Teaching, But Not Practicing, Etiquette-Based Medicine

Dr. Leonard Feldman

Disclosures - None

Objectives

• Describe the concept of Etiquette-based Medicine (EtBM)
• Evaluate how frequently IM interns at Johns Hopkins Hospital and Maryland practice EtBM
• Assess whether we need to increase EtBM practice among interns and residents at Johns Hopkins
• Discuss how we can increase EtBM practice
A brief history of work hours reform

- 1984 Libby Zion case
- 1989 NYS Section 408
- 1999 IOM publishes ‘To Err is Human’
- 2003 ACGME adopts 80-hour workweek
- 2011 ACGME adopts 16-hour shift rule

ACGME Common Program Rule 2011

- Limits continuous work hours for interns to 16
- Mandates 10 hours off between shifts
- Increases supervision requirements
- Maintains 80-hour workweek
- Aim to reduce resident fatigue, improve patient safety

Key questions

- How have work hour changes impacted...
  - Patient care
  - Education
  - Practice
  - Professionalism
- Will today’s training produce competent physicians?
- Are changes to the current system needed?
In 2012, how are interns spending their time in the hospital

“For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions”

--ACGME

Changing demands on intern time

- Shorter continuous work periods as of 2011
- Fewer hours per week in the hospital as of 2003
- Widespread adoption of electronic medical record

Etiquette-based Medicine

- ‘patients may care less about whether their doctors are reflective and empathic than whether they are respectful and attentive.’
- ‘medical education and postgraduate training should place more emphasis on this aspect of the doctor–patient relationship — what I would call “etiquette-based medicine.”'

Etiquette-based Medicine

1. Ask permission to enter the room; wait for an answer.
2. Introduce yourself, showing ID badge.
3. Shake hands (wear glove if needed).
4. Sit down. Smile if appropriate.
5. Briefly explain your role on the team.
6. Ask the patient how he or she is feeling about being in the hospital.

Advantages of check list

- Clear
- Efficient to teach and evaluate
- Easy for trainees to practice
- Does not address the way the doctor feels
- Focusses on observable behaviors (milestones)
- Complement efforts to train physicians to be humane
- May take priority over compassion-based medicine.
- Behavior provides the necessary foundation for the patient to have a satisfying experience.
- Simpler to change behavior than attitudes
- Prioritize behavior over feeling
- Stress practice and mastery over character development

Kalamazoo Consensus Conference- 1999

- Reviewed 5 models of doctor-patient communication described in the 1990’s
- Through a long process, developed the 7 tasks
- 7 essential sets of communication tasks:
  1. build the doctor–patient relationship
  2. open the discussion
  3. gather information
  4. understand the patient’s perspective
  5. share information
  6. reach agreement on problems and plans
  7. provide closure

Hopkins Medical School

M1-M2

- Teach to the checklist- patient-centered and relationship-centered paradigm
- Assessments
  - observed 40 minute patient interview
  - 4 station SP exam
- Pass rate in the communication skills domain
  - Very high, often 98%
  - Average score in this domain over the past 3 years is in the 88-93% range
- “Students completing CFM have a good sense of the value of communication skills and use them”

Johns Hopkins SOM

PRECEDE

- Taught specifically about patient-centered interview techniques to maximize relationship and clinical reasoning
  - empathy
  - agenda setting
  - open ended questions
- Receive EBM-based Feedback
  - directly from SP's through 2 different encounters
  - EBM covered in other settings
- bedside presentations and strategies for patient inclusion.
  - discharge counseling in which involves patient-centered communication strategies to maximize understanding and retention.
- Bayview- “knock, touch, and tell” campaign
  - focusing on etiquette
Methods - Setting

- Setting
  - PGY-1 residents in two internal medicine programs in Baltimore during January, 2012
  - Total of 29 interns observed through call cycle
    - 10 interns (21%) at site 1
    - 19 interns (32%) at site 2
  - Survey of Hopkins interns 6 months later

Methods - Sites

- Site 1
  - Large urban health system
  - 1051 beds
  - Modified overnight call
  - All notes electronic
  - Bedside rounds

- Site 2
  - Large urban health system
  - 757 beds
  - Night float system
  - Daily progress notes on paper
  - Office rounds
Methods - Observation

• Observers
  • 22 trained Hopkins undergraduate students
  • Orientation, hospital tour, sensitivity, HIPAA training
• Observation tool
  • Activities recorded on iPod Touch “TimeTracker” app
  • Observers certified at 85% concordance rate with researchers
• Quality control – 2 hours at each site


Definitions

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introducing self</td>
<td>Providing a name</td>
</tr>
<tr>
<td>Introducing role</td>
<td>Uses term “doctor”, “resident”, “intern”, or “medical team”</td>
</tr>
<tr>
<td>Sitting down</td>
<td>Sitting on the bed, in a chair, or crouching if no chair was available during at least part of the encounter</td>
</tr>
<tr>
<td>Touching the patient</td>
<td>Any form of physical contact that occurred at least once during the encounter including shaking a patient’s hand, touching a patient on the shoulder, or performing any part of the physical exam.</td>
</tr>
<tr>
<td>Asked open-ended question</td>
<td>Asked the patient any question that required more than a yes/no answer</td>
</tr>
</tbody>
</table>


Intern Introductions

<table>
<thead>
<tr>
<th></th>
<th>Total encounters N (%)</th>
<th>Introduced self</th>
<th>Introduced role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>732 (100%)</td>
<td>40%</td>
<td>36%</td>
</tr>
<tr>
<td>JHH</td>
<td>373 (51%)</td>
<td>35%*†</td>
<td>29%*†</td>
</tr>
<tr>
<td>UMD</td>
<td>359 (49%)</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Male</td>
<td>284 (39%)</td>
<td>39%</td>
<td>35%</td>
</tr>
<tr>
<td>Female</td>
<td>448 (61%)</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Day shift</td>
<td>551 (75%)</td>
<td>37%*</td>
<td>34%*</td>
</tr>
<tr>
<td>Night shift</td>
<td>181 (25%)</td>
<td>48%</td>
<td>45%</td>
</tr>
<tr>
<td>Admitting shift</td>
<td>377 (52%)</td>
<td>46%*</td>
<td>42%*</td>
</tr>
<tr>
<td>Non-admitting shift</td>
<td>355 (48%)</td>
<td>34%</td>
<td>30%</td>
</tr>
</tbody>
</table>

* p<0.05 in unadjusted bivariate analysis
† p<0.05 in analysis adjusted for clustering at observer and intern levels
### Touching Patients

<table>
<thead>
<tr>
<th></th>
<th>Total encounters N (%)</th>
<th>Touched patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>732 (100%)</td>
<td>64%</td>
</tr>
<tr>
<td>JHH</td>
<td>373 (51%)</td>
<td>62%*</td>
</tr>
<tr>
<td>UMD</td>
<td>359 (49%)</td>
<td>69%</td>
</tr>
<tr>
<td>Male</td>
<td>284 (39%)</td>
<td>64%</td>
</tr>
<tr>
<td>Female</td>
<td>448 (61%)</td>
<td>67%</td>
</tr>
<tr>
<td>Day shift</td>
<td>551 (75%)</td>
<td>66%</td>
</tr>
<tr>
<td>Night shift</td>
<td>181 (25%)</td>
<td>67%</td>
</tr>
<tr>
<td>Admitting shift</td>
<td>377 (52%)</td>
<td>63%</td>
</tr>
<tr>
<td>Non-admitting shift</td>
<td>355 (48%)</td>
<td>69%</td>
</tr>
</tbody>
</table>


### Sitting with Patients

<table>
<thead>
<tr>
<th></th>
<th>Total encounters N (%)</th>
<th>Sat down</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>732 (100%)</td>
<td>9%</td>
</tr>
<tr>
<td>JHH</td>
<td>373 (51%)</td>
<td>10%</td>
</tr>
<tr>
<td>UMD</td>
<td>359 (49%)</td>
<td>8%</td>
</tr>
<tr>
<td>Male</td>
<td>284 (39%)</td>
<td>9%</td>
</tr>
<tr>
<td>Female</td>
<td>448 (61%)</td>
<td>10%</td>
</tr>
<tr>
<td>Day shift</td>
<td>551 (75%)</td>
<td>9%</td>
</tr>
<tr>
<td>Night shift</td>
<td>181 (25%)</td>
<td>12%</td>
</tr>
<tr>
<td>Admitting shift</td>
<td>377 (52%)</td>
<td>10%</td>
</tr>
<tr>
<td>Non-admitting shift</td>
<td>355 (48%)</td>
<td>9%</td>
</tr>
</tbody>
</table>


### Asked Open-Ended Question

<table>
<thead>
<tr>
<th></th>
<th>Total encounters N (%)</th>
<th>Open-Ended Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>732 (100%)</td>
<td>75%</td>
</tr>
<tr>
<td>JHH</td>
<td>373 (51%)</td>
<td>70%*</td>
</tr>
<tr>
<td>UMD</td>
<td>359 (49%)</td>
<td>81%</td>
</tr>
<tr>
<td>Male</td>
<td>284 (39%)</td>
<td>74%</td>
</tr>
<tr>
<td>Female</td>
<td>448 (61%)</td>
<td>76%</td>
</tr>
<tr>
<td>Day shift</td>
<td>551 (75%)</td>
<td>77%</td>
</tr>
<tr>
<td>Night shift</td>
<td>181 (25%)</td>
<td>71%</td>
</tr>
<tr>
<td>Admitting shift</td>
<td>377 (52%)</td>
<td>75%</td>
</tr>
<tr>
<td>Non-admitting shift</td>
<td>355 (48%)</td>
<td>76%</td>
</tr>
</tbody>
</table>

Perception vs. Reality

Do we have a problem here?

Introducing yourself

- may improve patient satisfaction and acceptance of trainee involvement in care
- only 10% of hospitalized patients in 1 study correctly identified a physician on their inpatient team
- even during admitting shifts, when the first encounter with a patient likely took place, interns introduced themselves during 46% of encounters


Benefits of touch

- Reduces anxiety levels among patients and improve compliance with treatment regimens
- 66% of patients consider a physician’s touch comforting,
- 58% believe it to be healing


Sitting

- RCT found that most patients preferred a sitting physician
- Believed that practitioners who sat were more compassionate and spent more time with them


Is this just a Hopkins/Maryland problem?

Possible Solutions

- Role modeling
- Provide chairs
- Face sheet


Solutions

All patients did matching and pt satisfaction survey
Table 1

Table 1: Patient Demographics

<table>
<thead>
<tr>
<th>Parameter (Percent or Mean)</th>
<th>Control (%)</th>
<th>Intervention (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>86</td>
<td>111</td>
</tr>
<tr>
<td>Age (years)</td>
<td>54.75 (18.57)</td>
<td>55.06 (16.18)</td>
</tr>
<tr>
<td>Female*</td>
<td>46 (53.49)</td>
<td>44 (38.54)</td>
</tr>
<tr>
<td>Male*</td>
<td>40 (46.51)</td>
<td>67 (60.36)</td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>25 (29.07)</td>
<td>28 (25.22)</td>
</tr>
<tr>
<td>Black</td>
<td>55 (63.95)</td>
<td>68 (61.26)</td>
</tr>
<tr>
<td>Other (including Hispanic)</td>
<td>6 (6.98)</td>
<td>15 (13.51)</td>
</tr>
<tr>
<td>College Education</td>
<td>35 (40.70)</td>
<td>50 (45.94)</td>
</tr>
<tr>
<td>High School Education</td>
<td>45 (52.32)</td>
<td>57 (51.35)</td>
</tr>
<tr>
<td>Less than High School Education</td>
<td>6 (7.0)</td>
<td>4 (3.6)</td>
</tr>
<tr>
<td>Length of Stay (days)</td>
<td>Median, 4</td>
<td>Median, 4</td>
</tr>
</tbody>
</table>

Patient Survey

Matching

Figure 2: Hospital Rating and Subject Ability to Identify Providers

Patient Survey

Percent of participants strongly agreeing with the statement:
"different types of healthcare providers enjoyed working with each other"

Percent of participants strongly agreeing with the statement:
"different types of healthcare providers communicated well with each other"

Percent of participants strongly agreeing with the statement:
"different types of healthcare providers worked together effectively to coordinate my care"
Conclusions

• FACES sheets improved identification of healthcare team members and roles
• The FACES intervention patients more strongly perceived that providers worked cohesively as team and enjoyed working together
• There was a non-significant trend towards improved patient satisfaction and patient perception of healthcare member teamwork in the intervention arm
• There were no significant changes in the rates with which participants would recommend the Johns Hopkins Hospital to family members and friends
• Too few patients recognize the individual members of the healthcare team working on their behalf

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### Historical time motion studies

- 1961: First time motion study published
- 1971: First multi-department time motion study published
- 1988/1993: Lurie studies show more time spent documenting than with patients
- 1998: Moore and Dresselhaus studies - time in activities of low education value
- 1999: IOM publishes 'To Err is Human'
- 2003: ACGME adopts 80-hour workweek
- 2011: ACGME adopts 16-hour shift rule
- 2011: Time study of hospitalists finds similar pattern of time allocation

### Hypothesis

**Relative to historical studies,**

- **More time:**
  - Handoffs
  - Accessing EMR
  - Using computers
  - Direct patient care
  - Education
  - Sleeping

- **Less time:**
  - Handoffs
  - Accessing EMR
  - Using computers
  - Direct patient care
  - Education
  - Sleeping

### Methods - Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percent of time in Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Direct patient care</td>
</tr>
<tr>
<td></td>
<td>Admitting patients</td>
</tr>
<tr>
<td></td>
<td>Follow-up care</td>
</tr>
<tr>
<td></td>
<td>Family meetings</td>
</tr>
<tr>
<td>Secondary</td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>Rounds</td>
</tr>
<tr>
<td></td>
<td>Teaching</td>
</tr>
<tr>
<td></td>
<td>Conferences</td>
</tr>
<tr>
<td>Indirect patient care</td>
<td>Notes</td>
</tr>
<tr>
<td></td>
<td>Orders</td>
</tr>
<tr>
<td></td>
<td>Paperwork</td>
</tr>
<tr>
<td></td>
<td>Handoffs</td>
</tr>
<tr>
<td></td>
<td>Calling consultants</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Eating</td>
</tr>
<tr>
<td></td>
<td>Sleeping</td>
</tr>
<tr>
<td></td>
<td>Walking</td>
</tr>
</tbody>
</table>
Methods – Data analysis

- Percent of time in each activity aggregated
- Overlapping time (multitasking) assigned to activity more closely related to patient care
- Simple and mixed level regression analysis
  - Adjust for clustering at intern, observer level

Results - Time allocation

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>14.7%</td>
</tr>
<tr>
<td>Education</td>
<td>12.3%</td>
</tr>
<tr>
<td>Indirect pt care</td>
<td>9.3%</td>
</tr>
<tr>
<td>Misc</td>
<td>63.6%</td>
</tr>
</tbody>
</table>

Results – Time by activity and site

<table>
<thead>
<tr>
<th>Activity</th>
<th>Total time (hours)</th>
<th>Site 1</th>
<th>Site 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct patient care</td>
<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Initial patient evaluation</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Follow-up patient visits</td>
<td>0.9</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Family meeting</td>
<td>0.9</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Procedures</td>
<td>0.7</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Educational conferences</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Reading about medicine</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Reviewing patient chart</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Talking with providers</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Peppermint</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Writing orders</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Reading</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>0.7</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Eating, sleeping, &amp; social</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

* p<0.05 in unadjusted analysis
+ p<0.05 in adjusted analysis

<1% of time in patient education, teaching students, patient transport, procedure consent
Results - Time spent per patient

<table>
<thead>
<tr>
<th>Overall</th>
<th>Site 1</th>
<th>Site 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per patient overall Minutes (range)</td>
<td>7.7 (0-39.6)</td>
<td>7.3 (0.3-39.6)</td>
</tr>
<tr>
<td>Per new admission Minutes (range)</td>
<td>16.6 (4.4-54.5)</td>
<td>20.6 (10.2-54.5)</td>
</tr>
</tbody>
</table>


Results - Comparison to historical studies

Conclusions

- Minority of time in direct patient care
- Two thirds of time in indirect patient care
  - 40% of time in front of the computer
  - More time reviewing charts than seeing patients
  - 20% of time spent discussing cases
- Similar findings between two sites
- Call system did not impact patient care time

Conclusions

Relative to historical studies,

More time
- Computers
- Handoffs
- Discussion

Less time
- Direct patient care
- Eating & sleeping

Conclusions

On a typical 15-hour day, how is time allocated?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>1.8</td>
</tr>
<tr>
<td>Indirect patient care</td>
<td>9.6</td>
</tr>
<tr>
<td>Misc</td>
<td>1.4</td>
</tr>
<tr>
<td>Education</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Limitations

- External validity
- Measurement error
  - Using non-medical observers
  - Re-allocation of time spent multitasking
- Hawthorne effect
- Work outside of hospital setting not observed
- Did not assess quality of interactions or patient perspectives
Implications for residents

• Interns today can expect less face-to-face time with patients
• Increasing time constraints – 80-hour workweek, 16-hour shifts
• Increasing demands – educational activities, communication with large teams, documentation
• Activities of low educational value reduced
• Less eating, sleeping, transport, and phlebotomy

⇒ Will this impact patient-doctor relationship and quality of care?

References