"I Know This Must Have Been a Difficult Day for You:"

Personal Care in a Patient-centered Medical Home

Thomas R. Egnew, EdD, LICSW

In light of calls for a new model of care, family physicians are endeavoring to create a Patient-centered Medical Home. Yet, structures of care in themselves do not make a home; for the medical house to be a home requires physicians to demonstrate a personal touch that communicates caring to the patient. This essay describes one easily accomplished method by which to integrate personal care in a Patient-centered Medical Home.

(Fam Med 2011;43(6):435-6.)

Marian (names have been changed to protect patient confidentiality) is a delightful octogenarian whom I've known for 30 years. Following the death of Frank, her husband of 62 years, she approached me after a church service to seek help finding a physician, knowing my involvement in residency education and familiarity with the local medical community. We discussed her sense of vulnerability in living alone, which roused her awareness that she needed to establish care with a primary care physician. She wanted someone "good" and preferred a female doctor. After ascertaining that there was room in her practice, I facilitated a referral to one of our residency graduates.

I was pleased when, a couple of months later, Marian again took me aside after church and confided that she and her new physician had connected. She was pleased with her doctor's obvious professional acumen and appreciative of her personal demeanor.

"She's very thorough. I've been given just about every test known to man."

"And likely some known only to women," I quipped. We shared a laugh, and I felt reassured that a good friend now had a physician whom she trusted and who would see her through her remaining years.

Recently, Marian called me at home. I assumed she wished to speak with me about some church matter, so was surprised when she explained she wished to share with me a conversation she had with her physician. I privately feared Marian had received a grave diagnosis or that she and her physician had had a falling-out. Why else would she be calling me at home in the evening?

"You know, Tom," Marian explained, "yesterday was the first anniversary of Frank's death, and last night the most amazing thing happened. The phone rang and, when I answered, my doctor was calling me. She said, 'This is the anniversary of your husband's death, and I wanted to call to let you know that I know this must have been a difficult day for you. I just wanted you to know that I was thinking of you.' Isn't that extraordinary? I felt so touched! I can't begin to convey how much this meant to me and thought you'd like to know."

I agreed that Marian's story was indeed extraordinary and shared how pleased I was that she had felt supported during such an emotional time (to my chagrin, I had forgotten). We affirmed the sense of loneliness and emptiness that accompanies such occasions, and I shared, belatedly, lessons learned from my own experiences of grief concerning the value of creating personally meaningful rituals to perform on special days related to those we mourn—birthdays, death days, holidays (Marian added wedding anniversaries). Marian found the idea intriguing and said she would consider this as I wished her Godspeed.

Marian's experience is an illustration of exemplary bereavement care. Her doctor had no means to cure Marian's bereavement; indeed, while intensely painful, it is not a disease.[1] Yet, Marian's doctor clearly made a demonstrable difference—such that Marian felt compelled to share her experience. Herein are important lessons concerning the power of the physician-patient relationship to relieve suffering and thereby accomplish an enduring goal of medicine.[2,3] Bereavement surely involves suffering and is arguably exacerbated in contemporary society by the demise of many of the rituals

From Tacoma Family Medicine, Tacoma, WA

by which the bereaved publicly proclaimed their loss.[4] Yet, a moment of thoughtfulness and a short phone call that witnessed to Marian's suffering ameliorated some of Marian's loneliness and assuaged some of her pain.

I contacted Marian's physician to express my admiration and appreciation for her care of my friend. I was also curious as to her tickler system for remembering such events. She explained that she uses her electronic medical record (EMR). When a patient mentions a notable event, she uses her EMR to send herself an e-mail reminder in the future. She does this for anniversaries of a spouse's death, for abstinence dates for alcohol/substance abuse, to commemorate cancer remission dates, when a military spouse deploys or is deployed during the holidays, and for other significant events. She doesn't solicit this information because not all people want to be called, but she notes when patients mention something during a visit. If patients are comfortable enough to share that information, she believes they appreciate a call. She also calls patients who have surgery and sends cards to commemorate anniversaries of bad OB outcomes. Calls rarely take more than 3 minutes; any need for a more extended conversation warrants a recommendation for an appointment.

Much has been written about a new model of family medicine that involves the development of a patient-centered home.[5] Yet, most of what's written about the medical home focuses on the structural elements of a medical house—systems of care to increase access, track service delivery, and empower patients. But it is enduring qualities of relationship—affinity, reciprocity, continuity, and intimacy[6]—that transform a medical house into a home. Carmichael discussed these qualities long before EMRs existed, and tickler systems can easily be developed for physicians without EMRs. A simple appointment book dedicated to noting anniversaries with the mental note of checking the upcoming week when planning one's work would suffice.

The symbolic aspects of these phone calls encompass most of the behaviors patients identify with an ideal physician—empathetic, humane, personal, respectful, thorough[7]—in a time-efficient fashion. Ideally, all employees in the medical home might use such a system to reflect concern for and support of patients traversing notable anniversaries. Such acts of kindness should be pervasive throughout the medical home; a little kindness and consideration can reap incommensurately large rewards.

Still, not all staff will be aware of these events, as patients often selectively disclose sensitive information. If the physician has been solely entrusted with the information, a call delegated to office staff could potentially compromise confidentiality. It might also be counter-productive, analogous to a busy executive directing a secretary: "Call my son and give him my birthday wishes." But an efficient dispersal of services through a team approach to care can beget time for physicians to make these calls and thereby augment the healing powers of their doctor-patient relationships.

As the momentum for Patient-centered Medical Homes builds, physicians in training must be taught to pay attention not only to the structures and processes of practice plans but also to the spirit infusing patient-centered care. An essential element is thoughtfulness, the mentality necessary to enliven the whole-person orientation described in the new model of care. In reality, this is not new, for "the secret of patient care is caring for the patient."[8] Caring is both an attitude and an activity. The compassion of the heart must be conveyed in action for patients to appreciate the sentiments involved because "empathy withers in silence."[9] Establishing a tickler system for empathetic calls supporting patients during difficult times is one method to express personal caring while posing relatively little burden on physicians. It is also a way to practice exemplary bereavement care while making a medical house a home.

CORRESPONDENCE: Address correspondence to Dr Egnew, Tacoma Family Medicine, 521 Martin Luther King Junior Way, Tacoma, WA 98405-4238. 253-403-2929. Fax: 253-405-2915. tom.egnew@multicare.org.

References

1. Silverman PR, Klass D. Introduction: what's the problem? In: Klass D, Silverman PR, Nickman SL, eds. Continuing bonds: new understandings of grief. Philadelphia: Taylor & Francis, 1996:3-27.
2. Allert G, Blasszauer B, Boyd K, et al. The goals of medicine: specifying the goals of medicine. Hastings Cent Rep 1996;26 Suppl 6:S9-S13.
3. Egnew TR. Suffering, meaning and healing: challenges of contemporary medicine. Ann Fam Med 2009;7:170-5.
4. Silverman PR. Dying and bereavement in historical perspective. In: Berzoff J, Silverman PR, eds. Living with dying: a handbook for end-of-life healthcare practitioners. New York: Columbia University Press, 2004:128-49.
5. Martin JC, Avant RF, Bowman MA, et al. The future of family medicine: a collaborative project of the family medicine community. Ann Fam Med 2004;2 Suppl 1:S3-S32.
6. Carmichael LP. The family in medicine, process or entity? J Fam Pract 1976;3:562-3.
7. Bendapudi NM, Berry LL, Frey KA, Parish JT, Rayburn WL. Patients' perspectives on ideal physician behaviors. Mayo Clin Proc 2006;8:338-44.
8. Peabody FW. The care of the patient. JAMA 1927;88:877-82.
9. Spiro H. The practice of empathy. Acad Med 2009;84:1177-9.