in the hospital for a long time is akin to doing a brand new consult, and every patient I follow on the tail is one that my partner

FIGURE. Reorientation of the US health care system around relationships. EHR, electronic health record.

doesn't need to pick up." Points of discontinuity throughout the health care system increase the total volume of work and thus decrease the total system capacity.

Similarly, in the opening vignette, the deferral of an established patient of Dr Serra to Dr Breznik increased the total work for the physicians and staff of the unit. One appointment rather than two, along with fewer tests and referrals to resolve an issue reduces the total volume of work for the reception, rooming, billing, information technology, and other staff. It also increases the total amount of clinical resources available to the wider patient population. Future research could explore the impact of continuity and relationships on overall workload and rates of professional satisfaction and burnout.

An interruption in a patient's primary care relationship, such as when a primary care physician leaves their organization, is associated with higher costs and worse outcomes.[30] Based on analysis of Medicare claims, we have recently shown that loss of continuity due to primary care physician turnover results in nearly $1 billion in excess health care expenditures in the US each year[31] independent of the costs to recruit and replace the physician.[52,53] That estimate

does not take into account the costs of loss of continuity in subspecialty care.

Relationships between team members are also critical. Staff members are also often treated as interchangeable cogs in the machine of the clinic, operating room, or hospital ward. Yet stability is a prerequisite to developing trust, reliance, mutual emotional support, and optimized workflows within care teams.[40,43,45,54-56] Ilbawi et al[40] found that matching medical assistants with family physicians in stable pairings resulted in improvements in quality indicators for chronic illness care and screening; increased productivity (an 11% increase in relative value units generated per physician); and improved physician control over their work environment and satisfaction. A stable team also fosters trust between the care team and the patient. A patient who has a relationship not just with her physician but with the nurse, medical assistant, and scheduler has many more familiar faces to call on for support. In turn, a care team member who has a relationship with a patient is more likely to know and respond to the patient's unique needs.

One straightforward approach to support relationships is to schedule return visits for patients at the conclusion of each visit,[57,58]

including relevant pre-visit testing,[59] rather than simply stating "come back and see me in a year" or, perhaps even more commonly, not addressing the next appointment at all. This simple act tells the patient "We have a relationship, we want to see you again, and we will plan ahead to make that visit most meaningful." In addition, patients can be advised to "start with us first" for any problem that arises between scheduled appointments. A simple introduction to the people and processes of the practice[60] can go a long way toward enabling patients to reach out to their personal physician when new concerns develop.

One of the most fragile points of disjuncture within the health care system occurs at hospital discharge. In a health care system radically reoriented around relationships, the patient would not be discharged with advice to "call your doctor and make a follow-up appointment" with the attendant risk of not being able to arrange the appointment or being seen by a physician who does not have information about the recent hospitalization. Instead, the patient would leave the hospital with actual appointments (date, time, and location) for all of the follow-up required to safely continue her care. Systems would be built to communicate with the ambulatory clinic to arrange these appointments. Discharging physicians would identify the appropriate labs to be done before the follow-up appointment. Clear, concise, and actionable discharge summaries would be available at the time of the follow-up appointment making clear the key findings and changes made. If the discharging and receiving physicians are not the same physician, systems in the best of models would be built to support a conversation between the two physicians for the safest and most satisfying handoff.

Provision of continuity cannot rely solely on individual physicians' professionalism. Physicians' ability to provide continuity must be supported by the design of the systems in which they practice. Staffing models, communication channels, and scheduling systems must all support the physician in providing continuity without sacrificing their own well-being. Table 1[61-72] provides additional examples of strategies and tactics practices or health systems can use to improve continuity and support relationships.

Make Room for Relationships by Removing Sludge From the System

What gets in the way of continuity? In large part, as in the opening vignette, the administrative work or "sludge" of health care has reduced the capacity of physicians to see their own patients when a need arises. We believe that much of this sludge can and should be removed from the system, freeing physicians and their teams to focus more completely on their patients. In the current practice model, many physicians spend more time documenting care than delivering care.[73-75] Nurses spend hours on the phone on prescription refills that could be re-engineered out of the practice.[65,76,77] Medical assistants have a large number of low-value templated tasks to complete during the patient rooming process.[78] The inbox is Sisyphean — many physicians feel that the inbox work is never done.[79-88] A substantial portion of the physician workday is spent on low-value activities that do not directly benefit the patient, such as entering orders for low-risk interventions such as influenza vaccinations, oximetry measurements, and fingerstick glucose readings; processing prescription renewal requests that could be re-engineered out of the practice; performing password revalidation before entering a nonscheduled medication, and meeting insurance providers' requirements for prior authorizations that could be either streamlined or eliminated.

For physicians, the meaningful "solution shop" work, defined as the management of unstructured problems, and which in medicine consists of complex medical decision making and relationship building, is often pushed to the margins by the mandatory "production line" work of compliance, attestation, and performance measurement.[89]

These inefficiencies and this misdirected use of time form the tip of the iceberg of the largely invisible, and mostly avoidable,

TABLE 1. Operational, Technological, and Cultural Strategies and Tactics to Improve Continuity and Support Relationships

Strategy	Tactical examples
Operations	
Maximize team stability	Team members need an ongoing relationship with each other to build the trust necessary for continuous improvement, appropriate delegation, and to complement and support each other's unique strengths. Prioritizing the stability of the team within hiring and scheduling decisions will create the highest functioning teams.
	Ex: The same nurses and/or medical assistants are paired with the same physician for each clinic session.[40]
	Ex: The same team of OR staff routinely work with the same surgeon.
Optimize team size and skill level	Fully staffed teams have better outcomes.[44] Teams composed of members with higher training (ie, RNs) can delegate more of the tasks to nonphysician members.
	Ex: In advanced models of team-based care,[61] a nurse or medical assistant forms an independent relationship with patients as they perform agenda setting, medication reconciliation, self-management support, and, in some models, also assist with real-time documentation and order entry.[61-63] Therefore, the physician is able to provide undivided attention to his patient, focusing on medical decision making and relationship building.
	Ex: A hospital nurse, pharmacist, physician, and, in some cases, also a documentarian round together, contributing their unique domain knowledge, operationalizing care decisions in real time, and thus maximizing the undivided attention the physician can provide the patient and family.
Design physical space to support relationships	Connecting care teams by physical colocation[64,65] allows for the quick communication and small, frequent readjustments required for a day to go smoothly.
	Ex: Co-location of reception staff with the clinical team allows joint problem solving to serve the needs of the patient and accommodate urgent requests. Schedulers who are a part of a specific care team know their patients and their team's work style.
Design the schedule to support relationships	A well-designed and managed schedule is key to efficient practice, access, and continuity. It is often beneficial to provide the physician and team a degree of autonomy and control over the nature of the schedule. In some settings, this may include setting appointment duration and/or start/stop times for the clinic day.
	Ex: Scheduling patients on a wave allows more flexibility to meet the inherent unpredictability of patient needs.[66]
	Ex: Include a buffer time in each day where the patient care can expand as needed.
	Ex: Avoid setting the expectation that patients should be immediately roomed upon arrival. Instead set a standard for maximum waiting time that realistically accommodates the unpredictable needs of a population of patients.
Maximize inpatient continuity	Continuity, even within a single site of care, such as the inpatient setting, improves care.[25]
	Ex: A hospitalist continues to manage the patient when they are moved from one unit to another (ie, from the medical unit to a surgical unit).
	Ex: If multiple hospitalists are admitting, a hospitalist who previously cared for a given patient preferentially readmits the patient.
	Ex: A subspecialty attending continues to follow their patient through to discharge even if the attending is no longer on service.
Enhance inpatient-outpatient continuity	Recognize the importance of enhanced inpatient-outpatient continuity
	Ex: Support and recognize the value of the primary physician caring for their patients across inpatient and outpatient settings for those who are able to do so.[67] In such "comprehensivist models," the patient's personal physician in that specialty (eg, primary care, neurology, cardiology, or oncology) manages their patients' care across both ambulatory and hospital settings.[68]
	Ex: When the discharging and receiving physicians are not the same physician, create and support systems that foster conversation and coordination between the two physicians for the safest and most satisfying handoff.
	Ex: Rather than develop a stand-alone post-discharge clinic, patients are scheduled to see their personal physician in the appropriate specialty for hospital follow-up. For this to happen, the hospital discharging unit takes responsibility for setting up the follow-up appointment with pertinent previsit laboratory testing, and the receiving physician's practice takes responsibility for the efficiency and schedule flexibility required to see patients within the requested time frame.

Strategy	Tactical examples
TABLE 1. Continued	
Technology	
Design EHRs for relationships	EHRs designed to support relationships will facilitate rapid situational awareness of the patients' social and medical context.
	Ex: A thumbnail photo of the patient is on every screen, providing a visual cue to assist in recall of the patient.
	Ex: The EHR includes a list of the patient's "social vitals" (ie, their support people, hobbies, or job).
Design EHRs to reduce cognitive load	EHRs must also include human factors designed to reduce the cognitive load associated with the interacting with the EHR.
	Ex: The EHR includes a concise display of past history, medications, results, etc without the clutter of lower priority information, such as the detailed chemical names of medications or the units of measure of labs that are always resulted with standard units. (Hovering technology could make such lower priority information available in the rare instances when it is pertinent.)
Culture	
Support team communication	Structurally supporting communication among the clinical team will enhance performance.
	Ex: Daily team huddles (ie, 5-min stand-up meetings to share unique information for the day)
	Ex: Periodic team meetings (ie, 30- to 60-min step-aside meetings to optimize workflows) can improve communication, trust, and operations.
	Ex: Meeting practices that begin with an informal check-in or time for personal sharing can build trust and relationship among the team.
Support professional collegiality	Structurally supporting communication and relationships among professional colleagues will enhance care and professional satisfaction.
	Ex: A system that fosters relationships between inpatient and outpatient teams and between physicians of multiple specialties smooths care transitions, reduces redundant testing, and reduces professional isolation.
	Ex: Clinical spaces built with shared breakrooms, and organizational support for collegial dinners.[69]
	Ex: Programs that support relationship-building among leaders and building bridges between leaders and the clinical faculty, including listening sessions.[70-72]
	Ex: One model that structurally supports cross-specialty communication is to administratively nest subsets of interacting specialties together (eg, a "pod" of 20 primary care physicians, 4 cardiologists, 2 pulmonologists, 2 endocrinologists, etc) in which consultations and referrals are shared. This clustering can occur through collocated physical or virtual pods. It is easier to pick up the phone or walk down the hall to discuss the nuances of a patient's care with a colleague you know and trust, which may decrease the need for referrals, ensure appropriate testing is in place when a referral is necessary, and improve efficiency through direct, in-person communication rather than assuming a distant, unknown colleague will understand all by reading the EHR.

EHR, electronic health record; Ex, example; OR, operating room; RN, registered nurse.

operational waste clogging up the US health care system. Much of the waste can be avoided by considering the impact of each proposed policy change on the workload and ability of the care team to provide continuity, which in turn will impact the patient experience. Much of the existing waste can and should be redesigned out of the practice.[65] Additional administrative burdens can be removed by de-implementing outdated or non—evidence-based policies.[90-92] Removing waste and freeing practices of these administrative tasks

will allow physicians to more consistently see their own patients, and begin a virtuous cycle of value, efficiency, and satisfaction based on continuity and relationship.

Atrius Health reduced the inbox volume for their physicians by 25% by eliminating and automating select message types. Examples include turning off notification of tests results ordered by physicians in other specialties, automating routine labs and prescription renewals for patients, and converting admission/discharge/transfer

TABLE 2. Operational, Technological and Cultural Strategies and Tactics to Reduce Sludge and Waste That Present Barriers to Relationships

Strategy	Tactical Examples
Operations	
Reduce unnecessary work	Removing unnecessary work creates time to devote to deepening relationships. Ex: The Getting Rid of Stupid Stuff[90] toolkit provides a guide for organizational leaders in removing unnecessary sludge from their operations.
	Ex: Inbox. Organizations can turn off automatic notifications about test results not ordered by the particular physician, reducing both inbox overwhelm and also the hazards associated with ambiguity about who is responsible for responding to the result.
	Ex: Signatures. Requirements for signatures for low-risk activities, such as ear wash, fingerstick glucose, and for services that would not require an order in another setting, such as an influenza vaccination, should be removed.
	Ex: De-implement outdated policies. A De-implementation Checklist,[91] developed by the American Medical Association and reviewed by the Joint Commission, provides specific suggestions to minimize alerts, reduce inbox volume, decrease note bloat, and improve efficiency.
	Ex: Avoid over-interpretation of accreditation standards and state or federal policies. The Debunking Regulatory Myths[93] initiative prevents over-interpretation of state or federal regulations.
Technology	
Reduce the workload of visit note documentation and review	The time required for visit note documentation and chart review can be reduced by improved staffing, processes, and technology.
	Ex: Dictation to a human transcriptionist who over-edits speech-to-text output results in better notes and more efficient use of physician time than requiring the physician to manually type the note or to themselves edit the speech-to-text output.
	Ex: Concise, customized notes that communicate clear clinical information make less work for everyone. In place of heavily templated notes, which risk reducing patient interactions to a litany of close-ended questions, technology, regulatory and payment structures could promote the open-ended, conversational style of history-taking that elicits a full, coherent story.
Streamline log-in and log-out processes	The administrative and security processes involved in accessing the EHR costs time and cognitive focus. Reducing this burden can improve the work environment.
	Ex: Log-ins can be simplified, using RFID proximity identification or bio identification (ie, fingerprint or facial recognition).
	Ex: Intervals between auto-logouts can be extended, with the interval adjusted according to the location of the workstation.
Culture	
Governance structures	Changing the nature of the administrator-physician relationship so that both groups share accountability for common goals can result in better outcomes and job satisfaction.[72,94]
	Ex: The impact of new policies on physician workload, and thus on access and continuity, can be calculated before implementation, and the high cost of clinician burnout and turnover[31,52,53] can be treated with the urgency its financial and cultural impact deserve.

EHR, electronic health record; Ex, example; RFID, radio frequency identification.

notifications to a dashboard. They also eliminated 1500 clicks per physician per day by partnering information technology experts with clinical teams in optimization sprints (personal communication, April 11, 2022, Steve Strongwater, MD, CEO, Atrius Health). The time saved by eliminating this type of waste can and should be reinvested in relationships and reducing after-hours work (aka, "pajama time"). Kaiser-Permanente of Southern California removed the requirement for password revalidation for most orders, impacting 1.5 billion orders per week (personal communication, April 26, 2022, Dawn Clark, MD, Chief Wellness Officer). Table 2[31,52,53,72,90-95] provides additional examples of strategies and tactics practices can use to remove sludge and waste in an effort to support relationships.

Realign Reimbursement and Incentives
The current design of health care reimbursement and incentives has systematically undermined relationships: urgent care

TABLE 3. Financial Strategies and Tactics to Structurally Support Relationships

Strategy	Tactical Examples
Adopt an owner's mindset in practice	Physicians in practice can adopt an owner's mindset, whether they are employed by a health system or own their own practice, and thus strive to maximize their efficiency in how they spend their time and generate revenue. Ex: Hiring sufficient staff (in some settings this may be 2 clinical assistants per physician) to develop the capacity to offer same-day access for urgent and semi-urgent visits. Ex: Attending to the fundamentals of practice workflows,[100] such as incorporating the annual wellness visit into the rooming process for an evaluation and management visit; routinely prescribing 90 days plus 4 refills for stable medications[77]; and performing previsit laboratory testing.[59] Ex: Being willing to see one's own patients who call in on an urgent basis, recognizing that doing so improves patient care, increases patient loyalty, and increases revenues generated.
Align payment to support relationships	Payment systems can contribute to the sludge in health care that is a barrier to relationships and, on the other hand, can also fund the mechanisms that support relationships. Ex: Payers can simplify or eliminate prior authorization requirements or pay physicians for providing this service. Ex: Payers can provide funding for virtual consultations that support integrated care, including payment for physicians to discuss with colleagues the care of mutual patients. Ex: Delivery systems can more equitably distribute operating dollars to the clinical units that generate downstream revenue for the organization.

Ex, example.

centers, pharmacies, and retail clinics skim off lower-acuity, higher revenue care; and physician practices spend substantial resources supporting the profit-generating capacity of commercial entities, including pharmacy benefits managers, commercial pharmacies, durable medical equipment suppliers, and insurance providers.[96] As one example, in 2009, Casalino et al[96] estimated that physician practices annually spend $23-$31 billion interacting with insurance plans.

In another example, a Chair of Medicine is under pressure to increase access within her department for new patients, who generate downstream revenue through subspecialty care and procedures that contribute to the financial stability of the organization. Therefore, new patient appointments are prioritized in physicians' schedules. The result is overpaneled practices and a moral dilemma for physicians: see their established patients needing care as overbooked appointments, work longer hours and compromise personal and family well-being, or tell their established patients they are unable to be seen or must be managed by portal or seen by a substitute.

Fee-for-service (FFS) payment models are often blamed for suboptimal outcomes within the US health care system.[97,98] Fee-for-service can discourage continuity by incentivizing organizations to fill physicians' schedules far in advance, effectively resulting in practices that are overpaneled for their supporting resources,[99] leaving little room for short-term access for urgent needs and for hospital follow-up. On the other hand, FFS payment, when coupled with control over one's practice environment (eg, team size, structure, and skill level; number of exam rooms; and scheduling template) can also incentivize practice efficiency, although physicians in large organizations are rarely afforded such control.

A payment model that promotes relationships would financially incentivize continuity between a patient and a physician. Practices would be meaningfully reimbursed for coordination that occurs outside of a visit, whether two physicians conferring about a shared ambulatory patient or a hospital-based physician consulting with an outpatient colleague on hospital admission and again at discharge. Payment approaches that require documentation of ever-thinner slices of physician activity will quickly reach a point of diminishing returns where the work of justifying the service requires as much time as the delivering the actual service. Table 3[59,77,100] addresses financial strategies that individual physicians, health systems, and policy makers can consider as

means of supporting a health care system reoriented around relationships.

The National Institutes of Health and private industry invest $130 billion annually researching disease-specific treatments[101,102] whereas the Agency for Healthcare Research and Quality receives less than 1% of this amount ($500 million) to conduct research designed to optimize delivery models that determine whether or not those treatment advances are appropriately deployed and safely delivered to patients in day-to-day practice.[103] Increased funding for research addressing care delivery, including the role of continuity, will help shape a health care system that delivers more value, and could include: (1) optimizing care team size, structure, and skill level to fully leverage the skills of physicians and other clinicians, as is done in advanced models of team-based care with in-room support[61]; (2) reducing the cognitive workload and time-costs of interacting with electronic health records and other technologies[104]; (3) improving information flow and workflow within and across health care settings; and (4) analyzing the value of comprehensiveness, continuity, and cohesion.

Barriers to Reorientation of the US Health Care System Around Relationships

One of the biggest barriers to reorientation around relationships is simply recognizing the degree to which our current system has become conceptualized as a series of transactions. The power of relationships rests in our collective blind spot. Another important barrier is the difficulty physicians and leaders may have imagining a care model and health system that they have not yet experienced. Some physicians are overpaneled for their resources and percent full time equivalent, which can be a structural barrier to continuity and relationship. This is a particularly acute problem for physicians who reduce their clinical effort, often in an attempt to deal with work overload, without reducing the size of their patient panel. A final important barrier is a belief that the current constraints in health care cannot be changed. If only the physician can enter orders, if staffing is limited to half or one minimally trained clinical assistant per physician, if compliance concerns always trump the feasibility of the work, and if no systems are built to increase the ease of communication between individuals and between institutions, then substantive change is limited. But we have experienced and thus believe that a radical reorientation of the infrastructures, priorities, and practices of health care around relationships is possible and will be of benefit to patients, physicians, and payors.

Opening Vignette Revisited

"Dr Serra and the care team can see you for an urgent visit today." The receptionist, co-located with the clinical team, was able to check with the staff to offer a same-day appointment. Dr Serra is able to make the needed minor adjustment to address the patient's new symptoms. Because Dr Serra knows the patient well, this adjustment is made without unnecessary imaging and laboratories. A team member aids in real-time documentation and order entry, freeing Dr Serra to engage without distraction. The team now consists of Dr Serra and the same two clinical assistants (medical assistants or nurses) each day. This stable and upskilled team is able to perform much of the "production line" work for the practice, freeing up Dr Serra to both have greater capacity to see his own patients and greater focus on their concerns during the encounter. Because of the important contributions of team members, the encounter required a total of 10 minutes of Dr Serra's time. The patient was grateful to be seen quickly and felt reassured by Dr Serra, whom they trust. Drs Serra and Breznik and their team members all went home on time.

Conclusion

The transactional conceptualization of health care has been at odds with the fundamental relational nature of the work, to the detriment of health care costs, quality, and satisfaction.

In recommending a radical restructuring around relationships, we call for a fundamental shift in the mindset and actions of a

diverse set of stakeholders. No physician, leader, payor, or policy maker can single-handedly facilitate this shift. Yet we believe that a collective commitment by all stakeholders to examine every decision in light of its impact on relationships will result in better outcomes for patients, clinicians, and the health care delivery system.

POTENTIAL COMPETING INTERESTS

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SUPPLEMENTAL ONLINE MATERIAL

Supplemental material can be found online at http://www.mayoclinicproceedings.org. Supplemental material attached to journal articles has not been edited, and the authors take responsibility for the accuracy of all data.

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