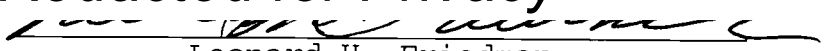AN ABSTRACT OF THE DISSERTATION OF

David C. Kailin for the degree of Doctor of Philosophy in
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Title: Quality Of Learning In Primary Care: A Social
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Abstract approved: _Redacted for Privacy_
Leonard H. Friedman

What constitutes quality of learning in primary care? A

social systems view of that central question regards the

relationships between dimensions of learning, purposes of

primary care, and quality of practice. The question of

learning quality was approached in three ways. First,

perceptions of learning quality were elicited through

recorded interviews with fifteen participants representing

diverse roles in a primary care medical clinic. Analysis

of the interviews indicated learning sources, factors, and

functional dimensions of learning. Second, because

learning is constituted in a social practice, the social

context of learning in primary care clinics was modeled

with qualitative systems diagrams. This exposed systemic

barriers and facilitators of learning in practice. Third,

learning is directed toward fulfilling the purposes of

primary care. The nature of those purposes is not well

articulated. A framework of seven core purposes was developed from the perspective of systems phenomenology. This framework extends the biopsychosocial framework in several regards. Perceptions of learning quality, the structural situation of learning in clinical practice, and the core purposes of primary care, all contribute to a social systems understanding of what constitutes learning quality, and how primary care organizations might procure it and assess it. Systems phenomenology represents a significant innovation in social systems science methods.

Quality Of Learning In Primary Care:
A Social Systems Inquiry

by
David C. Kailin

A DISSERTATION

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Doctor of Philosophy

Presented May 2, 2002
Commencement June 2002

<u>Doctor of Philosophy</u> dissertation of <u>David C. Kailin</u> presented on <u>May 2, 2002</u>.

APPROVED:

Redacted for Privacy

Major Professor, representing Public Health

Redacted for Privacy

Chair of Department of Public Health

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Dean of Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Redacted for Privacy

David C. Kailin, Author

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INTRODUCTION

PREFACE

This is a work of qualitative, interpretive research. It thus involves an interpreter, a person with perspectives related to their situation. Hence a few autobiographical notes are in order at the outset. I am a 53 year old married Caucasian American male. My mother is a physician, one of the pioneers of clinical ecology. I grew up in the neighborhood of the National Institutes of Health, with a window onto clinical practice, medical research, and the politics of knowledge in medicine.

My first career, for which I began training in 1969, has been acupuncture. I engaged in political struggles to organize and legislatively establish the profession, and experienced remarkable hostility from physicians who felt threatened by this form of alternative medicine. Fortunately, graceful accommodation is now the norm. I

have initiated the practice of acupuncture in major
hospitals, and currently provide acupuncture services at
a University student health center.

I have come to appreciate that all medicine is
culturally constructed, and that no medicine fully
understands the human condition and its care. My respect
for biomedicine is profound. It has saved my life, both
quietly and heroically.

That is also to say, I have spent time as a patient,
touched the edge of death, suffered extreme pain, endured
grievous loss, and experienced medical misadventures. I
carry the gravity of my patients' stories alongside my
own. Walking into a hospital still provokes anxiety.

Over the past six years I have embarked on a second
career, as a medical futurist. I help organizations
identify and create health care futures with humane value.
My focus is not technological advances, but cultural
choices. Bookish to a fault, I have previously completed
a Master of Public Health degree, and am now working
toward a doctorate. Research subjects in this study were
only made aware of my academic interests, and were not

told of my history in acupuncture, as the latter was quite
peripheral to my inquiry.

All of the above contribute to a constellation of
biases, perhaps better stated as rich and conflicted
perspectives, which I can no more walk away from than shed
my skin, and without which I would have nothing to offer.
The best I can do is make that skin partially visible, and
proceed with an intent toward truth. This is a self-
portrait of the active voice behind the passive voice of
the report.

I have chosen methods not only because they were
suited to an exploration of human social complexity, but
because they actively involved the people being
researched. Selected comments of participants in the
study have been presented verbatim. Participants and
academic advisors have reviewed the work and offered
corrections. My wider interest is in developing the
methods of humane sciences (Smith, 1997, ch.7), methods
open to the democratic involvement and critical review of
a broad community (including academics), methods suitable
to coming to know ourselves together.

I address this report to the patients, administrators, clinicians, support staff, and educators, who extended themselves into the research project, to reflect what I have gathered from their generosity, for their benefit, and for the benefit of all others involved in the calling to care.

PROLOGUE

What constitutes quality of learning in primary care? That central question depends on relationships between dimensions of learning, purposes of primary care, and quality of practice.

First, criteria for quality of learning are established on the basis of some definition of what ought to be learned. What ought to be learned involves multiple dimensions (and types) of knowledge. For example, learning for a patient involves at least these dimensions: diagnosis of symptoms; care of disease; prognosis; cost of treatment; payment for treatment; and how a patient is supposed to behave. Assessing quality of

learning clearly relates to what needs to be learned, the dimensions of learning.

The dimensions of learning, in turn, are related to the nature of the social transaction. For what purposes do patients and practitioners resort to primary care? This moves beyond a local functional assessment to inquire into the fundamental human purposes of a primary care medical encounter (Kleinman, 1988, p.253). These core purposes provide a root definition of dimensions of learning. Yet the purposes are not clearly articulated (Hanson and Callahan, 1999). To understand what constitutes the quality of learning, one must inquire into the core purposes of primary care.

The quality of practice relates to understandings of the purposes of primary care, and to the quality of learning. If the predominant purpose of primary care is taken by a clinic to be profitable monetary exchange for the biomedical remediation of organic diseases, then practice may well be driven into a high production mode of technological, pharmacological, and surgical inter-ventions. Limited understandings of this sort indeed supplant other fundamental human purposes, such that other

purposes become distorted or lost (Baume, 1998, ch.13; Habermas, 1989, p.355). The ordinary context of daily clinical practice forms an emergent barrier to acting in the transcendent context of core purposes.

Such restricted understandings present several forms of hazard. The efficient business of brief office visit time, combined with a narrow biomedical focus, delimit opportunities for learning by all involved, and thereby contribute to errors (Kohn, Corrigan and Donaldson, 2000, pp.35-40;60). Concentration on technological advances and profit motivations tend to increase the cost of care, exacerbating social injustices for the poor (Davis and Rowland, 1990). Other basic human purposes, such as caring, become overshadowed, presenting a moral hazard. Alternative forms of intervention, including those with lesser risk of physical harm, become systematically overlooked (Gaudet, 2001). In these regards, practice quality depends on the understanding of purposes of care, and on the quality of learning by all parties to the social transaction.

Thus a systems inquiry into what constitutes the quality of learning in primary care "sweeps in" the

quality of practice and the question of the purposes served in primary care (Churchman, 1979, ch.1). A schematic of these relationships, and the research methods employed, is depicted in Figure 1.

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                    ┌─────────────────┐
                    │  Core Purposes  │
                    └─────────────────┘
                       │   │   │   │
phenomenology of       │   │   │   │            Transcendent
core purposes          ▼   ▼   ▼   ▼            Context


                   ================== emergent
                          ┊     ┊      barrier
systems
diagrams                  ▼     ▼

                    ┌─────────────────┐
                    │ Emergent Purposes│
                    │    of Clinics    │
                    └─────────────────┘
                        │         │              Clinical
perceived               │         │              Context
learning                ▼         ▼
case study
            ┌───────────────┐   ┌──────────────┐
     ▲      │ Quality of    │◄─►│ Quality of   │
     │      │ Learning      │   │ Practice     │
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Methods
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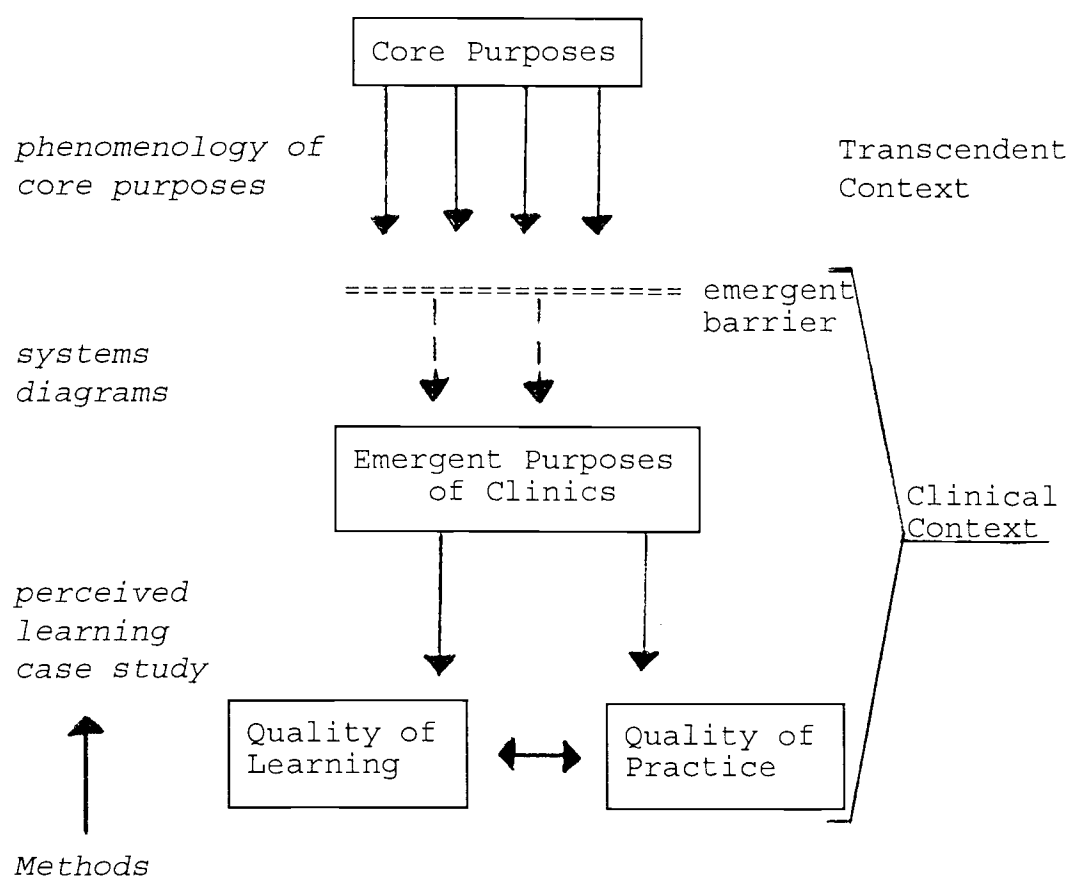
Figure 1. Purposes, learning, and practice

The question of what constitutes learning quality was approached in three interlinked ways. First, perceptions of learning quality were elicited through brief recorded interviews with fifteen participants representing diverse roles in a primary care medical clinic, as a case study of perceived learning in that clinic. Second, because learning occurs in a social setting, the social context of learning in a primary care clinic was modeled with qualitative systems diagrams. This exposed barriers and facilitators of learning in practice in a way that moved beyond personal blame for systemic problems. Interview subjects reviewed and critiqued systems diagrams, improving verisimilitude. Third, a framework of seven core purposes was developed from the perspective of systems phenomenology. This was compared with the interview transcripts to see if the core purposes were represented therein.

Perceptions of learning quality, the structural situation of learning in clinical practice, and the core purposes of primary care, all contribute to a systemic understanding of what constitutes learning quality, and how primary care organizations might procure it and assess it.

PURPOSE AND SIGNIFICANCE

Learning is an elemental function engaged in to accomplish the purposes of health care. The term "doctor" derives from the Latin *docere*, teacher. Educational components of care represent an abiding attribute of medical encounters. Teaching and learning are arguably of even greater importance in primary care than in more procedurally oriented specialties.

There is evidence to suggest that inadequate learning in medical visits contributes to undesired outcomes, as might arise from missed diagnoses, unintended drug interactions, unrealistic expectations, and misunderstood directives. According to a recent report of the Institute of Medicine, annual U.S. costs are estimated at between $17 billion - $29 billion for preventable adverse medical events, while annual hospital patient deaths in this category are estimated at between 44,000 and 98,000 (Kohn, Corrigan and Donaldson, 2000). Human factors include busyness, too many patients, and lack of concentration. These factors could reasonably impair learning. The cited statistics do not include adverse medical events that do

not involve error, nor adverse events outside of hospital practice. The magnitude of the hospital preventable adverse medical events mortality statistics alone suffices to place this matter within the purview of public health.

While some medical errors occur at the level of practitioner planning and action, many errors occur at the level of organization and management, introducing latent potentials for error residing in the system of care beyond the direct control of practitioners (ibid, p.55). Hence the learning of organizations (Argyris and Schon, 1996) is at issue as well as the learning of individuals. That is also to say, the situation of learners in the social system of the clinic is a factor in learning. These perspectives pertain to both health administration and social systems science.

The safety statistics do not take into account the qualitative aspects of medical encounters which leave many participants (e.g. patients, practitioners, staff, and administrators) frustrated and dissatisfied with the process, content, and/or costs of the exchange (Committee on Quality Health Care in America, 2001, ch.1). Beyond

safety concerns, participants are not being served in ways
they would like to be served (ibid).

The framework of seven core purposes developed in
this research may eventually serve as a basis for
assessments of learning quality in primary care, and more
generally, assessments of quality of care.

RESEARCH QUESTIONS

The research questions are not phrased as hypotheses
for disproof, but as topics for interpretive exploration.
They each bear on the larger question of what constitutes
quality of learning in primary care. The first question
addresses perceptions of participants in a primary care
medical clinic. This is of practical as well as academic
interest. The case study site - a family practice clinic
- receives a report (an abridgement of this dissertation)
as an assessment of their learning quality. To state the
question:

1. How do participants with diverse roles in a primary
    care clinic depict:

A. their perceptions of the quality of learning?

B. learning factors and sources?

C. dimensions of learning?

The second research question involves the use of qualitative systems diagrams to sketch the context of behaviors. Presenting such a diagram to interview subjects is expected to rapidly demonstrate emergent outcomes that are unintended and in need of attention.

2. How do participants with diverse roles in a primary care clinic respond to a qualitative systems diagram depicting barriers to learning in primary care?

A. Do subjects find the diagram to be rapidly comprehensible?

B. Can subjects provide useful critique to validate or improve the diagram?

Assessing the adequacy of learning implies a knowledge of the purposes of primary care. Hence the third research question follows:

3. What are the core purposes of primary care?

STUDY PARAMETERS

The following <u>assumptions</u> relating to interviewing clinic participants can be made explicit:

- Participants can recall and discuss their experiences of learning in medical visits.

- Participants can understand a qualitative systems diagram with brief instruction.

- Participants' reported perceptions can be used provisionally as a proxy for their actual perceptions.

Among explicit <u>delimitations</u>:

- Interviews were limited to voluntarily participating, mentally competent, English speaking adults without severe speech or hearing impairments.

- Subjects were selected for inclusion of diverse roles (patients, practitioners, support staff, and administrators) in one primary care clinic.

- Patients were selected for inclusion of diversity in generational groups and gender.

- The number of subjects and interview durations were confined to minimize impeding the work of the clinic.

The following list presents <u>limitations</u> of the study:

- The case study interview subjects were all Caucasian adults without severe disability or critical illness.

- While the sample of patients showed diversity of adult generational groups and parity of gender, most reported good health status.

- The selection process did not seek outliers in any dimension.

- The sample was not randomly selected.

- The interview sample size (n=15) was small, leaving open the question of whether saturation of categories was achieved. For example, a larger

sample may have exposed more learning dimensions than were uncovered in this study.

- Only two direct questions were focused on the topic of learning dimensions, without follow-up probes. A different line of direct, indirect, and follow-up questions may bring more information forth for comparison with these findings.

- The combination of methods (i.e. brief interviews with ethnographic analysis, qualitative systems diagramming, and phenomenological assessment of core purposes) used in this study was innovative, and therefore without a history for comparative reference.

- Interpretive methods such as these produce provisional findings, themselves subject to interpretation. Review of the case study findings by three research subjects provided a favorable appraisal of internal validity.

- Causal relationships may be inferred but not verified, because the methods were non-experimental.

Given that the sample does not accurately reflect the entire clinic patient population, a limited conceptual generalizability is warranted, taking into account that the conclusions should not be applied to those portions of the population not represented.

LITERATURE REVIEW

The review of literature is directed toward providing a concise overview of definitions of learning, followed by a broader exploration and development of the core purposes of primary care. The citations for these essays reflect the most relevant literature, but not the entirety of pertinent literature, as each topic is vast in scope. Database searches were done for books and journal articles, and mentors pointed out rich textual resources.

LEARNING THEORIES

How is learning defined, and what do various learning theories contribute to understanding learning in primary care? Does the nature of learning suggest methods for studying it? An immense literature attests to the complex character of learning - as much as there is to explain, yet more remains to explain away. Each learning theory contributes to a composite sense of learning.

Learning theories can be categorized in a continuum with respect to the level of analysis of learning: the brain, the minded person, and the societal - interactional levels. They will be considered in this order.

Brain-based theories attend to innate neurologic capacities and limitations to learning, and to functional regions and patterns of brain activity. Neural learning is not only a matter of the formation and pruning of dendritic interconnections between neurons, but the dynamic calling forth of associated networks of neurons (Shepherd, 1998). The brain self-organizes and activates complex networks of associations that are at some level meaningful, and breaks those patterns that are no longer so.

Neural encoding, whatever it adds in relationality, is also intrinsically selective and lossy with respect to environmental inputs to the senses. The brain is designed for rapid response, not perfect knowledge (Ornstein, 1992). The signal processing and neural network metaphors employed here have come to be widely applied in machine learning and artificial intelligence.

Research on the brain hemispheres (which communicate via the corpus callosum) suggests different learning activities for the right (synthetic, inductive, feeling) and left (analytic, deductive, logical) hemispheres (Sperry, 1982). The triune model of the brain (MacLean, 1990) attests that neo-cortical cognition is not independent of emotional states mediated by the limbic system, and that both of these interface with instinctive, non-learning, reptilian drives centralized in the brainstem and cerebellum.

Hence neural learning is dynamic, complex, selective, and messy, and not merely a direct translation of sensory stimuli. The learner is correspondingly complex, subject to shifts in perspective emanating from the sequential dominance of various brain routines arising in the transient flickering of neuronal assemblies, mostly operating below the level of consciousness (Ornstein, 1992). There are vital questions here about agency and identity: who's doing the driving?

Mind-based theories generally pose learning as acquired representations. Behaviorists see learning as entirely a process of operant conditioning (i.e.

representations of reward or punishment associated with stimuli and responses), which results in behaviors (Skinner, 1974). Piaget's (1977) developmental theory traces stages in the evolution of cognition extending from sensorimotor activity to abstract reasoning. That is to say, the nature of representation changes as we grow.

Piaget identifies the foundation of learning in the spatio-temporal engagement of the body with the world: learning is based on doing, active being, and not passive reception. Even reflexes must be used to be assimilated (Piaget, 1952, p.42). However, representation does not universally apply to this level of kinesthetic patterns and presentation potentials, residing beyond word and image. Bodily practices, particularly in the subtlety of cultural micro-rhythms, are predominantly non-objectifiable (Bourdieu 1990, p.11; Condon, 1982). Piaget's work in this regard bridges mind-body duality.

Information processing theories are concerned with the intermediary processes of cognition, involving attention, perception, encoding, types of knowledge, types of memory, and recall (Schunk, 2000, ch.4). Here, acquired representations are considered as largely given

by sensory input, translations modified to some extent as a by-product of processing.

Yet the sum of these processes is not equivalent with the experience of cognition (or of learning). Gestalt theory approaches the end products of processing with respect to the perception of patterns and wholes. Learning is the making of unified representations (Ash, 1995; Peterman, 1932).

Representing wholes is not just a happenstance of processing, but a meaning-motivated process. Now representations are understood to be acquired by acts of construction, purposive modification, and sense-making. Learning involves inductive discoveries which create meaning (Bruner, 1990).   This is the essence of constructivist theories.

Take note of the sharp edge here: representations are not mirrors of external reality, but situated interpretations. And so in all that we learn, we reflect our own situation. And then recall that we can never get entirely beyond historical and cultural circumstances.

The ability to know the Real is delimited to explication, beyond certainty.

Existentialist and more than a few postmodern philosophers (e.g. Sartre, Derrida), having overlooked the continual tacit impress of the Real (Polanyi, 1983), took one step over the edge and denied any foundational connection to the Real. Learning here is reduced to dealing with competing fictions.

The constructivist theories provide a bridge into societal theories with the recognition that meaning is negotiated together. Several health education related social learning theories (e.g. theory of reasoned action, theory of planned behavior, social cognitive theory) include social factors such as perceived norms and modeling of behaviors, but the individual remains the primary focus of attention. The theories just mentioned define learning in terms of an outcome of acquired representations, changed behavior (Rimer, 1997; Baranowski, Perry, and Parcel, 1997).

At the societal level of analysis, individual psychologic factors are no longer the primary focus.

Learning involves appropriating and negotiating the shared practices of a culture, coming to dwell in the formative perspectives from which we attend and respond in a situated field of activity (Polanyi and Prosch 1975; Dreyfus 1980). Schein's (1992) text on organizational culture exemplifies this level of analysis.

Argyris and Schon (1996) also discuss the question of how institutions learn. Single-loop learning occurs when identification and correction of errors does not involve the normative frame, when "correct" and "error" remain unexamined and the norm is maintained. Double-loop learning occurs when the organizationally practiced normative frame is called into question in the course of error identification and correction. But this form of learning reveals dysfunctional assumptions and thereby calls personal complicity and competency into question. Durable conscious and subconscious defenses consistently derail double loop learning.

Institutions learn through the actions of individuals, while individuals learn through the normative commitments and historically reiterated forms of institutions (Douglas, 1986). And so the societal level

of analysis must also be an interactional level of analysis, as all the theories mentioned in this category affirm. Agency is recast as inter-agency, and individual traits as communal potentialities.

In such mutual interactions, causes and effects are in a circular relationship: effects loop back to become causes of their own causes (e.g. society affects individuals, who then affect society, etc.). The matter becomes thornier yet when the parts (e.g. people) and wholes have multiple purposes of their own, and when mutual adaptation is an active modifier. The study of this type of ordinary and yet complex, adaptive, and non-linear situation calls for methods beyond linear analyses of dependent and independent variables. This is the province of the interpretive methods of the humanities, such as ethnography, history, and social systems science.

At a more general level of culture, Vygotsky's (1978) sociocultural theory emphasizes the primacy of the cultural context in shaping the content and processes of thinking. Wenger's (1998, p.226) communities of practice theory proposes that learning changes individual and community identities by changing the "ability to

participate, to belong, to negotiate meaning." Learning requires doing within context, and in doing, making sense of our situation, creating identities for ourselves and for others.

No consideration of the societal - interactional level (and indeed, no consideration of learning theory) would be complete without reference to John Dewey, whose 1897 essay on education remains a timeless and muscular statement of the fundamentally social and layered situation of learning (Dewey, 1897).

Specific to health behavior are Bronfenbrenner's (1979) ecological model, and the social action (Alisnky, 1969) and community building approaches (Minkler, 1997). These applied societal methods have produced only a marginal record of efficacy in changing health behavior (despite demonstrating other aspects of change), in part due to limitations in assessment methods (Sallis and Owen, 1997, p.419-22).

In the tradition of health education and health promotion (which can be taken to be in at least moderate alignment with primary care practitioner perspectives),

learning is equated with behavior change, a pragmatic thread common to multiple definitions (Glanz, Lewis, and Rimer, 1997, p.7-10). The rubber hits the road with lasting change in individual action. It is worth mentioning that theories of practice provide insights into tacitly negotiated, embodied, and enacted learning (Bourdieu, 1990). However, this practical societal epistemology is quite different in intent from the pragmatic interests of health educators. It may nevertheless have much to offer.

The health education definition maintains a steadfast insistence on material results. Yet it reflects the individualistic focus of modern American culture, supported by a mind-based level of analysis. The primary focus on the individual tends to remove the societal context from critique, while simultaneously externalizing "the problem" as someone else's behavior, thereby denying aspects of our complicity. These commitments, coupled with linear methods of study and distant (versus involved) knowledge practices, arguably overshadow systemic societal level opportunities for understanding and change.

Behavior change remains the elusive holy grail of health education. As Glanz states in passing, "...there are currently few health issues for which a variety of demonstrably effective strategies are known" (Glanz, Lewis, and Rimer, 1997, p.353). A capable counterpoint to this appraisal is provided in an extensive report by the Center for the Advancement of Health (Center for the Advancement of Health, 2000). Perhaps there are avenues of understanding individual action through improving our explication of the complex situation and interactivity of human agents.

In summary, definitions of learning depend on level of analysis. At the brain level, learning is the selective processing of stimuli, and the creation, amendment, and calling forth of associational networks of neurons. Processing is a complex bio-evolutionary activity involving interactions among multiple routines, occurring largely below the threshold of consciousness. At the level of the minded person, learning is acquired representation. It involves cognitive processing and (leaving aside behaviorism) the construction and discovery of meaning. But the learning of practices may reside in un-representable potentials for presentations. At the

societal - interactional level, learning is the co-
evolution of identity accomplished via participation,
belonging, and negotiating meanings within socio-cultural
contexts. This involves mutual interactions across levels
(e.g. brain, minded person, and society; or individual,
organization, and culture). Individual health behavior
change is one learning outcome of interest, one which
rests on navigating the quotidian world of layered human
complexity. Linear knowledge practices are not adequate
to the task of understanding learning and health
behaviors, which are fundamentally non-linear and complex.

CORE PURPOSES OF PRIMARY CARE

The quality of learning in primary care might be
approached from a different angle than asking how learning
happens or where the locus of learning resides, by asking
what should be learned and (most fundamentally) why.
Medical encounters have multiple purposes (e.g. bodily
care, reduction of anxiety, negotiation of the sick role,
etc.). In the transactions of the clinic, learning occurs
that ought to be relevant to those purposes. Purposes
provide the systemic orientation, the intentional context,

the transcendent design environment of the clinic. At
issue then is defining the core purposes of primary care.
In social systems methods, this step is an antecedent to
defining   problems   or   to   determining   solutions
(Gharajedaghi, 1999, p.116).

When one critiques a social practice, it is with some
sense of an alternative in mind. That is to say, every
critique emanates from a standpoint, and points toward an
end or ideal. But that ideal is often under-developed,
either indicated as a vague region for improvement, or
inferred through negation by statement of what is not
desired. To approach the purposes of primary care is to
explicate the cultural, historical, and anthropological
situation of a complex social practice.

It is a matter which has not often been addressed
explicitly. The direct literature is recent, and despite
being relatively scant is remarkably rich. Besides
direct sources, there are indirect sources in medical
history, phenomenology, and anthropology. Furthermore,
this is a territory of common lived experience. But why
have the purposes of primary care largely been taken for
granted, as a given, and treated as if beyond question?

The research preference for simple and small questions makes raising "messy" and big questions (e.g. the identity of core purposes) all the more formidable. Yet it is precisely by attention to the realm of complex and big questions that many small (and not so small) problems might be dissolved.

The human purposes pursued in health care run from the gross to the exceedingly subtle. Few among us, if asked, could adequately express the full breadth of motivations present in a medical encounter. Attending to bodily ailments is an easily owned purpose, but who might speak fluently of the re-affirmation of personal identity called into question by medical crisis?

To ask about core purposes is a double-loop learning project, challenging what we should (and should not) be doing. It is therefore subject to resistance that is well shielded from view (Argyris and Schon, 1996). This is all the more the case because health care practices might result in life or death outcomes. Certitude tends to be amplified precisely where questions prove most disturbing. The surgeon cannot ply his steel in doubt. Patients as

well face existential uncertainty in medical crisis, and desire belief in the care and trust in the care givers.

Core purposes present a complex topic for inquiry; they can be exceedingly subtle; and inquiry may face resistance. These abiding characteristics have all contributed to the languishing of a conspicuous question.

Focusing The Question

Purposes can be defined as the role of a system in its larger, containing environment. Purposes provide the context within which structures, functions, and processes should exist, the greater or ultimate rationale. Structures in this sense includes actors and relationships, inputs, and means for action. Processes are the actions, interchanges, and understandings that occur. Functions are the outputs, results, effects, and immediate ends of action (Gharajedaghi, 1999, ch.5).

In different terminology, Liss (1996) provides a valuable analysis of the concept of a goal. Goals can express a desire, or a norm, or a potentiality. Goals can

be inherent (as an essence), or extrinsic (as a social construction) (Pellegrino, 1999). Goals guide action, motivate, and symbolize an enterprise. Final goals express ends, defining what is to be achieved, while instrumental goals tend to be more restricted and functional or operational (Liss, 1996).

Ackoff (1999, p.55) differentiates between ideals, goals, and objectives. Ideals are ends that cannot be plausibly achieved, but ever approached. Goals are desired outcomes that can be achieved in some time frame, while objectives are achievable, but over an unspecifiable longer term.

Pellegrino (1999) distinguishes ends from goals and purposes. He equates ends with intrinsic essences, the *telos* of medicine in the human activity of the clinical encounter. Ends confer the ethical basis for practice. Goals and purposes he relegates to socially constructed uses, which may or may not be in alignment with the ends internal to the practice.

Purposes will be taken herein to mean final and often tacit ends inherently sought through the social

transactions of primary care. They are better stated as ultimate concerns, or perennial transcendent ends, and in this sense they are never finally fulfilled.

A further exploration of what is meant by core purposes moves through several statements to arrive at a succinct response. First, return to the contrast between social structures and functions. Parsons (1951, p.24-6) defined a social system as consisting of networks of structured relationships between actors within a larger culture. *Status* represents the structure of inter-relationships between actors, while *role* represents the process, the patterns of interaction. Social systems (in effect) convene expectations which mutually orient actors, defining norms of action in situations. Actors have motivations, and negotiate their needs in the functional processes and structural contexts of social systems. It is roughly toward motivations and needs that the meaning of core purposes is first directed.

Motivations are multiple and not simple to snare. People engage in social exchanges in part to maintain their own sense of belonging, and to hold open the possibility of future exchanges. But one might

nevertheless discern motivations related to health care. What do people seek when they consult a primary care practitioner? What needs are present (voiced or not)?

However, there are purposes that exceed overt personal motivations and service requests, going beyond a consumer framework of understanding. What do people in the process of illness and healing require? This comes much closer to demarcating the fundamental territory of primary health care. The statement confers some requisite generality, but might be mistaken as largely a biologic or biomedical question. Furthermore, the intrinsically social nature of the illness experience is not highlighted.

What fundamental and legitimate human concerns are present in primary care medical encounters? This statement gets to the heart of what is intended by core purposes. The basic human concerns at issue involve more than an ill person - at the very least, there are also a practitioner and a societal context. But then, what is meant by fundamental and legitimate?

Fundamental suggests an enduring quality, those purposes which have deep experiential and historical ground. Fundamentally human implies that such purposes are intrinsic and not uncommon across cultures. These criteria mean that historical, anthropological, and phenomenological materials have something to offer in research.

The way a purpose is understood or transacted will not necessarily be the same over time or across cultures. Practices are "thick", locally conditioned, highly variable, means toward attaining a number of competing purposeful ends. However, there are some common "thin", transcendent human concerns which can be stated as core purposes (Geertz, 1973, ch.1; Walzer, 1994; Brown, 1991; Murdock, 1945). This is to argue for a larger case than needed, as this analysis is generally restricted to modern American culture. Nevertheless, the larger frame is a topic for further study.

A core purpose of primary care is recognized as legitimate with respect to its related practices being lawful; approval by the public and by the professions engaged in the related practices; and affirmation as a

matter of conscience. The legitimacy of a core purpose of primary care, quite apart from its associated practices, rests on recognition of its trueness to human experience, as well as its rightness. Practitioners' legitimacy rests on professional training, the support of claims to competent performance. Legitimacy involves determinations of what is right to do, and how to do it right.

At issue in legitimacy are definitions of the Good and right, whatever local forms they take. Health care is a Good long before it is goods, a commodity. Not an unalloyed Good by any means - the shaman was fearsome, too. It is a personal Good, a social Good, and a societal Good.

As a personal Good, health confers capacity for continued action (among other blessings) (Nordenfelt, 1996). As a social Good, the capacity of individuals impacts families and broader networks of communal association and interaction. Illness brings burdens of care and re-allocations of responsibilities. As a societal (or cultural level) Good, health and political stability bear on each other in several regards. For example, deviant behaviors are in part defined and

controlled through medical diagnoses and interventions. Norms of social justice are in part defined by the distribution of inputs to health. The health status of populations is part of collective societal capital. Epidemics have felled armies, destabilized societal arrangements, and toppled governments, radically altering world history (Diamond, 1997; Temkin, 1977). Hence the Good of health long ago became a legitimate matter of societal regulation and governance.

The definition of that Good involves a set of practices deemed right, which are deployed righteously - by designated practitioners, for proper purposes, directed to appropriate beneficiaries, at personal, social, and societal levels. The qualifier of legitimacy contributes to an appreciation of the interests of several parties involved in negotiating multiple core purposes.

When the somewhat differing Goods of multiple beneficiaries are all at stake in one social transaction, rest assured there will be grounds for negotiation. With the increasing complexity and specialization of societal arrangements, a host of recent beneficiaries has arisen. The purposes of patient, family, practitioner, medical

college, pharmaceutical industry, health care organization, insurer, regulatory agency, lawyer, and society, are all at the table shaping the encounter. It would help to distinguish core purposes from secondary purposes.

Core purposes are <u>fundamental and legitimate</u>. Given the above definitions, several the interests of modern American health care organizations are not fundamental to health care. Some may be of questionable legitimacy as well, but that will not be taken up at this time. Consider that health care organizations must attend to inter-institutional relationships, satisfy shareholders, meet the payroll, and cater to the interests of various professional groups. These are essential purposes in the context of our time and place, but they ought to be secondary to the enduring purposes in the transaction of care.

As society becomes more complex, secondary purposes eventually so overshadow core purposes that some core purposes either become lost or radically distorted (Baume, 1998, ch.13). This process is not necessarily driven by disagreement over the core purposes, but conceivably by

the gradual encroachment of emergent levels of focus. We become distracted by intense mundane demands, by unavoidable secondary games that demand high concentration and significant resource allocation. This is the context within which organizations and practitioners typically work.

Whose core purposes are primary? Patients and families, practitioners and societies, each have a valid historical and ethical claim to primacy. Nature, holder of the human condition in the tidal sea of life, has a tacit claim that trumps them all.

To speak of Nature as having purposes (as did Aristotle in terms of final causes) obviously refers to purposes of a different order, known in a different way, than those of individual cognitive stakeholders. One might discern the purposes of Nature (from the Latin *natura*, birth, to be born) in the trajectory of life, and in the course of illness, healing, and eventual death. Nature is the immanent presence unfolding time to live, time to die, and ways to proceed. This is negotiated with medical technology.

The purposes of Nature might be termed biological, with certain and regrettable loss of spiritual meaning. The Greek term *physis* (the root of physician) is more adequate in its pre-Socratic meanings, on the order of Being itself, spontaneous emergence and unfolding (Heidegger, 1959, p.61), dynamic becoming (Peters, 1967), breathed into enduring being. To the ancients, Nature contained moral essence, intrinsic Good, Sacred presence. To respectfully accommodate or cleverly contravene Nature remains a pivotal matter in health care.

The core purposes of health care are negotiated among these five primary "stakeholders" - patients, families, practitioners, societies, and Nature. The claims of insurers and purposes of stockholders, etc., are historically secondary, though their purposes might not be substantially different in kind from other human stakeholders.

In summary, the core purposes of primary care can be understood as fundamental and legitimate human concerns intrinsic to healing and illness, negotiated in medical encounters. Medical care is a social systemic act on three levels, involving the individual (often the

patient), the social (family and practitioner), and the societal. Socio-medical activity is permeated by Nature, the cardinal order of play, the ultimate negotiant in a self-dialogue. This comprises the field within which human purposes must next be determined.

From the foregoing discussion, several research orientations may be extracted. To ask what people want leads to the literature on satisfaction. To ask what people need points toward needs assessments and quality assessments. Inquiry about enduring purposes implies a medical historical approach. The legitimate interests of multiple stakeholders (including Nature) directs one toward health psychology, phenomenology of illness, sociology, social justice, biology, global ecology, and sacred medical practices. Negotiation of purposes suggests the study of power, communication, and cooperation. The potential for distortion of core purposes again directs one toward historical literature and the phenomenology of illness, disability, and dying; suppressed traditions such as spiritual healing; cross-cultural medical practices; and emergent outcomes in human affairs. What follows then is a progress report, a condensed commentary on the most germane resources.

In the last few years, several texts have directly and extensively addressed core purposes. These will next be introduced, and used to expand upon key topics. Then the discussion will be gathered into a novel framework of seven core purposes of primary care.

Core Purposes Literature

Arthur Kleinman (1988), psychiatrist and medical anthropologist at Harvard University, addressed the importance of explicating core purposes with these words:

> Yet, until we pose the question of purpose it is not possible to hold the profession or the practitioner accountable. Nor can we know what patients should ask of health care. By not asking, moreover, we acquiesce with the dominant economic cliches of our age: namely that the doctor-patient relationship is no more and no less than any other commercial relationship between a purveyor of services and a customer, that the medical profession is a conglomerate whose purpose is to control a share of the market.
> (Kleinman, 1988, p.253)

His response is that the universal moral core of medicine involves the care of illness: interpreting the meanings of illness and the particular experience of individuals. This he holds as more fundamental than the

control of biomedically defined disease states, which in our society has distorted and displaced caring.

The most ambitious attempts to define core purposes have emanated from a Hastings Center international project on the goals of medicine, pursued since 1992. Three books and one report have direct bearing. The first book, *The Goals and Limits of Medicine* (Nordenfelt and Tengland, 1996) comes from the Swedish group at the University of Linkoping. Nordenfelt (1996) locates medicine as a set of clinical practices which are a subset of broader health enhancement strategies. He proposes that medicine could be defined beyond biomedical diagnosis and treatment as including various components of rehabilitation, psychologic care, and social work on the health care side; and components of prevention, education, legal health protection, and environmental reform on the health promotion side of health enhancement activities.

Another contributor to this text, Hellstrom (1996), raises questions about legitimacy of purposes, and limits of professional competencies. He sees education as a goal if it emancipates the patient and develops the doctor's understanding. The point is well taken: education

certainly can be an end, a purpose. But at a "thinner" level of analysis, it is a means (or an instrumental goal) and not an end. A person might go to school for the purpose of education as an end in itself, but in the context of health care they use education as a means to stay well or get well, etc. When establishing a statement of core purposes, it is important to maintain a consistent level of analysis.

Hellstrom agrees with Kleinman that healing, tending to the patient's lived dilemma, is central to medicine, thereby establishing the encounter of a patient's personhood as a goal. He briefly indicates a range of proposed goals: saving life, relieving suffering, curing illness, promoting health, and reduction of morbidity and mortality. The theme of psycho-spiritual illness crops up in his mention of the management of meaninglessness and the escape from negative self-image through illness. Hellstrom also speaks of fostering choice and autonomy, reflecting the transaction of social power relations in medical visits.

In the second Hastings Center book, *The Goals of Medicine* (Hanson and Callahan, 1999), a 1996 goals of

medicine project consensus document is reprinted (Hastings

Center, 1996). It lists four proper goals:

> (1) the prevention of disease and injury and
> the promotion and maintenance of health; (2)
> the relief of pain and suffering caused by
> maladies; (3)the care and cure of those with a
> malady, and the care of those who cannot be
> cured; and (4) the avoidance of premature death
> and the pursuit of a peaceful death.
> (Hanson and Callahan, 1999, p.xi)

These four goals are traditional to medicine.

Indeed, the consensus statement seems at first to say

little more than "we take care of sick people." However,

given current technological prowess, the meanings of these

expressions are in need of thoughtful reinterpretation.

On careful review, the areas of concern represented are

cure of the body, attending to suffering, care of the

person, enhancement of health, and minimization of

morbidity and mortality. With the pursuit of peaceful

death, there is a discernable note of accommodation to the

Real, accepting the inevitability of Nature.

The meaning of malady is key to understanding these

goals. It is defined in the following terms:

> The term "malady" is meant to cover a variety
> of conditions, in addition to disease, that
> threaten health. They include impairment,
> injury, and defect. With this range of
> conditions in mind it is possible to define

> "malady" as that circumstance in which a person
> is suffering, or at an increased risk of
> suffering an evil (untimely death, pain,
> disability, loss of freedom or opportunity, or
> loss of pleasure) in the absence of a distinct
> external cause. The phrase "in the absence of
> a distinct external cause" is meant to
> distinguish the internal sources of malady from
> a continuing dependence upon causes clearly
> distinct from oneself (e.g. the pain caused by
> torture or civil violence). The harm, in
> short, comes from within the person, not from
> the outside.
>
> (Hastings Center, 1996)

The above definition is a reaffirmation of the isolated individual as the locus of health, disease, and intervention, and it marks a conscious professional denial of interest in social causes. Within this definition lurks one dark facet of a broader core purpose of medicine: the reiteration of the social status quo.

The authors of the Hastings Center consensus report are aware that issues of limits and legitimacy surface here. Should medicine attend to violence in society, and to environmental degradation? How far should medicine go to relieve suffering? The report develops what clinical medicine should be largely from the biomedical perspective of what it currently is. The report does not attend to the potentialities of what it ought to be, nor to the larger frame of health care practices in the context of

culture and natural environment, and nor to the socio-
economic sources of health and disease.

Pellegrino (1999) emphasizes in his fine chapter that
medicine exists in response to the universal phenomenology
of illness. The same ends of medicine are present today
as in the time of Hippocrates. Pellegrino states them in
this manner:

> ...medicine exists because humans become sick.
> It is an activity conceived to attain the
> overall end of coping with the individual and
> social experience of disordered health. Its end
> is to heal, help, care and cure, to prevent
> illness, and cultivate health. Medicine,
> itself, is a true art because it pursues its
> ends with knowledge and understanding for the
> good of its object - the sick person or social
> group - and in a practical way.
> (Pellegrino, 1999, p.62-63)

These are chiefly the same areas of concern presented
in the Hastings Center consensus report, albeit with some
acknowledgment of social goods. The intrinsic ends of
medicine, according to Pellegrino, are to be located in
the practices themselves, in the phenomenology of illness,
in the clinical encounter.

Pellegrino goes on to speak of the primacy of the physician's covenant with the patient, uncompromised by societal and financial interests:

> When serving the ends of medicine as medicine, the physician's focus must be his covenant of trust which must not be compromised by other roles of, for example, the physician as gatekeeper, entrepreneur, guardian of social resources, or by the economic pressure to undertreat.
>
> (Pellegrino, 1999, p.65)

This is (with all due respects) a misplaced statement of ideals, a trenchant fiction that deflects attention from the real and abiding nature of the clinical transaction. Attending to the real conflicts of interests opens the possibility of improving the fairness of the exchange and the lot of patients. The intrinsic ends of medicine always include and hold in dynamic tension the goals of patients, families, practitioners, and society (Eisenberg and Kleinman, 1981).

Most pointedly, the clinical encounter is an enduring and complex socio-medical exchange. Roles (sick person, healer) are granted (Parsons, 1951, ch.X), societal norms are conveyed, goods are prescribed, wealth is transferred, and (with fortune) symptoms are abated and souls are soothed. Human participants have a core purpose of

obtaining fair exchange in this enigmatic transaction, one which is irreducible to monetary terms. Fair exchange is not incidental to medical care, but intrinsic to medical care, regardless of the identity of the payer. We do not present as patients to just obtain healing, but to socially negotiate healing as an exchange. That social negotiation additionally involves Nature. Examples of this aspect of negotiation are found in the Native American Coyote stories related to healing (Storm, 1972).

If this fundamental fact has been overlooked, perhaps that is because it unmasks transactions reliant on subtlety for power. Patients, families, practitioners, and society, all have justifiable interests, financial and otherwise, mutually transacted in the context of clinical medicine. The fairness of the exchange belongs on the table in full view, without the pretense of perfect altruism, the denial of multiple legitimate beneficiaries, the negation of negotiation, or the dismissal of costs as incidental. Fair exchange is a core purpose, and a crucial dimension of social legitimacy.

Gracia's (1999) chapter provides an exposition on the cultural transformation of the meaning of health and

disease, which casts some light on spiritual purposes. He attributes to the primitive Mediterranean religions the equation of health with the unmerited gift of grace, and the equation of disease with disgrace (sin being the refusal of grace). With the (post-Socratic, Hippocratic) Greeks, health became equated with *kosmos*, natural order, and disease with *chaos*, disorder, unnatural conditions. Now in the modern era, we have reduced Nature to mechanical necessity, and have come to disregard the gift of grace.

The meaning of disease thus becomes transformed into a capricious biological expropriation of happiness, an impersonally determined loss of bodily autonomy, a random biographical affliction. This restriction of meaning (moving here in a direction quite different than Gracia) is one which pervades modern life and is simply more pronounced in the crisis of illness. It binds an enduring hunger for the transcendent. The human appetite for transcendent meaning is a facet of the intrinsic spiritual purposes of medicine. Meanings may change over time and culture, but the quest for meaning does not (Frankl, 1992).

It is perhaps unusual to think of making meaning as not only a cognitive enterprise, but a spiritual one. Illness presents an existential predicament, a profound encounter with uncertainty, a fracturing of unified identity and personal significance. The embodied self is homeless in a disrupted body, in exile, uncoordinated with the world (Toombs, 1992). The quest for meaning in this situation calls forth our ultimate concerns. What is this supplication for the ground of Being, if not spiritual?

This is a reminder that from the earliest times, healer and spiritual guide have been combined in a single role (Mails, 1991). With increased social specialization, at least three major roles have been broken out: physician, pastor, and teacher. It is still the combined functions that are humanly called forth daily in primary care. The legitimate scope and identity of medico-spiritual functions in a pluralist society are at issue.

Those issues can be navigated better when the religious is not conflated with the spiritual. Religions are bounded organizations expressing concerns with the Sacred through their various great traditions. Spiritual concerns are universal. The Sacred both informs and

transcends bounded organizations. The religious is the legitimate domain of the pastor, with all that entails in the way of belonging and creeds, deities and entities, and forms of worship.

There are still spiritual needs present in primary care, beyond those referred to appropriate religious specialists. They are not esoteric but intrinsic concerns, so ordinary that we overlook their spiritual identity. The quest for meaning is one such fundamental concern. Accommodation to the Real is a second, involving acceptance of our condition with its attendant uncertainties. A third is immanent in Being itself: the presence, witness, and compassion that are (or are not) innately offered in meeting.

Refining the language of affliction will help to enrich the understanding of some core purposes. Cassell (1999) makes a vital distinction in *The Goals of Medicine* between the distresses of pain and suffering:

> *Pain is this entire process of sensing, interpreting, and modulating the nociceptive process, assigning cause, anticipating course, and determining response.*
> (Cassell, 1999, p.103; italics in original)

> Suffering is a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity.
>
>   (Cassell, 1999, p.106-7)

Hence pain and suffering are independent of each other, but can, and often do, co-occur. Pain is mistaken as only direct neural nociception, for it is a multi-tiered phenomenon. Suffering is a lonely state of internal conflict, resistance to the present Real in preference for a desired future or a recalled past. And from suffering emerges a call that healers cannot well refuse. To designate it a moral duty to respond (as will be done later) belies the deep and unpremeditated root of that response. Here another core purpose has been explicated: attending to suffering.

The Hastings Center report, *The Goals of Medicine, Setting New Priorities* (1996) defines disease, illness, and sickness:

> By a "disease" we will mean a physiological or mental malfunction based on a deviation from statistically standard norms, that brings about illness or disability or increases the chance of a premature death. By "illness" we will mean a subjective feeling on the part of a person that bodily or mental well-being is

> absent or impaired and thus ordinary
> functioning in life is impaired. By "sickness"
> we will mean society's perception of the health
> status of a person, ordinarily encompassing an
> outside perception that the person is not
> functioning well, mentally or physically.
> (Hastings Center, 1996)

Thus illness is a common territory of unique personal experiences, while disease is a normative professional objectification, and sickness is a normative social objectification. These differential definitions provide evidence of the standing tensions between patient, practitioner, and society.

The third Hastings Center book of interest, *Enhancing Human Traits: Ethical and Social Implications* (Parens, 1998), discriminates between remedial treatments and improvements above normal. Enhancement augments normal conditions. Cosmetic surgery, medical enhancement of sports performance, high function psychopharmacology, life extension, and genetic modification, are all examples of such augmentation. So too are vaccinations and fluoridated water. The shamanic resort to hallucinogens is an augmentation of esoteric spiritual awareness. The consumption of herbal tonics and dietary supplements is

not only remedial and preventative, but augmentative, for
the expansion of normal capacities.

However, the education of children, and more
generally, educational, psychological, and social
interventions aimed at maximizing human potential,
resilience, and coping skills, are also augmentative.
Given these latter examples, augmentation can be
appreciated as familial and social nurturing, extended as
health promotion aspects of primary care.

With the expansion of medical power, augmentation is
on the verge of explosive growth. The limits and
legitimacy of augmentation will be matters of great debate
in the next decades. But take note that augmentation, the
desire for increase, is an insatiable and primal human
hunger (Young, 1991), our earliest prayer which could not
fail to be present as a core purpose of primary care.

There are a number of other significant texts and
articles which directly shed light on the topic of core
purposes, make fine distinctions, and highlight the
details. Among worthy resources are Baume, 1998; Cassell,

1997; Good, 1994; Kleinman, 1980; Little, 1995; McWhinney, 1972; White, 1988; and Williams and van der Reis, 1997.

The Seven Core Purposes

From what has been adduced a framework of seven core purposes can be organized. The framework presages a novel way of evaluating learning quality and practice quality in primary care. It is a nascent bud, an outline not yet subjected to the rigors of critical scrutiny, advanced here with this proviso.

Table 1. Seven core purposes

Ecological	sustainable biosystemic balance
Societal	good of the body politic
Spiritual	quest for meaning
Moral	attending to suffering
Augmentative	enhancing capacities
Corporeal	bodily care
Economic	fair exchange

The seven core purposes are encapsulated in Table 1. Each core purpose will be briefly defined in turn, along with preliminary evidence of their existence.

The ecological purpose is aboriginal in derivation, concerned with the balance of the human community in its more than human context. David Abram (1996), speaking of the role of tribal shamanic healers, says:

> Without a continually adjusted awareness of the relative balance or imbalance between the human group and its nonhuman environ, along with the skills necessary to modulate that primary relation, any "healer" is worthless - indeed, not a healer at all.
>
> (Abram, 1996, p.8)

While ecological purposes have changed in cultural valuation and local expression, they are nevertheless present and accounted for. Minimizing antibiotic use to delay the development of microbial resistance modestly reflects ecological purpose in modern clinical practice. Environmental health engineering programs, from clean water to sewage removal, have done more to preserve health than has remedial medical care. While engineering is not a primary care discipline, it has taken on a portion of the ecological function. The view has been toward human benefit more than the well being of Nature's biosystems.

But a more comprehensive movement toward a clinical, social, environmental medicine - regarding the health of humans, societies, and the health of the biosphere as they are interrelated - has been brewing for years (Ausubel, 2001; Rosenblatt, 1997). Ecological purposes are fundamental and to some degree legitimated. Such purposes place Nature in our moral community, while positioning humans in Nature's community. This intrinsic purpose has been overlooked by current commentators on the goals of medicine.

If the boundaries of ecological purposes are Nature and the biosphere, the boundaries of societal purposes are of a collective human order, the good of the body politic. Society is a legitimate stakeholder in the transaction of health care, but what is at stake? Societies are concerned with their own continuance. This relates to not only the continuation of a system of association, production, distribution, and ideation, but to the people who constitute the system. Excessive morbidity and mortality exact a cost on society.

Prevention and control of epidemic diseases as a societal interest take a place along side care of the sick

very early on in the history of medicine. In ancient China, Ho-Po, the River God, was placated with beautiful daughters, human sacrificial offerings to secure the communal Good (Waley, 1955, p.49). Now we accept requisite immunizations, offering an arm to inject for the common Good. Prevention is a dimension of societal purpose, albeit with social and personal benefits.

Preserving societal order is a double-edged politico-medical purpose. A measure of social justice eases dissent, and so it is wise governance to adopt redistributive policies (Diamond, 1997). Extending access to health care is one modern example. But the reigning societal inequalities and ideologies are also staunchly defended. Health care practices define and control deviancy, reiterate power relationships, and mirror the social systems of which they are part.

The arrangement of social power is re-conveyed (and opened anew for re-interpretation) via the dramas of authority in each medical interchange. The autonomy of the patient, the authority of the practitioner, and the interests of the larger societal order are actively negotiated (Katon and Kleinman, 1981). Whereas power

relations have a dynamic potential for change, explanatory models tend to be more static. Biomedicine's mechanistic explanatory models of the body and disease recapitulate the industrial culture, just as naturalistic explanatory models recapitulate their agrarian cultures.

Health care practitioners have always had a regulative function, serving not just patients and families and their own practitioners' guild, but also representing sanctioned societal interests. The individual patient has never been constituted as the sole beneficiary of professional medical practice. The tension of serving multiple masters comes with the job of healer. The play is in the balance of services rendered across a moral community. Societal concerns of this order were not recognized by the Hastings Center participants as a category of fundamental and legitimate clinical purposes. However, they did mention prevention and minimization of morbidity and mortality.

Spiritual purposes involve the quest for meaning. It has previously been mentioned that illness presents an existential dilemma, and that making meaning is spiritual work. Indeed, meaning is human medicine of the highest

potency. The alleviation of uncertainty via the exchange
of meaning is fundamental to medical practice, and goes
far to explain the power and authority granted to healers,
in whom we hope to find surety anew.

But certitude (when little is to be had) is a flight
from the Real, when the spiritual task is accommodation to
the Real. The heroic healer carries us through anxiety by
active courage. The wounded healer does so by graceful
acceptance. In either case, acts of Being convey the
medicine of meaning. Presence, witness, and compassion
are healing treasures (McKivergin and Daubenmire, 1994;
Savary and Berne, 1988; Seiden, 1996; Seiden, 1997; Fox,
1979), saving graces transferred as the spiritual core
purposes of primary care. What has been termed caring
(Phillips and Benner, 1994) belongs in the category of
spiritual purpose, as well as in the category of moral
purpose.

There are many moral dimensions to medicine,
involving duties of performance: a patient is not to
malinger, a practitioner is to protect confidential
information, etc. Attending to suffering is the
fundamental moral purpose, known as a theoretic duty only

after being experienced as an innate compunction. Cassell suggests that the expression of that compunction has changed over time, as we have come to appreciate more facets of the human condition (Cassell, 1999, p.111-112). Shogan (1988) develops the notion of caring as a moral motivation.

Suffering is an inescapable part of the human condition, disrupting the experience of the body, relationships, time, and space (Ferrell, 1996, p.23). Distinctions can be made between aspects of suffering: physical (reacting to pain, bodily dysfunction); mental (conflicts, double binds, worry); emotional (affective, anguish, grief, fear); spiritual (nihilism, abandonment, guilt, hopelessness); and social (isolation, stigma, social death). This is only a modest framework for understanding the lived territories of suffering that differ with each person, and that can only come to be known through attending to that person.

Cassell (1991, p.44-45) points to meaning, transcendence, and borrowed strength as methods of melioration of suffering. The dimensions of spiritual purpose are the medicines of moral purpose, in addition to

their intrinsic value. Cassell notes the ancient call to
attend to suffering, and the paradox that suffering is
often magnified by medical treatment. Why is this the
case?

> This lack is not a failure of good intentions.
> None are more concerned about the relief of
> pain or the restoration of lost function than
> physicians. Instead, it is a failure of
> knowledge and understanding. We lack knowledge
> because, in working within the constraints of a
> dichotomy contrived in a historical context far
> removed from our own, we have artificially
> circumscribed our task in caring for the sick.
>   (Cassell, 1991, p.46)

Attending to suffering is a fundamental and
legitimate purpose of primary care, but through education
in a mechanistic biomedical system, and work in modern
clinical contexts, some practitioners have sacrificed
adequacy in serving this purpose, while others have made
significant sacrifices to continue to be able to. The
issue involves systemic moral accountability perhaps even
more than individual moral accountability.

The augmentative purposes involve enhancement of
capacities, increases above normal conditions, and the
maximization of potentials. There are aspects of growth
(simple increase, change amount of a quality) and

development (change in capability and competence) (Ackoff, 1999, p.44).

Distinction also can be made between augmentations that decrease biomedical downside risks (disease prevention measures, e.g. vaccinations, fluoridated water) and augmentations that seek increase purely for perceived positive value (e.g. anabolic steroids for athletic competitive advantage, cosmetic surgery, teaching coping skills). This is a key difference between disease prevention and health promotion activities. Augmentative interventions can introduce risks, and so risk/benefit ratios must be considered in the dialogue on augmentative legitimacy.

Disease prevention has already been recognized as a societal purpose; it is reiterated here as an augmentative purpose along with health promotion and the other aspects of augmentation. There is little argument that prevention and health promotion are fundamental and legitimate purposes of primary care. The debate revolves around the extent of augmentative activities. Technologic and genetic tinkering for augmentation leads toward cyborgian, post-human futures (Gray, 1995; Fukuyama, 2002).

Corporeal purposes involve the care and treatment of individual bodies to decrease morbidity and mortality. These purposes are well recognized as the central objectives of biomedical practice. Indeed, so much so that bodily curative functions have come to overshadow other crucial purposes. Not only are other purposes dominated by corporeal purposes, but other corporeal approaches are dominated by biomedical ones. Thus ecological, spiritual, and moral purposes have become submerged, and alternative medicines marginalized. A Good, such as corporeal purpose, when realized in the extreme can become oppressive.

The final category, economic purposes, concerns fair exchange. Aristotle referred in his *Politics* (1988) to *oikonomos,* the management of the household, indicating that the right purpose of exchange was not primarily that of amassing profits. Patients, families, and practitioners, negotiate the complex exchange of healing (with the implicit and powerful presences of society and Nature) in terms that cannot be appropriately reduced to monetary value. Among the "units of exchange" are the sick role and the healer role; affirmations of identity; norms of behavior; commodities such as medical appliances

and pharmaceuticals; money; social power and authority; caring; relationship and being known; time; skills; and knowledge.

Conveyances in the dimensions of all the previously stated core purposes are tacitly evaluated within the economic purpose of fair exchange. Each human party wants satisfaction in terms of their accounting of fair exchange. The Goods of practitioners overlap and differ from the Goods of patients and families. Society enacts multiple regulatory measures to attain its Goods and its accounting of fair exchange, with the practitioner as proxy negotiator. Nature settles her accounts in the fullness of time.

What is given, and how does it accord with what is received, and with what is needed, by each party? The determination of fair exchange is a clouded calculus for which metrics are of little avail. Fair exchange is beyond accounting solely in monetary terms, but not beyond accountability.

Medical care provides a well worn path to poverty for the seriously and chronically ill. It has become an

irresistible mechanism for the transfer of wealth, and a tragic distortion of fair exchange. There is a trajectory from ill health to job loss to health insurance coverage loss to inability to bear the costs of care (Himmelstein and Woolhandler, 1994; Bartley, Ferrie, and Montgomery, 1999; Davis and Rowland, 1990). Material, social, and psychological effects of poverty then compound health risks (Shaw, Dorling, and Smith, 1999). The inflated costs and reduced benefits of health insurance coverage place many working people and their families at risk of falling into poverty through illness (Weiss, 1992; Rolde, 1992). Issues of social justice, poverty, and health equity are becoming more sharply drawn as disparities increase (Daniels, Kennedy, and Kawachi, 2000). The fulfillment of corporeal purposes through technological interventions has led to a systematic neglect of more economical and more humane opportunities residing in the other core purposes. These outcomes (intended or not) arise from the emergent economic purposes of the health care system. They serve as distressing reminders of how far American society has strayed from the core purpose of fair exchange.

Roter and Hall (1992, p.154-155) provide a telling example, reporting on a research intervention at a nursing home, wherein one group of residents were encouraged to take responsibility for and control of their own lives - to arrange their rooms and their daily schedules. They were each given a houseplant, and asked to be responsible for it. On other floors, residents were told that the nursing home was responsible for them. They were each given a houseplant, without a responsibility reminder. The former group experienced a 15% mortality rate, while the latter group experienced a 30% mortality rate, in the following year and a half.

A chat and a houseplant, through which matters of significant human consequence were negotiated and <u>learned</u>, cut the mortality rate in half. Attending to <u>purposes</u> other than corporeal - shifting power (societal), making meaning (spiritual), and thereby promoting health (augmentative) - accomplished what no amount of corporeal biomedical intervention could have done. Here, learning and purposes impacted quality of <u>practice</u>, seen in remarkable health outcomes attained at little risk and minimal cost. Even caring, for all its intrinsic value,

may also demonstrate economic benefits (Issel, L.M. and Kahn, D., 1998).

An empowering conversation with residents of a nursing home (not seen in the context of presenting patients in a clinic) does not at first appear to be within the province of primary care. Nevertheless, it elegantly accomplished a portion of what primary care medicine is supposed to accomplish. The very conception of primary care is called into question here.

Recall that the overwhelming majority of all health care is self care, family care, and community care. To take primary care as beginning with professional medical practice is an error (Cassell, 1997, ch.1). To take primary care as composed exclusively of biomedical interventions is to compound the error, and to reiterate the social distortions of core purposes that arise among the emergent purposes of health care organizations. Observing the misfit between practices and purposes reveals opportunities for improvement.

The seven core purposes of primary care are intrinsic to medical practice, tacitly transacted in every primary

care encounter, whether attended to or not. They are the
enduring dimensions of human value, indicating the bases
for quality assessment in learning and practice. The
choice is between addressing them consciously and
conscientiously, or unconsciously and unaccountably.

Providers of primary care (individual and
organizational), and the citizenry, have a conjoint
responsibility to attend well to all the fundamental and
legitimate purposes. To the extent that the participants
in primary care fail to address the core purposes
competently, and fail to even adequately recognize those
purposes, they are in default on a covenant, and
requisite value cannot be delivered. With the over-
dominance of corporeal purposes, and the distortion of
fair exchange to monetary profit, the ethics of human
relevance in primary care is starkly at issue. The seven
core purposes are the neglected yet essential avenues for
improvement of quality of learning and quality of practice
in primary care.

Seven Core Purposes And The Biopsychosocial Framework

Engel (1977) defined the biopsychosocial (BPS) framework of care as an alternative to the biomedical framework. His approach was based on a systems view of determinants of health, moving from the biological level of organic diseases to the psychological level of the person, and then to the sociological level of the person in their milieu (e.g. family and work contexts). Engel's approach necessitated re-designing the training of physicians. Change in educational institutions does not come easy (Brown, 2000; White, 1988). But the then-new specialty of family practice endorsed the BPS framework, and included it in training. What does the seven core purposes (7CP) framework offer as a guide for practice, that the BPS framework does not?

The BPS framework is based on a theoretical system of <u>logical levels</u> corresponding with material (or reified) referents - biologic, mental, and social entities. The 7CP framework is based on a practical system of <u>phenomenological patterns</u> - the human purposes of primary care. Phenomenological reduction identifies the structure

of meaning, the intentionality of consciousness (Svenaeus,
2000, p.77).

There is a subtle but important difference of intent.
The BPS framework is intent on a deeper than biomedical
understanding and diagnosis of <u>patients</u> as people with
problems in psychological and social contexts. The 7CP
framework is intent on a deeper understanding and
diagnosis of the mutual negotiation of human purposes for
<u>all the participants</u> in the enterprise of primary care.
The ownership of mutual participation and distinct
interests in the negotiation, particularly on behalf of
practitioners, is more emphasized in the 7CP framework.

The contrast in systems approach (from logical to
phenomenological) leads to a different view of the
territory. The BPS framework does not recognize the
economic purposes of fair exchange, but instead might take
note of the patient's socio-economic status, or perhaps
personal monetary concerns. Nor does the BPS framework
mention ecological, spiritual, moral, or augmentative
purposes. The 7CP framework's <u>corporeal</u> purposes are
roughly analogous to the BPS framework's <u>biological</u>
category.

The BPS framework's psychologic category catches portions of the patient's moral, spiritual, and augmentative purposes and experiences, but encases them in terms of the medical discipline of psychology. In that context they become compressed and deformed, emerging in a professional language of pathology. The moral, spiritual, and augmentative purposes of the practitioner remain hidden from view. The BPS's social category is also angled more toward the patient's social conditions, and less toward the societal presences that inform the visit. In sum, the BPS framework does not distinguish as clearly between human purposes as does the 7CP framework, and hence cannot elucidate as well the synergies and conflicts between purposes for all participants.

To perform competently as a clinician in terms of either framework calls for professional retraining. Here, the BPS framework holds the advantage in familiarity (and the distinct disadvantage in relevancy), as it reiterates professionally recognized categories of knowledge. What type of knowledge, and what knowledge practices, are necessary for competency in a 7CP framework? Not so much theoretic and expert knowledge established from afar, but practical knowledge established from involvement. This

may be referred to *phronesis*, practical wisdom, "common knowledge of the second kind" (Bella and King, 1989). The ongoing crises in health care - truly crises of purpose rather than merely monetary constraints - may make the opportunities in such retraining appear attractive enough to overcome conjoint academic and professional resistance to change. The 7CP framework harbors the potential to guide more deeply humane practices in primary care.

METHODS

Learning in primary care medical visits is (like many ordinary human social activities) complex, layered, and mutually interactive. That is to say, it has properties of a system. How should such topics be approached in terms of methods, to explore what constitutes the quality of learning in primary care? The choice of methods is best approached by matching the method to the character of the research question, rather than restricting the question to match the method.

It is helpful to distinguish among three types of problems, following Weaver (1948). Problems of simplicity are those with few parts and lawfully determinate interactions (e.g. calculating the rate of acceleration of a falling rock). Problems of disorganized complexity are those with many parts and lawfully indeterminate (random) interactions (e.g. the behavior of gas molecules in a closed space). Problems of organized complexity are those with many parts and non-lawfully indeterminate interactions, somewhere between lawful and chaotic (e.g. the actions of individuals at a dance, or a clinic). They

are problems with multiple factors which act as inter-
related wholes, or systems. Weaver noted the paucity of
methods and the urgent priority for dealing with the
latter category of problems.

The culture of science has few well established and
legitimated methods for revealing systems of social
practice, for mapping the context of human activity
systems. Weaver considered mathematical and statistical
methods, the instruments of certainty and probability, to
be inappropriate for the understanding of organized
complexity. The latter is the territory of plausibility
(Rescher, 2001).

Weaver's advice should not be taken to imply that
quantitative modeling of social practices is improper. It
is just insufficient to the scope of inquiry necessary for
comprehension. But more than calculations are at issue
here.

The normal science approach is to break complex
problems into simple parts, analyze the parts, and thereby
arrive at knowledge of the whole through the sum of the
parts. An alternate approach, known as systems thinking,

is initially synthetic and inductive: seeking to
understand the whole as a part of a larger frame, and then
explaining roles and functions in terms of that larger
frame. Ackoff states the case admirably:

> Analysis focuses on *structure*; it reveals *how
> things work*. Synthesis focuses on *function*; it
> reveals *why things operate as they do*.
> Therefore, analysis yields *knowledge*; synthesis
> yields *understanding*. The former enables us to
> *describe*; the latter, to *explain*.
>
> (Ackoff,1999, p.17-18)

Both quantitative and analytic methods were carried
over from the bench sciences into the social sciences, in
the process of reaching for the certitude and cultural
legitimacy attained by the bench sciences, and previously
held by the church as a dominant European socio-political
institution (Wallerstein, 1999, ch.14). The fundamental
error here is in assuming no difference between natural
sciences and social sciences, and hence detecting no need
for different methods. Problems of organized complexity
were (and still are) mistaken for problems of simplicity
or problems of disorganized complexity.

Problems of organized complexity, when involving
human activity systems, require methods that are both
systemic and interpretive. Neither systems thinking alone

nor human judgement alone suffice. These are encompassed in what are known as "soft systems" methods (Ulrich, 1994, p.329).

INTERPRETIVE METHODS

Interpretive methods are needed to understand the situated complexity of human activity systems. What is the basis for interpretive understanding? Dilthey contrasted *verstehen*, understanding, with *erklaren*, explanation (Harrington, 2000). This distinction is also discussed in terms of *reasons for* versus *causes* of social actions (Borger and Cioffi, 1970). Dilthey proposed that empathy was at the root of understanding, while Weber posited understanding on more empirical grounds (Ekstrom, 1992). Heidegger presented understanding as an interpretive interplay between the background of cultural practices constituting the lifeworld (*vorhabe*); the theoretic or conceptual construction of a situation (*vorsicht*); and the actions of individuals dealing with a question at hand (*vorgriff*) (Heelan, 1997).

Understanding, whether given by intuition or constructed through deliberate hermeneutic inquiry, is a synthetic process and not a simple matter of analytic method. Once cannot be certain of correctness. People come to both understand and misunderstand each other. There are worlds of substantial differences in the interactions of cultural conditioning, categories of thought, and particularities of gender, age, and life experience. Woven through it, human universals remind us of pre-conceptually shared natures (Brown, 1991), the possibility of grounds for understanding that bridge the subjective-objective dichotomy (Heidegger, 1975, p.103).

How are misunderstandings recognized? From a methods standpoint, if research subjects review and comment on research conclusions, then readers can see areas of agreement and disagreement in interpretation, and better judge for themselves. The domination of the voice of the researcher over the voices of the researched is to some extent thereby delimited. This strategy also provides a basis for establishing internal validity.

Interpretation of complex social reality requires judgment, a form of inductive thought. Accounting for

values and purposes is ascribed by Aristotle to *phronesis*,
practical wisdom. Practical wisdom stands in contrast to
episteme, theoretical knowledge. *Phronesis* requires
experience of the particulars of a social context or
situation under study (Flyvbjerg, 2001, p.55-7). That
particularity of experience is required for the
understanding of meaning conveyed in phenomenological
accounts.

By phenomenology, Husserl (1973) referred to a method
for recovering the absolute essences of cognition.
Heidegger moved phenomenology toward ontological
hermeneutics, interpreting the meaning of situated Being
rather than of pure cognition (McCall, 1983, p.63),
working with what is given or reported as experience.
Experiences are the primary data, reflected upon to
understand their intentional framing.

Phenomenological assessment is not a difficult
concept. Every act of cognition has two poles: that which
is attended to, and the "meaning frames" attended from.
Seeing a hungry lion on the prowl, a person <u>attends to</u>
(focuses on) the lion, and might <u>attend from</u> the meaning
frames of "carnivore" and "personal danger". The

psychological experience is yet a different territory: terror! The locus of the meaning frame is in the inter-relationship of person and lion, arising in the context of meeting. Phenomenology in this regard is largely a methodical injunction to focus on where people attend from, to discern frames of meaning.

What would be learned from listening to the experiences of multiple stakeholders in a social transaction, and determining the common meaning structures? The result would be a phenomenological assessment of a human activity system. This was the interpretive approach applied to the review of literature, used in the construction of the core purposes framework. Examples of such a method were not located in the systems literature. The intellectual precedents are in anthropology, mythology, and cultural history: Levi-Strauss (1979, 1969a, 1969b), Eliade (1971), Campbell (1956, 1988), van Gennep (1960), and Bachelard (1964).

SYSTEMS METHODS

A system is a set with at least two elements, wherein each element affects the whole. The elements and effects are inter-dependent, and none of them are independent (Ackoff, 1999, p.15-16). Ackoff (1999, ch.2) defines four types of systems: deterministic, animated, social, and ecological. Deterministic systems (e.g. carburetors) are mechanisms that serve a purpose but have no purposes of their own. Nor do their parts have independent purposes. These characteristics enable causal analyses and the development of rule-based descriptions of behavior.

Animated systems (e.g. catfish), typically living animals, have independent purposes. The parts of organisms (organs) do not have independent purposes, but do have functions. The appropriate method of research depends on the degree of independence and adaptability of purpose. Animated systems may present problems of organized complexity.

Human social systems (e.g. clinics), and individual people as the parts of social systems, are both purposeful. It is most appropriate to use social systemic

models that take account of the interdependent, adaptive,
and often conflicting behaviors of the parts and the
whole. This cannot be approached without reliance on
human interpretation.

Ackoff classifies ecological systems (e.g. creeks) as
not having purposes of their own, but of serving the
purposes of their parts. Parts may includes social,
organismic, and mechanistic systems. However, there may
be ecological purposes beyond those of which we are aware.

A purposeful system can change how it achieves
outcomes, and can change what outcomes it wants to
achieve. An ideal-seeking system pursues ultimate ends
that are beyond attainment. An adaptive system can adjust
to change (or create change) to enable it to more
efficiently pursue goals. A dynamic system changes over
time (ibid, p.50-58), while a non-linear system changes in
geometric, discontinuous, or irregular ways that cannot be
reduced to a stable linear ratio of input and output.

Approaching the interpretation of a social system
with "systems thinking" methods, the initial phase
involves understanding the context. The next phase moves

to _problem definition_, followed by _solution design_ (Gharajedaghi, 1999, p.167). The concerns of this research, identifying what constitutes quality of learning in primary care, are with the initial phase of understanding the context.

Social systems methods are of mutual interest to sociology and systems science. The essential issue is how to understand what Weaver termed "problems of organized complexity." These can be re-stated as social systemic problems.

The response in social science has moved from structural/functional analyses (e.g. Parsons, 1951) to post-structuralist (Bourdieu, 1990; Flyvbjerg, 2001) and communicative (Luhmann, 1995; Habermas, 1989) accounts. The movement is toward recognition of the necessary incompleteness of interpretations, and the need for iterative, inclusive, communicative processes of learning. Critical theory has had a significant impact, exposing power and ideology in social systems (Habermas 1989). Methods include phenomenological inquiries, "thick description" (Geertz, 1973), narrative analyses, and

historical accounts. These approaches are in many regards
similar to ethnography (Flyvbjerg, 2001, ch.9).

In systems science, the response has moved from the
engineering approaches of operations research,
cybernetics, and systems dynamics, to biologic and
organismic modeling (von Bertalanffy, 1969; Miller, 1978;
Maturana and Varela, 1987; Kaufmann, 1993). Complexity
theory and chaos theory have been explored, and each has
contributed to modeling systems (Axlerod and Cohen, 1999;
Cilliers, 1998; Kellert, 1993). The thrust of all these
has been computational and taxonomical more than
qualitatively interpretive.

A third group of systems methods has arisen over the
last thirty years, which relies on qualitative
interpretations of purposeful systems and their generally
ill-defined, "messy", and value-laden problems (Churchman,
1979; Checkland, 1981; Ackoff, 1999). These "soft
systems" methods deal with a set of concerns similar to
the post-structuralist sociological thinkers, although
employing different methods. Critical theory has also
come to the fore in the work of Flood and Jackson (1991),
Flood and Romm (1996), and Ulrich (1994). Methods include

systems analysis, obstruction analysis, qualitative
mapping or diagramming techniques, narrative storying,
idealized design, and boundary critique (Gharajedaghi,
1999; Ulrich, 1994).

There is a growing convergence of interpretive
concerns among the social science and systems science
practitioners. But shared methods have not been the rule.
Bausch presents five inventive syntheses of methods
(Bausch, 2001, pt.4). They are each remarkably involved,
massively abstract, complex amalgams of systems methods
from disparate traditions, applied to problems of design;
social theory; communication; cognition; and lastly
epistemology. There is no indication that his composite
methods have ever been applied.

Despite shared interpretive concerns, the methods of
social science and systems science practitioners remain
divergent. This is as much a matter of professional
history as focal distance traits. Systems scientists
generally do not carry a history of closely specified
methods for the analysis of communication. They take
communication as relatively unproblematical, and move
deftly in negotiating and forming practical assessments of

complex situations. For example, Gharajedaghi (1999)
defines a number of types of assessment inquiries
performed by groups of individuals, but never mentions a
method for close examination of what people said.
Interpretive systems thinkers tend to be big picture
people, with a macro scale focus (e.g. Banathy, 2000).

By contrast, social scientists bring a longer history
of methodical development under justificatory pressure.
In disciplines such as anthropology and history, broad
generalizations are indeed common, but there is also a
detail orientation based in method. Communication is not
taken for granted, but considered methodically and
examined in depth. The tensions between practitioners of
quantitative and qualitative social science methods lends
some restraint (for better and worse) to the culture of
the social sciences.

The methods used in the case study hereafter reported
represent a bridging of social science and systems science
cultures. Ethnographic methods, used in obtaining and
analyzing interview data, exemplify observing and
listening well, the better part of dialogue. From systems

science, the method of qualitative systems diagramming was
used, with interview subjects reviewing the diagrams.

SKETCHING THE CONTEXT

The method of systems diagramming used was developed
by Bella at Oregon State University. It is intended to
sketch human activity systems which may be characterized
as complex, adaptive, and non-linear (Bella, 1987).

The method of diagramming requires a presentation of
behaviors from the sense-making perspectives of the people
doing the behaviors. This calls for asking and listening
to those involved, as well as critical review of the
diagram for accuracy, also by those whom it depicts. The
diagrams themselves consist of statements of behavior or
perceptions, which are placed in boxes, and then the boxes
are linked by arrows. Note that the boxes do not contain
things, such as might be found in stock and flow diagrams.
The orientation is to verbs rather than nouns.

The diagram requires two simple rules: first, every
behavior (if it is to be sustained) must have a reason.

This means that every box must have an incoming arrow (other than double-walled boxes which indicate system inputs, and which are in effect links to larger systems). The second rule is that every persistent behavior must have a consequence. This means that every box must have an outgoing arrow to another box (other than double-walled boxes which indicate systems outputs). The result of these two requirements is that the diagrams take on the form of loops. Reading forward in the direction of the arrow, one says "therefore." Reading backwards, one says "because." Thus logical connections are established between the boxes. It is the lived logic of people engaged in social practices. A simple example is given in Figure 2.

The patterns demonstrate the behavioral context within which participants find reasons for some behaviors and not others. That is to say, context shapes behavior. Much of what is ascribed to individual traits and value choices is better ascribed to context. This was a key finding of the Milgram obedience experiments (Milgram, 1974). Demonstrating the influence of context tends to remove participants from individual blame, conceivably making them less defensive and hence more able to confront

the contextual problems in which they participate. However, the appreciation of context does not absolve participants from responsibility. While personal blame may be decreased, personal responsibility is increased to include the system and the self.

```
        ┌─────────────────────┐         ┌─────────────────┐
        │ Telephone staff     │ ──────> │ Many callers'   │
        │ hurries             │         │ needs are not   │
        │ through each call   │         │ adequately met  │
        └─────────────────────┘         └─────────────────┘
                  ^                                │
                  │                                v
        ┌─────────────────────┐         ┌─────────────────┐
        │ Telephone staff     │ <────── │ Callers call    │
        │ is very busy        │         │ back            │
        │                     │         │ repeatedly      │
        └─────────────────────┘         └─────────────────┘
```
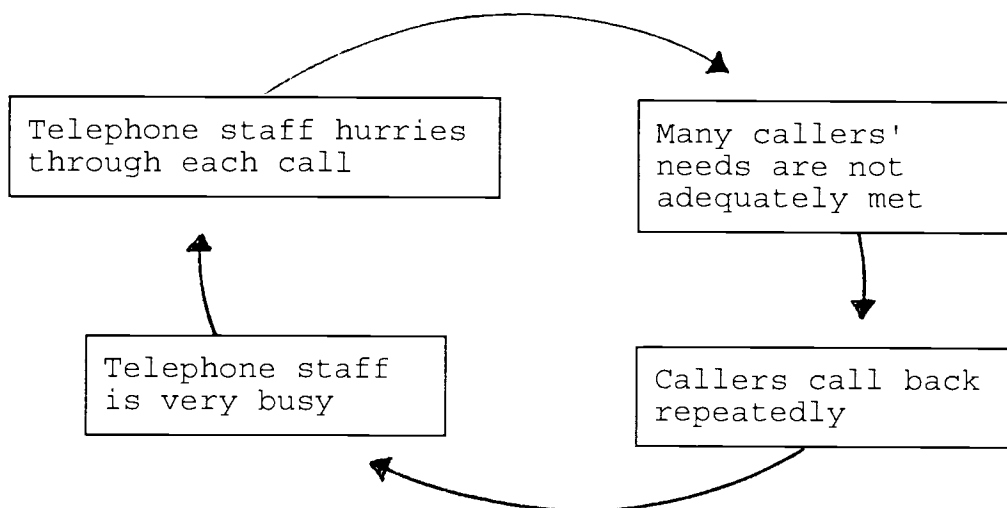
Figure 2. Example of loop diagramming

This method can visually depict complex inter-linked behaviors in a way that is easy to comprehend by ordinary citizens. Twelve to fifteen boxes is the maximum for an easily comprehensible diagram. The diagram is a simplification, a model with distracting details removed.

The diagrams have the capacity to reveal the mutual involvements of multiple parties in patterns of behavior that make sense from each actor's perspective, but that as a whole result in dysfunction or an emergent error. The visual presentation makes for rapid assimilation of information that would take much longer to convey in prose.

One such diagram (depicting a lifestyle-related cycle of chronic back pain) was used to demonstrate how to read this type of diagram. A second diagram (Figure 3a.) was then presented for critique by research subjects. That diagram concerned a dysfunctional pattern of medical care wherein learning was not optimal.

The dysfunctional learning diagram began as an academic exercise in sketching in 1999. The diagram went through several revisions as a result of field studies and further consideration. The form initially presented to subjects in this research is as shown in Figure 3a.

Patterns of living
produce symptoms

Management responds
to market forces,
pressing providers
to be more productive

Total health care system
costs increase from
ineffectiveness

People consult providers
who are very busy

Some patients
drop out of health
care system

People experience
symptoms

Office visits are designed
to use providers' time
efficiently

Symptoms frequently
continue or return

Patients' lived stories are often
not invited because stories are
not deemed medically relevant

Healing and satisfaction
are not optimal

Providers continue
to understand
problems mostly
in a medical context

Medical interventions
inadequately address
patients' needs

Providers don't learn enough about
patients' lives and experiences

Figure 3a. Dysfunctional learning system

The crux of the diagram is that everyone is doing their job capably, beyond blame, but unintended outcomes occur. Managers seek productive efficiency, operationalized as more patients seen per unit time. Practitioners seek medical efficacy, operationalized in terms of biomedical diagnosis and treatment. Patients seek effectiveness for a set of lived concerns. The distinction between efficiency and effectiveness is made by Ackoff (1999, p.171). A framework of care more appropriate for acute diseases and injuries may be less appropriate for chronic diseases, lifestyle causes, and coping with the experience of illness. It is a diagram that leads to asking about what should be done, and thence to identifying the core purposes of primary care.

CASE STUDY RESEARCH PLAN

A concise overview of the case study research plan is given next, followed by a more detailed description. Fifteen participants in a primary care medical clinic participated in private tape recorded interviews lasting about forty-five minutes. The interviews consisted of open ended questions about perceptions of the quality of

learning at medical visits. Subjects also provided feedback on a systems diagram depicting insufficient learning.

The purposive sample of research subjects included clinic administrators, practitioners, staff, and patients. The interviews were transcribed verbatim, and subjected to qualitative ethnographic coding and analysis (Strauss and Corbin, 1998, pt.II; Glaser and Strauss, 1967, ch.5). A draft report on perceptions of learning and satisfaction with care was prepared for the clinic. The report was an abridgement of this dissertation, preceded by an executive summary, edited for brevity, and with discussions of core purposes removed. One administrator, one practitioner, and one patient (each of whom had been an interview subject) reviewed a copy of the draft report, and provided feedback, stating their agreements and disagreements with the findings and conclusions. This critical input was included in a final report delivered to the clinic administration. A copy of the executive summary of the final clinic report is located in Appendix A.

The interviewees provided suggestions for several amendments of the systems diagram. Interview transcripts

also opened a window onto dimensions of learning, and contained evidence of relationships to the framework of core purposes of primary care previous described.

A detailed exposition of the above plan and its implementation now follows. The field research case was defined as a primary care medical clinic. Primary care refers to generalist practitioners (e.g. internists, family practitioners, pediatricians, and general practice physicians) who serve as an entry point into the health care system, and who provide comprehensive and continuing care and patient advocacy (AAFP, 2002a). The case site was chosen on the basis of ability to obtain access, arranged through introduction of the study to the clinic by a health care system administrator.

The site was a family practice group with approximately ten practitioners, located in a modern medical complex in an Oregon city with a population of under 150,000. The group practice formed in 1994, and since then joined an integrated health systems network with about twenty other group practices. Integration does not necessarily preclude a high level of local autonomy.

Family practice, as a primary care specialty, carries a characteristic set of values. Notably, family practice reflects Engel's (1977) biopsychosocial framework of care, attempting to recognize and balance the needs of the patient as a person in a social context, experiencing biomedical problems. Family practice emphasizes the importance of teaching and caring as part of the medical encounter. The American Academy of Family Physicians (AAFP) defines family practice in part as "the specialty in breadth which integrates the biological, clinical, and behavioral sciences" (AAFP, 2002b). Mean national pre-tax income for general and family practice physicians in 1996 was approximately $139,100. By comparison, mean pre-tax income for all physicians was $199,000, and for internal medicine physicians, $185,700 (MedBoard USA, 1999).

The primary medical specialty of family practice was officially recognized by the American Board of Medical Specialties in 1969. The family practice specialty was created in response to a rapid decline in graduating medical students entering general practice, and entailed a redefinition of the skills - and status - of general practice physicians (Pisacano, 2001).

As a case, this clinic provides a perspective on the questions of whether, and how, the family practice ideals concerning patient education can survive within the encompassing organizational, reimbursement, and medical practice system. The perceived quality of learning is a particular point of interest.

Tape recorded interviews of approximately forty-five minutes duration were planned, following a schedule of open ended questions and ad lib probes and follow-ups about perceptions of the quality of learning. Questions also sought feedback about a systems diagram of deficient learning in medical encounters. There were also several demographic questions. The schedule of questions is located in Appendix B. Interview questions included items such as the following: "What contributes to a medical visit in which patients do not optimally learn what they need to learn?" "What contributes to a medical visit in which patients do optimally learn what they need to learn?"

Fifteen volunteering adult research subjects were interviewed. Subject inclusion criteria were designed to incorporate a diversity of role perspectives. To this

end, two clinic administrators, two clinic staff employees, three clinic primary care practitioners, and eight patients were selected. The purposive sample was intended to select for variety, but not for outliers on any dimension. The sample selection was non-random, hence statistically justified generalizability was not possible.

Potential research subjects were notified of the study by a letter posted at the clinic entrance reception desk. Sample letters inviting participation are located in Appendix C. The clinic manager informed and recruited practitioners and staff. Clinic reception and scheduling staff and clinic practitioners recruited patients meeting the inclusion criteria. All interviews were conducted in a two week period, from September 6 to September 21, 2001. Most of the interviews were done in a private conference room at the clinic. Two patients were interviewed at their homes, and one at his place of employment.

The researcher (the author of this dissertation) kept a journal to record commentaries on the research process. Journal notes were completed within 24 hours of interviews. The researcher was clearly identified by name

tag as affiliated with Oregon State University Department of Public Health.

The inclusion criteria for subjects were as follows. All subjects were mentally competent, consenting, English-speaking adults without extreme disabilities of speech or hearing. Administrators were defined as individuals whose job duties in the clinic were primarily managerial. Practitioners were defined as individuals whose responsibilities in the clinic were primarily patient care. Examples were physicians, nurse practitioners, and physician assistants. Staff were defined as individuals whose job duties in the clinic were primarily medical records, secretarial or reception, and who had either direct or vocal contact with patients.

Patients were defined as adult clinic clients who had seen a primary care provider at the clinic within the last twelve months. Patients were selected to obtain a balance by gender, and also by age. Age was operationalized by generational cohort, as defined by Strauss and Howe (1991, p.32). One male and one female were selected from each generational cohort, consisting of the following age ranges: 20-40; 41-58; 59-76; and 77-over.

Of patient subjects meeting these criteria, an
inquiry was made into self-reported global health status
(good/fair/poor), to take account of health status
diversity. Because patients are the majority of
participants in the clinic, they were represented in
greater number than other participants.

Subjects were asked to volunteer to review and
provide written comments on a draft report of the study
being prepared for the clinic, until a sub-sample of three
were obtained, consisting of one provider, one
administrator, and one patient.

HUMAN SUBJECTS

The study was reviewed and approved by the Oregon
State University Institutional Review Board (IRB). A copy
of IRB approval is located in Appendix C. In addition,
the participating clinic provided a letter of permission
to run the study.

Two earlier pilot tests, conducted at other sites and
involving providers and patients respectively,

demonstrated no risks to subjects. The line of
questioning neither sought nor uncovered traumatic,
illegal, or immoral events.

Potential subject benefits were thought to include:
(a) the satisfaction of participation in a research
project where their perspectives are sought after; and (b)
an increased appreciation of the provider-patient
relationship from a systems perspective. Subjects and the
participating clinic were offered a copy of the final
report.

All subjects were mentally competent English-speaking
adults over 18 years of age who volunteered participation
and provided written consent. A copy of the consent form
is located in Appendix C.

Potential participants were given a written letter of
invitation describing the study, including purposes,
procedures, benefits and risks, confidentiality, and the
voluntary nature of participation. Volunteers received an
oral description of the study (reiterating the information
provided in the informed consent document) and were
invited to ask questions. They were asked to read and

sign a written consent form, which also indicated the identity of the researchers and whom to call if they have questions. They were given a copy of this form.

With regards to confidentiality, the participating clinic is referred to only by pseudonym herein, and in any other published or public accounts of the research. All subjects are referred to only by pseudonym as well, in this and any other published or public accounts of the research. A document linking pseudonyms to real names is stored in a locked file, and is to be destroyed after three years. Informed consent documents and human subjects correspondence will also be retained for at least three years after completion of research.

In the report to the clinic, quotations pseudonymously attributed to interviewed staff, practitioners, and managers, may nevertheless be characteristic enough of specific individuals as to be recognizable within the clinic and health system. Information conveyed in the interviews and thereafter quoted did not contain revelations of a personally sensitive or socio-politically indiscreet nature.

IMPLEMENTATION

At a first clinical site, an internal medicine group which had agreed to host the research in June of 2001, there were so few interview volunteers (two in two months) that the researcher terminated the research at that site in late August, 2001. The problems involved management and communications within the clinic. The site's level of commitment to the research may have been at issue. Herewith is one telling example of a communications problem.

Contacting a clinician (who had left the researcher a message volunteering to be interviewed) by telephone proved to be a difficult and frustrating week-long task. Calls were put on hold for many minutes, and the researcher spoke with different people at each call back, never receiving the same advice on when to reach the clinician. When calling back at suggested times, it still was not possible to speak with the clinician. No good time was identifiable. When the researcher finally did speak with the clinician, an interview was arranged in under two minutes of conversation. The clinician wanted

to speak with the researcher, and the researcher wanted to speak with the clinician, yet it took a week of dealing with intermediary staff for this simple exchange to happen.

The long hold times and inability to talk directly to the clinician suggest that the staff and clinician were very busy. This can be represented as a classic feedback loop, as depicted in Figure 1. The staff is busy and not able to respond adequately to the needs of callers, who then call back many times attempting to get their needs filled, increasingly making the staff too busy to respond to the needs of callers.

This is the sort of systemic problem that the case study had hoped to reveal and open dialogue on. Paradoxically, a clinic that could have benefitted was either too disinterested, defensive, or dysfunctional, to effectively host the research.

The second site provided a diametrically opposite experience. In September, 2001, the researcher contacted a family practice group, where the study progressed rapidly. The clinic manager and staff were efficient,

communicative, and helpful, despite the minor inconveniences of the project, such as locating and scheduling patient volunteers meeting age and gender criteria. Interviews were completed in two weeks, as anticipated.

One of the clinic's schedulers, calling patients to remind them of upcoming appointments, inquired if those patients might come a bit early and participate in the study. Four calls yielded four willing participants. As regards the potential for selection bias, the scheduler noted for one elderly patient, "Oh, he'll have opinions okay!" Apparently, "model patients" were not being intentionally selected.

Interviewing subjects at the clinic was a practical matter of convenience. An off-site location might have made subjects more comfortable in voicing negative opinions, if they had any. Three patients were interviewed off-site, and their comments were uniformly supportive of the high quality of service they experienced at the clinic. The infamous September 11th terrorist attacks occurred in the midst of the study, but this event did not appear to have an effect on the research findings.

DATA ANALYSIS

Interviews were transcribed from tapes verbatim, and read for accuracy and a sense of content at least three times before ethnographic coding. Coding was performed with the aid of the ethnographic software *winMax* (Kuckartz, 1998).

Coding is the process of categorizing meaningful portions of texts. The unit of meaning may be as fine as single words, or as diffuse as identifying the emotional tone in paragraphs or pages. Open coding was done as a first pass through, picking out from the text that which appeared meaningful in the estimation of the researcher, whether directly related to research questions or not (Strauss and Corbin, 1998, pt.II; Glaser and Strauss, 1967, ch.5).

This is the essence of qualitative work, making distinctions about what is and is not significant. Textual interpretation is an interplay between text and interpreter. The text speaks, sometimes in ways quite apart from research questions. Then again, some frames of

meaning are imposed by the line of interview questioning, the nature of the research problems, and the theoretic structures applied by the researcher. Meaning does not reside objectively in text or researcher alone.

As the open coding process continued, a consistent set of categorical themes evolved. Memos were written to define codes and to record preliminary analytic thoughts and questions. Categorical themes contain a number of related units of meaning, the dimensions of the category. The open coded texts were re-coded to reflect the organization into categorical themes (Strauss and Corbin, 1998, pt.II; Glaser and Strauss, 1967, ch.5). Open coding, organizing into categories, and re-coding, was a fairly fluid process rather than a discretely sequential one. Finally, the sub-categories within categorical themes were re-arranged for simplicity and coherence, essentially a "housekeeping" step. This describes the coding process employed in the study.

Six substantive categorical themes were developed in coding the interview texts. *Learning sources* itemized mention of the sources of learning (e.g. interpersonal sources, media sources, educational sources, etc.).

Learning factors tracked potential influences on quality

of learning (e.g. age and generational factors, honesty,

denial, cultural and linguistic barriers, etc.), *Learning*

dimensions marked the topical areas participants learned

about (e.g. how to manage a visit, finding common ground,

trust, etc.) Entries in this category were largely driven

by the textual material. The researcher then went on to

code in terms of *core purposes*, applying an external

theoretic framework. The interest here was in whether the

core purpose topics arose in the narratives. *Diagram*

reactions tracked responses to a line of questioning

seeking critique of a systems diagram depicting a

dysfunctional situation of learning. *Satisfaction* picked

out expressions of satisfaction with care (or working

conditions) at this clinic and elsewhere. This

information had not been specifically sought out, but was

present and was thought to be of potential interest to the

host clinic.

In addition to these six substantive categories,

demographic and descriptive data were coded. Included in

descriptive data were comments on perceived quality of

learning. Finally, an attempt was made to identify and

code the central issues of each interview, providing a gestalt overview under the heading of *core problem identity*. A list of categories, codes, and code frequencies, is located in Appendix B. Transcribed text of the interviews is located in Appendix D. In the following presentation of results and conclusions, numbers listed in brackets, e.g. (105-130), refer to the numbered lines of the transcribed interview text. In the interview texts, comments following an asterisk (*) are those of the researcher.

RESULTS

DESCRIPTIVE PORTRAITS

Of the fifteen subjects interviewed, all were Caucasian; six were male and nine female. One male and one female patient were in each generational category (with a 76 year old male, two weeks shy of his 77th birthday, placed in the 77 year old and greater category, as a matter of expedience). Six patients reported their global health status as good, and two as fair. This did not correlate with the reported number of medical visits in the past year. One patient reporting fair health reported only one visit, while another reported sixteen visits. In the good health category, number of visits ranged from one to more than twelve. Administrators, practitioners, and staff ranged in age from 29 to 48. One patient (Sonia) was known to the researcher as an acquaintance from a clinic where we worked in different departments.

Herewith are thumbnail portraits of the subjects, whose responses are encountered in the presentation of

results. Fred (Admin1) is the 45 year old chief operating officer for the health system, a trim man with a Master's in public administration and a keen eye to the big picture. He humorously describes his job as "driving a nitroglycerine truck"(46), a reflection of the stresses accompanying the turbulent conditions of the marketplace.

Sue (Admin2), age 34, is the clinic manager, and has a B.S. in management. She is a natural communicator, a people person who uses relational skills and warmth to stay in touch and resolve conflicts.

Siobhan (Staff1) is a 29 year old receptionist-scheduler with a high school education. She articulates the ideal of caring, and is remarkably insightful into the situation of people with problems, and the pressures on the health care system.

Jill (Staff2) is a 40 year old certified medical assistant (CMA) with two years of college training. She has been a CMA for one year, and seems to know what is required to facilitate office visits for her practitioner, and to smooth the way for patients.

Carl (Prov1) is a 35 year old family practice M.D. with a predominantly pediatric clientele. He went into medicine to attend to healing, a most human art of connecting, and he keeps that vision intact.

Cindy (Prov2) is a 48 year old physician assistant (P.A.), a seasoned clinician with 24 years' experience. She has a confident presence, and reports fulfills duties no different than the physicians'.

Joyce (Prov3) is a 42 year old family practice M.D., a former teacher in her first year of clinical practice in this second career. She is appreciative of the guidance available, and of the low pressure culture of this clinic.

Turning to the patient subjects, Megan (Pt1) is a 31 year old physician referral line representative. She has completed a year of studies at a community college, and voices some frustration with her unresolved back pain.

Sonia (Pt2) is a 57 year old nurse in an outpatient clinic. She has a very practical and forthright persona, and is a veteran clinician, nearly unflappable.

Whit (Pt3) is a 64 year old with an A.A. degree, retired from a tax office. She reports that she is in good health, and keeps impeccable records of her health care. She conveys an independent spirit, looking into health matters on her own and assessing medical advice carefully.

Rodeo (Pt4) is a 56 year old insurance agent. He has attended two years of college, reports his health status as fair, and is coping with a recent diagnosis of diabetes.

Pete (Pt5), almost 77, is a retired Air Force pilot with two years of college education. His responses are measured and direct, and his gaze is somehow both strong and gentle. He has enjoyed close working relationships with Air Force physicians.

Rose (Pt6), at 81, reports her health status as good, though several years ago she barely survived a ruptured aortic aneurism. She values being able to choose her practitioners, and does not accept the restrictions on choice that she associates with HMO's.

Arnold (Pt7) is a 74 year old with two Ph.D.'s. He is a retired educational researcher with failing hearing and an inquisitive mind. He reads cutting edge medical research, and his physicians must be challenged to keep up with his learning.

Joe (Pt8) is a 38 year old school music teacher with a Master of Education degree. He reports his health as fair, and reports over sixteen medical visits in the last year. Although pleased with his current care, he tells of dropping out of the health care system for a number of years, out of frustration with it.

PERCEIVED QUALITY OF LEARNING

Subjects were asked whether their learning in medical visits had been optimal or not. They were also asked whether they thought learning had been optimal for the practitioner. All but one assessed the quality of learning for both patients and practitioners at the clinic in positive terms. For example, here's what Pete said in an interchange on perceptions of practitioner learning quality:

* Does your medical provider adequately learn
these things from you?

Oh, I think so. Because as I say, I don't know
whether it's through an access or what, but
I've had nothing but doctors that I could
relate with, we could talk informally, one to
one. (100-105)

Megan, asked if the quality of her learning was

optimal, offered this:

I would say, I would say yes. There may be one
or two questions that I may not understand but,
otherwise I would say yeah, would say yeah.
(103-105)

The clinic manager, staff, and practitioners, are

proud of the quality of learning, and the emphasis on

education, evident in most patient encounters here. As

receptionist-scheduler Siobhan put it:

You know I, I like to think that we really try
to take care of our patients, and that we
really are as receptive and as, I guess as
caring as we can be. I work in a really good
pod with three physicians and two assistants
who are really good with their patients. I
mean I would be able to feel comfortable to, if
anyone of my friends say, you can see any one
of these physicians and know that you're going
to be taken care of. I think yes, I think
mostly within our facility it's a good
experience, and I think I can say that with a
clear conscience, because the other facilities
((laughter)) I worked in I would say were
considerably less. (326-336)

Fred was the lone dissenting voice. As chief operating officer, he was asked to assess the quality of learning for the entire health system, and not specifically this clinic. His reservations about the quality of patient learning were attributed to a systemic cause:

> But where your fundamental problem in all of it is, is the physicians are paid on a piece work basis. And by sitting down and giving the people as much time to answer the questions, a physician can't charge for their time and so there's a loss of revenue. So the system is completely upside-down, because it's designed to go in, take care of a problem, and go to the next one. It's not designed to be educational. (227-234)

SATISFACTION

No questions were directed to the topic of satisfaction per se, but subjects offered a number of comments, not all addressed to experiences with this clinic. These are summarized in terms of detecting dissatisfaction, and factors of satisfaction.

Both administrators raised the issue of detecting dissatisfaction. Chief operating officer Fred noted the superficiality of surveys, and the difficulty of obtaining

feedback from a broader community that may not look entirely favorably on some aspects of your services, in this manner:

> Well traditionally, we do patient satisfaction surveys, it's superficial stuff you know. Were you pleased with your visit? Is it easy to park? Was the place clean? How did you like your doc? Did they answer your questions? And most of the docs place out very well, but that's in the group that's coming here. So they're happy. How can you get the ones... so you assume the people that eat at Burger King are happy with Burger King, but you have a percent of population that don't ever come to Burger King. (483-491)

Clinic manager Sue described her pro-active approach to detecting and dealing with dissatisfaction, in this way:

> My staff is really well trained in terms of, they detect any frustration, dissatisfaction from our patients, they will come in -- in fact yesterday was a great example of that, somebody came in, said "just heads up, it seems like when this lady left she wasn't entirely satisfied", so today what I will do is call her and just kind of probe that a little bit. (119-125)

A number of factors in satisfaction and dissatisfaction were mentioned, not all relating to this clinic. The factor of time was raised by several subjects: taking (or not taking) enough time to take care; long waits in the waiting room; and being (or not being)

able to schedule a visit right away. Arnold praised this

clinic's prompt scheduling of visits in these words:

> And in terms of, we've been very lucky with the
> people we have here, because the office visits
> are designed not to provide the provider time
> efficiency, with the group of doctors we have,
> are very open, we go in, or get told come in,
> we'll find space for you, and that is not true
> of other doctors, because people, in the
> community, that we know, simply can't believe
> that we get treated this way because they are
> commonly told, you know, we'll talk to you in
> six weeks. And again, that's why I talk about
> the training of these people, these particular
> doctors, the four that we've been interacting
> with over time. (302-312)

At times moving beyond experiences with this clinic,

patients spoke of lack of medical efficacy, definitive

tests not being run, not getting good information, and

mis-diagnoses as contributing to dissatisfaction. Rodeo

summed it up this way:

> ...there's a lot of things that's wasted. A
> lot of wasted efforts that says we're going to
> do all this stuff, now all this stuff, when the
> pain's there and I says this is where it is,
> you know as an example. You still gotta go
> through all these other steps, and come back
> and come back and come back. And like I said I
> felt it, MRI should have been done six or eight
> months ago. And it's tough to get referred. I
> mean just as an example, I'll give you another
> example, I had a skin condition and I came to
> the doctor and they couldn't get it stopped. So
> I said I think all I need is a dermatologist,
> so I finally raised enough Cain that they
> referred me to dermatologist. He gave me one
> medication prescription, I've never had a
> problem with that rash again. (191-202)

Relational quality and trust in practitioner
competency were noteworthy factors in the context of
satisfaction. In this interchange, Joe spoke to being
humanly known:

> Yeah, I think, my doctor knows me probably
> better than I do.
>
> * Wow, that's a high compliment.
>
> Well it is, I think he's a genius, I really do.
> He's the most compassionate man, and luckily
> the last two physicians I've had know me well.
> (137-143)

Knowing and being known is not just a need of
patients. Family practitioner Carl offered this comment:

> Because if I didn't have that human contact and
> really knowing that I've touched a person,
> they've touched me back emotionally on that
> level, I wouldn't be able to continue doing
> what I'm doing, because that wouldn't get me
> any satisfaction. (727-730)

Practitioners and staff addressed the nature and role
of job satisfaction. Siobhan provided this eloquent
statement on the systemic ramifications of providing
quality service to patients, from her experience at a
previous clinic:

> I mean, I would probably say honestly that 70
> percent of the people I worked with were
> unhappy, and I think part of that comes from

job satisfaction. If you're someplace eight
hours a day and you don't feel that you're
doing good, you know that you're doing
something for the better good of humanity and
that, you know, you don't have physicians who
are willing to take the time, that you don't
have physicians and management who, instead of
caring about numbers and how much you can get
accomplished, rather than being able to take
care of the people, which is what we're
supposed to do, it's a service industry, that's
exactly what we're supposed to be doing. You
know, nobody's going to be happy. And it
reflects, and the sad thing is the people that
I worked with before were absolutely incredible
people, lovely people, but when the management
part of that doesn't flow, when not everybody's
mission is the same, when not everybody has the
single like-mindedness of team work, of caring
for the community, which is kind of what we
are supposed to be doing, everybody suffers. I
mean not only the community but the office, we
had horrible turnover, I mean it really was
multi-dimensional and multi-faceted. It wasn't
just that we were providing some inadequate, I
mean quite a bit of inadequate care, my guess
is, to our patients, but we weren't doing
ourselves any favor either as an office. (745-
767)

Other staff and practitioner remarks on satisfaction

pointed out the coordination and dedication of the entire

team, the lack of production pressure, and the capable

facilitation of the clinic manager.

LEARNING SOURCES

Everybody involved in a medical encounter has to learn, not only patients. The learning sources category catalogues where information comes from, based on the interview texts. Few of these sources require commentary or textual reference. They are listed here as an indication of the multiplicity of channels. One key reminder: a source might provide good information and/or bad. And so unlearning is sometimes the first challenge of an educational process.

The nine classes of learning source were as follows: formal education programs; meetings; management and organizational culture; media sources; text sources; medical tests; practitioners and staff; patients and their social networks; and intra-personal sources (such as memory, experience, and reflection).

On management and organizational culture as a source of learning, Whit spoke of "doctors being forced to practice differently." (314-315) A source of learning is simultaneously a factor shaping learning. Whit had this to say about organizational influences learned by

practitioners, and the impact this has on learning by patients:

> I think their knowledge that goes back out to a patient might be put in a capsule form and given to them quickly because of the time element, because of knowing that there's this umbrella hanging over them. They have to come forth with the rules of the program that they're under. (288-293)

LEARNING FACTORS

Learning factors encompassed a broad and complex array that can be organized along the following lines. Learning factor sub-categories are noted in italics.

Within a cultural context partially shaped by *mass media messages*, an *organization's management and culture of care* provides conditions (including *time*) and resources that influence learning. However, *cultural and linguistic barriers*, and *educational influences*, highlight the differences among societal, organizational, practitioner, and patient participants. Thus *power and conflict* come to the fore as factors in learning, as seen in *patient clarity and assertiveness* in medical encounters. *Dialogue*

and relational practices are the crucible of conveyance,

involving *attitudes toward teaching and learning*, and the

particulars of personal situation: *gender and generation*,

and *emotional loading*.

This phenomenological trove will be examined in the

above order. *Mass media messages* were mentioned by Sue,

who recognized media-made barriers:

> Well, you hear about the wrong leg being cut
> off or accidental overdose of medication or
> medication that caused horrible outcomes. The
> media from my perspective blows things terribly
> out of proportion, and people come here with
> that. (311-314)

The organization's *management and culture of care*

included making available equipment, materials, and

personnel; team coordination, sense of mission, and the

spirit of the workplace; reimbursement policies; and

documentation policies. Family practitioner Joyce spoke

about the effects of organizational conditions:

> ...facility a year ago just before I started
> practice. And, uh, they'd do everything, they
> would put up brick walls, you know in terms of
> administration and paperwork and medical
> records, you know hoops and you know problems,
> and coming down here is just a real sigh of, a
> breath of fresh air. Everybody works together
> well, that's what facilitates things. We've got
> a clinical, a clinic manager, you know, who

kind of like works behind the scenes to make
things work well. The medical assistants
facilitate things real well, that, partners,
who every time I am not clear on something,
they're happy to help me, or recommend a
referral, you know who you send for, who's a
good neurologist in town ((?)) you know her, do
you go to ((one neighboring city)) or to
((another neighboring city)) for tests, you
know, things that are real helpful there. (64-
77)

The organizational structure of *time* was a widespread

concern. Sub-topics included telephone hold time,

availability of appointments, repeated appointments,

waiting room time, appointments of the right duration for

the complexity of the problem, and taking the time to do

what is called for by the patient. Sonia pointed out the

structures of time in different clinics, in this way:

Well, probably the biggest thing is, there's
not a whole lot of time to take care of
people... like at (college clinic name) we have
a lot more time to spend with our patients than
in a clinic like this. Or when I compare
going, I went and visited a naturopath in
(neighboring local city) last year to get a
second opinion on hormones, there was just a
lot more conversation that happened. It makes
a huge difference in care, in trust, in
relationship. (247-254)

Cultural and linguistic barriers to learning involved

culturally taboo topics of conversation, the culture clash

between doctors and hospitals, interpretive errors, and

translation of medical-ese into the patient's language.

This entire sub-category depicts multi-layered cultural

influences on communication and learning. If teamwork is

a facilitator of learning, then consider the consequence

of what Fred had to say about the cultures of doctors and

hospitals:

> I think it's interesting, the biggest brick
> wall that I've faced for years is, though it
> doesn't seem like it should be, there is a very
> different world between physicians and
> hospitals. And there's different cultures,
> there's different philosophy. The way to
> describe my view is, you look at hospitals as a
> restaurant which is a low volume high price
> type of entree, where the clinics are more of
> a McDonald's, where you are serving fast,
> high-volume low price type things. Though you
> think hospitals and doctors work together, the
> cultures are very different and they clash
> significantly. (59-68)

Educational influences referred to more than the

patients' level of education. It included the formative

effects of medical education on physicians, leading to a

selective emphasis on procedural interventions over

education. Fred cited this latter point:

> If you go to an orthopedic surgeon, they're
> trained on telling you: I can solve the problem
> and I can cut on this and I can fix it. Okay,
> but educate me on what caused it. That's not
> part of their training. So I think there needs
> to be more of a focus on an educational
> component to (a) the patient needs to ask for
> it, but (b) I think providers need to feel

comfortable in explaining more to the patient.
(166-173)

Power and conflict are inevitable when multiple
parties with somewhat conflicting interests meet.
Authority and personal pride are at stake, along with
other overt and covert agendas, which may issue in
noncompliance. Physician assistant Cindy brought out
conflicting health beliefs as a source of non-compliance,
as distinct from a failure of learning, in this
interchange:

> If you leave out of that equation the folks
> that are never going to agree with you or
> accept what you recommend, it doesn't
> necessarily mean there's a failure in learning.
> There's different ways to approach the same
> problem and maybe they're coming at it from a
> different perspective. Does that mean their
> learning failed? I don't think so.
>
> * So the teaching may have been there, the
> interest in learning...
>
> Or acceptance.
>
> * ...or acceptance, might not have.
>
> Yeah, an example of that might be the whole
> immunizations issue, parents who elect not to
> immunize. And we try to teach them the
> benefits of immunization, and they still elect
> not to. Is that a failure of learning?
> Perhaps, I don't know. Or is that then
> choosing another source to learn from, i.e. the
> Internet or other health, alternative
> providers? (181-200)

A normative ideal was expressed concerning *patient clarity and assertiveness*: patients should clearly express the reasons for their visit and assert their interests if they expect to have them met. Siobhan addressed this norm of frankness:

> If they really want to be clear with me so that I can be a good advocate for them with the doctor and the assistant, then they need to learn to really trust that everything we say is confidential, that they can tell me, I'm sure that no matter what they say, I've heard more bizarre stories ((laughter)), or, you know, I think a lot of people are just afraid to be truthful. So to learn to be truthful and to be very clear in their communication, would be the best thing to learn. The second thing, is a don't thing, as far as an office visit goes, a doctor can't help you, unless you are truthful with them. You know, if you go in and you only hear what you want to hear, and you don't really go in with an open mind, and be open with why you need what you need, or asking for help with something, the doctor is not going to be able to treat something that he does not know about. They can't read your mind. They can only be as intuitive or in tune as they can be on their best day, you know. (137-153)

Dialogue and relational practices have been commonly addressed under the rubric of communication skills, when they more fundamentally involve human presences, in the qualities of openness, caring, respect, and trust. We locate common ground to be humanly understood. Pete discussed his experience with an eye doctor, and made the

distinction between his being understood and his eye being

understood:

> The people that I've been talking to act
> mechanically and don't talk to me, and I can't
> relate to them, whether they really understand
> the way I feel about my eye problem. I have, I
> get with my permanent doctor that I have just
> seen today, I get more understanding of my
> problem than I did with a specialist. (263-268)

Under *attitudes toward teaching and learning* are

comments indicating practitioner and patient must be

mutually willing to participate, both receptive and

motivated. That motivation is fueled by concern and by

hope. The practitioners's valuation of teaching is a

factor, in addition to organizational and systemic

valuations of teaching. Patients assess the quality of

information and advice conveyed, and sometimes find it

lacking. Whit exemplified positive patient involvement in

care:

> I happen to be one that will come well prepared
> for my physical. I gather all the information
> that I feel it is necessary for him to know
> about me, even though, well you know, it's been
> a year, I haven't seen him in a year's time,
> what changes have taken place from the previous
> year. So if he hasn't, or she, hasn't asked me
> the questions about my body or health or
> whatever, I am surely going to be on the other
> end asking them. (167-174)

Learning is mediated by the particularities of personal situation. These include the influences of *gender and generation*. Men and women present themselves differently at medical visits. Elders carry different expectations of responsibility and care than the middle aged. Loss of hearing and hidden non-comprehension may hinder learning. Generational influences also affect practitioners' understanding of their role. Carl spoke in these two segments to his generation's view of the practitioner role:

> I'm part of a younger generation of physicians though that do understand that, and I'm really going to try to set limits, because especially if you have a family, if they grow up too fast, and... so I think there's a younger generation of physicians knowing that work is work and home time is home time, and you try to protect that as much as possible. (114-119)

> They need to learn that this is a partnership. My concept of medicine is, gone are the days where the doctor sat on an ivory tower and said you shall do this. (188-190)

Individuals come to a medical visit often bearing considerable stress and *emotional loading*, related to the illness experience, previous reactions to medical encounters, or other life conditions. Staff and practitioners do not necessarily arrive as empty vessels in this regard, either. The litany of negative emotional

states reads like the contents of Pandora's box: anger,

blame, worry about potential blame, defensiveness, fear,

distrust, rudeness, and stress. Emotional management is

a necessary concomitant of medical practice. Medical

assistant Jill noted the presence of emotional baggage:

> Well, they might get mad, or they don't
> necessarily agree with what they're being told,
> they might leave, they leave before they are
> given the things they need, that's mainly what
> I would say. Being irritated or they don't like
> the answers. (202-205)

Siobhan connected emotional management and learning

in this way:

> You know, not only I'm on the phone with a
> patient trying to figure out exactly what's
> wrong and how urgent it is that they see
> someone, but even the doctor, by how gentle
> they are with the patient, you know like, "I
> know this is kind of scary, but we're going to
> go through it together, and if you have any"...
> you know what I mean? I think that they learn
> by us telling them, and if it is something very
> sensitive, by being gentle and being supportive
> and caring. (220-227)

DIMENSIONS OF LEARNING

Dimensions of learning are distinct topical areas of

interest, the areas of functional concern in medical

visits. Two interview questions asked about the range of

dimensions, with little follow-up probe. Despite limited direct inquiry, the conversations provided evidence for a set of six topical areas. These were: *costs and coverages*; *negotiating the clinic*; *negotiating the visit*; *biomedical constructions*; *relationship and caring*; and *personal meaning*.

Costs and coverages concerns learning about reimbursement and access issues, and involves parties beyond the level of a particular clinic. It simultaneously touches the patient's wallet, and impinges on choice of practitioner. Carl addressed the history of how costs have come to dominate practice:

> And then as medicine became more technologically advanced, the costs of medicine started to go up. The people that managed medical costs dictated amounts of patients that needed to be seen. That put more stress on physicians to meet the bottom line, especially with the increasing costs of technology of medicine. Patients would expect the highest technology because it was available, but not as willing to pay for those added costs. So ultimately the insurance companies, hospital systems, physician groups, and then later on patients with their own insurance costs and deductibles, all started to pay into that. So that in my mind created a system that wasn't truly treating patients as people anymore, but patients as the problem that needed to be fixed. (446-458)

Rose expressed her views about health maintenance

organizations and choice in these two segments:

> Because we don't have an HMO.   I'm on a
> different health plan, and one doctor said to
> me one time, "I'm very glad you're not on an
> HMO plan so I can send you to any specialist I
> want to." (180-182)

> Because I had the impression definitely that
> there was a specialist he wanted, he wouldn't
> have been able to do it had I been with an HMO,
> he'd have had to send me to someone else or end
> up with no one. (198-201)

Negotiating the clinic encompasses dealings with

clinical organizations, learning the avenues of

communication, the constraints of the institution, the

regulation and scheduling of access to primary care

practitioners and referral to specialists.   From her

perspective as clinic manager, Sue recognized the

importance of this dimension of learning:

> At the minimum the patient needs to learn how
> the office functions, not in great detail but
> certainly things like how do you handle
> prescription refills, how are you going to
> handle referrals, which groups do you refer to,
> those kinds of things. (195-199)

Negotiating the visit involves learning about

expectations and allocations of power, decision, and

responsibility in the therapeutic dyad.   Common purposes

also must be determined. Fred spoke to learning about the

social power dynamic in these words:

> I think that you hear more and more stories
> about - in fact my wife does it - goes on the
> Internet and pulls off pages and then comes in
> and asks the docs about it, and that was never
> done years ago. Then the doc was on a pedestal
> and told you what to do. Even your older
> patients, rarely did they challenge a physician
> or ask why, they just quietly did what the doc
> said. And now you have more people coming in
> and trying to negotiate. Okay doc, here's what
> I think I have. And some of that depending on
> the physician again, some of them are, you know
> you are challenging my authority, I'm not going
> to do that. And then you have others that are
> willing to sit down. (217-227)

Sonia processed learning about the need to be an

assertive patient, in this segment:

> I thought part of the responsibility could have
> been myself, to say you know what, to just ask
> for what I needed, except I didn't think about
> it until later. Because I thought about that. I
> have a responsibility as a patient also to, if
> I have a concern, to state that, you know. So
> it just made me think more about asking for
> what I think I need, although in that case
> you're stunned and all of that, and I honestly
> didn't think about it until later. But I would
> have said just do you mind checking my, doing
> these things. Or to just outright ask for... so
> can you just tell me as my husband sits here,
> so he too knows what to look for, what to
> expect and all that. So I think to ask or to
> not, I think a patient, it's important that we
> don't take what our provider says, and not
> question it, or not to be assertive, because
> you need to be. (103-116)

Cindy put the determination of common purpose at the top of the list of what a practitioner needs to learn from a patient, in the following interchange:

> * Okay, what types of things does a provider need to learn in a medical visit?
>
> In a visit? Umm, well, real basic things of why the patient is there, understanding of what their symptoms are, what disease process if any is going on, what the patient's expectations are for that visit. (202-208)

Biomedical constructions involves learning about causes and prevention, diagnosis and therapeutic interventions, and outcomes, primarily from biomedical perspectives. As Cindy said, "If it's from an acute illness, they need to learn what their diagnosis is, what's going on, why they're sick." (89-90) Comments in this dimension were well represented, with over 100 catalogued. The nature of this dimension is readily apparent, and requires no further explanation or examples.

Relationship and caring comprises learning to form interpersonal connections, how to know and be known to another; learning to convey and accept compassion and caring; learning the status of trust and safety; and recognizing the will to participate.

Megan came to recognize a lack of being known in this passage:

> I know that the providers are busy and, you know, have to be on track on seeing patients but sometimes I don't think they take, they're there to help you have a better healthier life and sometimes I don't think that they...they make their judgments before getting really to know you better. (417-421)

Rodeo reflected on his dearth of involvement in preventive care when he was told he was pre-diabetic. Teaching had been present, but not learning. He has learned about the importance of mutual participation:

> Probably, maybe a misunderstanding, I've learned I've got diabetes, a misunderstanding, not taking care of myself properly because I maybe didn't listen close enough to how serious it could be. (43-46)

Personal meanings involve a person's framing of their situation (such as whether their condition is dire or minor), interpretations of their progression through illness in the context of their life. Through conversation, reflection, and action, meanings are not just lived but learned, and potentially re-shaped.

Rodeo appeared to be coming to grips with the meanings of chronic illness, narrating the tension between hope and acceptance:

> You know, and sometimes you just, you just come
> to the point that says, well I guess that I'm
> deemed to live with it, you know, and maybe you
> shouldn't have to. (280-282)

Personal meaning is not just the province of patients. Here, Carl pondered his meaning making process as a clinician:

> Learning personally on a daily visit is, even
> on those patient encounters when you haven't
> been the happiest, or that you had a patient
> encounter that made you really frustrated, is
> try to look back and see, well, how did I still
> help that person for that visit. (318-322)

CORE PURPOSES

The dimensions of learning were constructed without a predetermined theoretical framework, working directly from the interview texts. By contrast, the seven core purposes framework is a novel external framework, which was then applied to the interview texts. No interview questions were directed to core purposes, but as subjects spoke of perceptions of learning, there was evidence that

all of the core purposes were represented, with the possible exception of the ecological. Table 2. presents the frequencies of coded comments relating to each core purpose.

Table 2. Core purpose frequencies

Purpose	Frequency
Ecological	1
Societal	53
Spiritual	77
Moral	25
Augmentative	9
Corporeal	108
Economic	109

The seven core purposes framework defines fundamental and legitimate purposes of primary care, stating in a general way the individual, social, and societal ends that are intrinsic to the enterprise of primary care. The core purposes are: *ecological* (sustainable bio-systemic balance); *societal* (good of the body politic); *spiritual* (quest for meaning); *moral* (attending to suffering);

augmentative (enhancing capacities); *corporeal* (bodily care); and *economic* (fair exchange).

The core purpose least in evidence in the interview texts was *ecological*. Family medicine practitioner Joyce made the only comment that could possibly be interpreted as an ecological concern, directed to forestalling antibiotic resistance in bacteria. However, the segment could more easily be interpreted as refraining from doing what is ineffective biomedically:

> ...the other is preconceptions, I think when patients come in knowing that they need an antibiotic, they've always gotten an antibiotic for this, and it doesn't go away unless they get an antibiotic, and you know you try and have the discussion with them of why that doesn't work.(249-253)

Societal purposes were far better represented, with 53 comments catalogued. Topics included equitable access, minimization of societal costs, and the reiteration of societal order (particularly through authority and control of deviance). While there are deeper socio-economic access concerns, Siobhan told of trying to schedule everyone who needed to be seen during flu season, a matter of practical and local equitable access:

> Some days are more hectic, especially when you
> have a lot of sick patients, if there's a bug
> going around, everybody wants to be seen right
> now, they don't want to wait ((laughter)).
> ((inaudible joking comment, laughter)) (70-74)

Carl addressed the large scale societal interest of

minimizing cost in these terms:

> And if we look at the rate of obesity, and it
> has skyrocketed in just children over the last
> 10 years due to increased inactivity, increased
> fast food, that's going to be a problem for us
> twenty years down the road in even higher rates
> of diabetes, higher rates of hypertension,
> higher rates of heart disease, and then that
> will produce even more strain on the medical
> system and the resources available. (472-478)

In this next segment, Carl noted a cultural barrier

to learning, taboo topics. This segment is cited to

indicate how the reiteration of societal norms is

participated in by patients, and not only passed down by

clinicians:

> Other barriers at times is just purely cultural
> too, and that can be linguistic and cultural
> just in terms of, oh, different thoughts about
> medical practice, or things that you should and
> should not share with your family physician.
> (59-63)

Joyce talked about working in an HMO where patients

didn't want personal questions asked. Here is the tension

between seeing the practitioner as an instrument of social
control, and as an instrument of personal healing:

> And you know when I would start to ask them
> more ((laughter)) about the stressors in their
> life or something, they were shocked, they move
> on, you know it was like, no, you know, these
> bruises didn't come from my husband you know,
> ((laughter)) or whatever. So there is some
> self selection there, I think not, and you know
> some people choose ((name of HMO)) because it
> is like that because it's, you know, fast, it's
> efficient, and they don't ask you personal
> questions. (603-610)

To speak of *spiritual* purposes is difficult in the
desacralized modern world. Spiritual purposes concern the
quest for meaning. Herewith are three aspects of
spiritual purpose in the secular world: accommodation to
the Real; presence, witness, and compassion; and medicine
as meaning.

Accommodation to the Real is about coming to grips
with what is, in a diagnosis or a condition of life. Joe
related a story of ignoring severe chest pain with acute
onset until after his work duties were completed. In
retrospect, he considered his denial of real urgency:

> But I did have a learning curve experience in
> the office, the immediate visit thereafter, as
> to the importance of getting things checked out
> right away. (101-103)

Accommodation to the Real is not only a patient's task. In this passage, physician assistant Cindy spoke of coming to grips with the real complexity of a patient, and the real limits of what can be accomplished:

> And you do always look at that before you go into the exam room, you need to take a sigh, you just feel overwhelmed before you go in. That happens, that does happen, all of those things can't be addressed at that first visit, and so sometimes you do have to break things down, and say we need to focus on this and then we'll get to the bigger issues later. Again, I think our practice, and I think it's good in recognizing lifestyle and social factors and so forth to play a huge role, and if you don't address those issues you're never going to fix the ((?)). (373-382)

Of the 77 comments catalogued in the spiritual dimension, 46 pertained to presence, witness, and compassion. Presence involves being humanly available. Witness carries the dual meaning of seeing and saying: to recognize another, and to speak to the truth of their situation. Compassion is the heart of *caritas*, caring. As Joe put it, "So it's nice, you feel like the guy cares." (172-173) Caring, of course, is a matter essential to medicine, not merely a nicety.

The act of presence, openness to the patient's story, and the act of witness, in listening, are together therapeutic. Carl pointed to this power:

> And trying to decrease that pain, whether it is just by listening to them and they feel like their pain has been better, or whether it is by doing the other traditional medical approaches. (556-559)

Medicine as meaning refers to making sense of our condition, particularly in a larger than individual context, a transcendent context. In this regard, both narrative therapy and Frankl's logotherapy are exemplars (White and Epston, 1990; Frankl, 1992). Only three comments were catalogued under meaning, and three more under hope. Rodeo found a larger meaning that fueled his will to maintain his health with the recognition that he wanted to stay alive for his granddaughter. Finding a positive meaning is concurrently locating hope. Rodeo expressed it this way: "It kind of hit home, this is a, we have a granddaughter, I know you want to live a little longer and spend some time with her." (76-78)

Siobhan considered the sense of shared mission that makes a health care organization meaningful for all the participants:

> The only thing maybe I would add is that like I
> said, it doesn't only affect the doctors and
> the patients but it affects the clinic as well,
> the workers, the co-workers. If they're not
> feeling that like I said, that they're not all
> working on the same level, and we don't see
> patient satisfaction, and we don't feel like
> we're part of the bigger loop, you feel kind of
> worthless.   You   feel   like   you're   not
> accomplishing anything, you feel like, God if
> we could just make this all kind of synergized
> together and make everybody have the common
> vision that this is what we're supposed to be
> doing, then you would feel satisfied, you'd
> feel like you'd done something worthwhile.
> (873-884)

Moral purposes involve a call: at the most basic

level, people are called to respond to suffering. When

people suffer, they call for help. Physical suffering and

its relationship with pain is better acknowledged than

mental, emotional, and social suffering. The vocabulary

for spiritual suffering has largely been lost. Among the

25 comments catalogued under moral purpose, Carl's stood

out for clarity about the centrality and dimensionality of

suffering:

> And I think first and foremost, I think we can
> document and state that a lot of our medical
> problems result from pain. Pain not only from
> muscular or skeletal, but emotional pain. And
> why does a patient go see a doctor in the first
> place, they're having pain somewhere, it could
> be pain from depression, pain from anxiety,
> it's a different type of pain, or too, maybe a
> painful cut finger that they need sewn up. I
> guess in, we have to get better at
> understanding the role of pain and how it

affects the persons' whole well-being. (547-556)

Augmentative purposes are related to the enhancement of capacities and potentials above normal. Education is one means of attaining augmentative purposes. Education might be tacit, such as when modeling a behavior. Nourishing individual capacities is not the dominant purpose of primary care, but it does express a function of health promotion. Only nine comments were catalogued as pertaining to this category. Improving resilience and coping skills, and improving social engagement skills, are aspects of this purpose. So are the many cosmetic concerns with the body: acne-free skin, shapely nose, etc.

Coping is a central demand of illness. Rodeo said of changing his lifestyle to accommodate diabetes, "I'm having a heck of a time adjusting to that, but I'm getting there." (58-59)

Joyce spoke of the difficulty of reaching a patient whose social engagement skills were impaired, pointing out their foundational nature:

> Which is fine, but you know there's no
> educating her and there's no helping her, you
> know nobody will be able to maintain or even

establish a relationship with her to be able to
help her. (312-314)

Carl addressed his own coping skills in dealing with

the ever-present possibility of bad outcomes this way:

> But still mistakes happen, and bad things
> happen, and that unfortunately I see that over
> the last, you know 20, 30 years, there's been
> more and more focus on shifting blame to
> somebody. And I think everybody should take
> care in positioning anybody, outside of
> negligence. If there's pure negligence that
> occurs, that's very different, but I think that
> if you get patients to buy in with you, and
> getting a better appreciation of a team
> approach to medical help, then you will get
> less problems in putting blame on, when results
> aren't met. (624-632)

The *corporeal* purposes are so dominant in biomedicine

that supporting quotations are largely unnecessary to

illustrate attendance to diagnosis, disease causation,

disease prevention, biomedical intervention, and disease

prognosis.

The dominance of corporeal purposes over other

purposes was pointed out by Fred:

> I think the education, the physician has
> requirements to continue their learning, to do
> the medical. And what are they learning? They
> continue to learn technical information. If
> you have two courses, here's a course presented
> by Oregon Health Sciences on CF, and here's a
> course on interacting with your patients, the

vast majority are going to go to the CF one as opposed to the interaction one, the scientific rather than touchy-feely. (264-271)

Fred went on to wonder what needs were missed, and whether alternative providers met some of those needs:

When I was reading it, thinking about, those thoughts go off in your head, that you're doing this analysis, and I've always been fascinated where you hear stories about millions and millions and millions of dollars people pay out-of-pocket to go to alternative type of providers, chiropractors, naturopaths, those types of things, well why do people do that? Are they getting... where are they in essence doing it right, and where is the traditional medicine doing it wrong.

*What need have we missed?

Right. That's an excellent way to put. We're missing something, we should be able to learn. Is it that the chiropractor, is the touch that they appreciate, that they feel like something's being done as opposed to just a cognitive exercise? Are they able, in a negative sense, to manipulate those people to get what they want as opposed to not in health care? I don't know that. (316-333)

The final purpose is *economic*, understood as fair exchange. Health care is a complex exchange of knowledge, procedural skills, social and personal identity, trust, caring, time, and money. But the value of the exchange is not reducible to money. There is no way to price the many "goods" conveyed to the multiple beneficiaries of any

single transaction. Nevertheless, participants do evaluate the justness of the exchange. 109 comments were catalogued relating to fair exchange or the sub-category of social exchange. Social exchange includes the settlement of roles - sick roles and healer roles are both conferred in medical encounters.

The question of beneficiaries of the exchange came up in this segment from Whit:

> If you need to get a referral from your primary care doctor, that referral more than likely is going to be right here to somebody else that's right here in these buildings on the hill in (name of this city). Because they are all in under the same umbrella. And so it's like maybe they all, you know, you scratch my back, I'll scratch yours. It's a kind of, a set up. They forget there could be, that there's somebody else in another town, in another area, that is as qualified or better, or whatever. (368-376)

Joe expressed amazement with (and appreciation for) the time his practitioner spent with him. This can be taken in part as an evaluation of fair exchange:

> He takes time, he must take less patients an hour than most people, I swear, because he's - how can I say that politely - he's not really far behind. Because he sits in a room with me sometimes, a half an hour. And I'm talking with other patients, or how does he keep this close to time, the worst I've ever been was 45 minutes late, behind in his office. So he takes the time and he asks questions. (166-172)

Pete characterized the social exchange relationship he experienced with physicians as one of "family":

> That relates back to my experience in the Air Force with our flight surgeons. Because our flight surgeons were part of the family. (275-277)

Joe also noted the value of the social aspect of exchange, in these words:

> ...so we have a chance to sit down and, you know, how are the kids, back and forth. So besides how's it going, what's my blood pressure, what's the blood work say, there's some connection beyond that. (144-147)

DIAGRAM REACTIONS

Subjects were shown a systems diagram of a dysfunctional situation of learning in medical visits (Figure 3a.). The diagram was intended to be easily comprehensible. This presumption was tested in three ways: by timing how long it took subjects to acknowledge they were ready to be asked questions about the diagram; by asking if the subject understood the diagram; and by asking what the diagram depicted. The average time elapsed was 47 seconds, with a low of 20 seconds and a

high of 130 seconds. Every subject claimed that they could understand the diagram.

No reports of what the diagram depicted were wrong, although they differed in comprehensiveness. Megan found the diagram challenging, had the most difficulty explaining it, and took the longest to be ready to discuss it. In her words:

> Hmm. I'm not quite sure, I don't know how to say it. Umm, it's very structured... I don't know I don't even know if I'm going to get it right but, to me it's, if you go, they are trying to describe how an office would work I guess. ((Note: very tentative voice)) That if you go in to see somebody, um, they have it very structured that you go in for this amount of time, that you tell them exactly what you are there for, you don't have time to elaborate on, you know, other things or what's happening in your life, or...um, I don't know, hmm. ((8 second pause)) I guess if you go there you go through, even you've seen the doctor for what you want to see them for, but you're still having the symptoms, like this direction says some patients drop out of the health care system, and that's probably because they're not getting anything within that diagram, they're not feeling that they're being listened to, feeling rushed maybe, which is, I don't know. That's I guess what I see. (283-301)

Rose, at 81 years of age, took 105 seconds to be ready to discuss the diagram. Her explanation of what it showed was succinct:

It wants to know how well the management, such
as the HMO, meets the patients' needs. We
don't belong to an HMO. (144-145)

Joyce's response provided an example of high
comprehensiveness and tight articulation at 40 seconds:

Umm, how not listening to our patients and
fully understanding them hurts the health care
system, and overloads it, whereas we're
thinking we are being more efficient, we're
actually being less efficient, driving more
patients into the system...

* Precisely so.

... and out of the system. (540-547)

Critique was sought from subjects concerning the
accuracy of the diagram. All respondents to this question
affirmed that it was an accurate representation.
Practitioners Carl (531) and Cindy (343) each qualified
their endorsement to indicate that there were also other
patterns that can occur.

Clarification was sought concerning whether this
pattern took place, where it took place, and how common it
was perceived to be. All respondents agreed that it was
a pattern that actually occurred. Three patients
specified that it did not occur to them, although they had
heard stories that fit such a pattern. No respondents

claimed it was a common pattern at this clinic, and five subjects averred that it applied more generally in the practice of medicine. Perceptions of the commonness of the pattern varied, with six respondents saying it was common; five respondents hedging their response in between common and rare; one respondent saying it was rare; and two saying they did not know.

Another approach to validation of the existence of the pattern depicted in the diagram was afforded through asking if subjects had ever experienced the pattern. Every subject reported that they had experienced the pattern, or knew of it from the experience of others. (Sue, 597-601, 578-581; Fred, 425; Megan, 387-398; Sonia, 228-236; Whit, 428-453; Rodeo, 268-282; Pete, 229-230, 257-270; Rose, 162-206; Arnold, 295-302, 405-408; Joe, 285-308; Carl, 665-682; Cindy, 361-382; Joyce, 676-689; Siobhan, 730-731, 738-741; Jill, 557-562, 530-539)

Rose (173-206) provided the weakest affirmation, saying that she had not experienced the pattern. But she then went on to explain how she avoided it by not belonging to an HMO. She had just previously (162-171)

affirmed that the pattern was a common one, based on what she had heard from friends.

An example of strong identity with the pattern was provided by Siobhan, who said:

> I do know that this pattern, this pattern of inadequate care, really was exactly where I was in my other clinic. It didn't just affect the patients, it affected the people who worked there, a gob. (738-741)

An inquiry was made about the fairness of the language in the diagram statements - had the researcher maligned anybody? This question brought out eleven affirmations that the language was fair. Three of those bore a single qualification: fair for the purposes of this diagram (Sue, 587-590); fair but objected to the use of the word "provider" (Carl, 603-608); and fair in general, but not for the practitioners at this clinic (Jill, 546-555).

A fourth "fair" respondent, physician assistant Cindy (403-413), offered several qualifications: overall fair, but not to the management of this clinic. Furthermore, she asserted that practitioners do learn enough about patients over time. She also expressed that learning about

patients in a medical context was not bad, and the structure of clinical time for practitioner efficiency was for the good of patients.

In addition, one patient respondent (Whit, 406-426) said the diagram might not place enough emphasis on the patient's role in making a visit work well; and an administrator respondent (Fred, 383-403) said that the statement that physicians do not learn enough about patients lives might not be fair to physicians, who do pick up on subtle cues about patients.

One more respondent, a physician (Joyce, 651-674; 691-710), suggested that the diagram arrow linking "office visits are designed to use provider's time efficiently" to "medical interventions inadequately address patient needs" was an incorrect link. Finally, one patient respondent (Arnold, 344-350) said the language was neither fair nor unfair. Comments of all respondents were welcomed.

Asking about fairness of language brought out suggestions for correction that were more substantive than linguistic. A request for substantive review for errors or mistakes was also made. While five respondents had no

suggestions for change, this question brought out yet more comments, in addition to those above.

Fred (341-363; 473-474) suggested that people do not drop out of the heath care system forever, and so maybe the language should indicate that they relocate within the system, or take a temporary leave. He also wondered if a loop could be included that showed how to obtain feedback from dissatisfied patients.

Carl (460-472) questioned whether patients wanted to do the work of lifestyle change, which ill accords with a quick- fix, fast food society. The diagram presumes an interest in lifestyle care, a presumption which may not be warranted. Carl (612-614) also wanted to see reference to the humanity and fallibility of practitioners included in the diagram.

Cindy (330-336) made clear that the diagram was incorrect for this clinic in that there was (fortunately) no management production pressure here.

Siobhan (723-725) brought out the distinction that the diagram was not about insufficient learning, but

insufficient care. She also suggested (867-890) a loop that showed when patients are frustrated with care, everybody in the system is frustrated as well. And Jill (546-555) emphasized that patients come to this clinic because they do not feel like a number here.

Subjects were asked how we might recognize, alter, or prevent the dysfunctional pattern. Whit (348-390) and Rose (177-193) suggested avoiding managed care. Rodeo (241-247) said that if we could get the politics of the American Medical Association and the pharmaceutical industry out of the way, we could fix things. Pete (292-314) noted that men will tend to drop out of the system more than women. Joe (315-343) indicated that it would take listening to the experience of patients, and reconsidering the fairness of the exchange. Carl (727-743) suggested that practitioner focus on a humane mission was important, but he also had cited (495-515) resistance to change from patients and insurance companies. Joyce (558-566) thought that if practitioners learned more from patients, it could defuse the dysfunctional situation.

Siobhan (807-838) suggested that if clinics recognize that quality of care pays off, they will be motivated to

change. She also spoke of a transcendent responsibility to attend to patients. Her comments express the ancient meaning of faith (Smith, 1998):

> So sometimes you have to take responsibility and break, it sounds horrible, but sometimes you have to be responsible enough to break the rules for the better good. (858-861)

Subjects were asked if the diagram showed anything useful or interesting, and if it made anything clearer. Six subjects responded in the negative, or with tepid affirmation. (Sue, 556-573; Pete, 208-214; Rose, 147-151; Joe, 255-265; Cindy, 327-336; Jill, 564-572) Pete provided an example of pale praise, saying, "No, actually this is putting down a lot of common sense..."(212), and he went on to affirm that it mirrored how he sees the system.

For Megan (400-429) and Carl (684-712), the diagram's reference to the importance of patients' stories was a welcome reminder, touching something basic to care. Fred (458-479) remarked that the diagram raised the question of why people drop out of the system, and how to manage that.

What Arnold (370-384) reported as interesting was first, the systems diagramming approach to studying a complex situation. Second, (448-470) he recognized that

the diagram would raise uncomfortable questions of purpose and responsibility for patients, practitioners, and management.

DISCUSSION

PERCEIVED LEARNING CASE STUDY

The first research question involved assessing quality of learning at a case study clinic by interviewing participants representing diverse roles to depict reported perceptions of the quality of learning; learning factors and sources; and dimensions of learning.

All subjects who assessed the quality of learning for both patients and practitioners specifically at this clinic site, did so in positive terms. Pride was evident in the quality of education, care, and service.

Unsolicited comments relating to satisfaction with the clinic, coming from diverse participants, were also largely positive. The manager described training staff to report potentially dissatisfied clients, and spoke of her initiation of problem resolution. Employees spoke of their job satisfaction, and attributed it to the lack of production pressure, the coordination and dedication of

the staff, and capable management. Patients spoke highly
of caring and competency.

Beyond the interview materials, through the process
of making arrangements for and conducting the study at the
clinic, the researcher experienced excellent
communications. For example, the researcher could reach
staff on the phone without long holds. Information about
the study was conveyed from the clinic manager to the
staff, and smooth coordination resulted. People were
genuinely helpful, despite the impositions of the study.

The interviews demonstrated learning sources in nine
classes: formal education programs; meetings; management
and organizational culture; media sources; text sources;
medical tests; practitioners and staff; patients and their
social networks; and intra-personal sources (such as
memory, experience, and reflection). This is a reminder
of the diversity of educational channels.

The interviews presented a phenomenological array of
learning factors, attesting to the complex, layered, and
inter-related situation of learning. The categories were:
mass media messages; organization's management and culture

of care; time; cultural and linguistic barriers;
educational influences; power and conflict; patient
clarity and assertiveness; dialogue and relational
practices; attitudes toward teaching and learning; gender
and generation; and emotional loading. The improvement of
learning may simultaneously involve several of these
factors.

A conception of dimensions of learning, as distinct
topical areas of common concern in medical visits, was
developed from the interview texts. The conversations
provided evidence for a set of six dimensions: costs and
coverages; negotiating the clinic; negotiating the visit;
biomedical constructions; relationship and caring; and
personal meaning. This preliminary functional description
of areas of learning requires further study to determine
if other functional dimensions can be identified.

It is necessary to distinguish functional dimensions
of learning from core purposes. Functional dimensions are
structured by the need to negotiate the realities of the
clinic. Core purposes, while informing the realities of

the clinic, also greatly transcend them. Core purposes
are more fundamental than functional dimensions of
learning.

From the above perceptions of learning quality at the
case clinic, reported patient and employee satisfaction,
and first hand experiences of the clinic, the researcher
would deem this a model clinic in terms of learning
quality. That is apparent when looking from within the
context of the emergent purposes of the clinic, and by
comparison with other clinics operating within the context
of similar emergent purposes. However, perceptions of
learning quality are only one approach to determining
learning quality. Furthermore, from the perspective of
core purposes, quality of learning can not be adequately
determined from this level of inquiry.

SYSTEMS DIAGRAMS

The second research question concerned interview
subjects' responses to a systems diagram of a
dysfunctional clinical situation of learning. The diagram
was intended to convey emergent outcomes that were

unintended but in need of attention. The focus of the research question was to determine if the diagram was rapidly comprehensible, and if subjects were capable of providing useful critique of the diagram.

Subjects were presented with a diagram depicting a pattern of insufficient learning (Figure 3a., repeated below as Figure 3b.). The diagram was rapidly comprehensible, taking on average 47 seconds for subjects to be ready to field questions about it. All subjects also reported and demonstrated comprehension of the diagram.

From a methods standpoint, these are findings of substantial interest. It is reasonable to presume that a written narrative explanation would take many times longer to convey the inter-relationships depicted graphically. Furthermore, the language in the diagrams is simple, leading to comprehension by not only experts but arguably by most English-literate adult participants in primary care as well. The method has demonstrated potential to assist in communicating to ordinary citizens the context of complex social behaviors.

Patterns of living
produce symptoms

Management responds
to market forces,
pressing providers
to be more productive

Total health care system
costs increase from
ineffectiveness

People consult providers
who are very busy

Some patients
drop out of health
care system

People experience
symptoms

Office visits are designed
to use providers' time
efficiently

Symptoms frequently
continue or return

Patients' lived stories are often
not invited because stories are
not deemed medically relevant

Healing and satisfaction
are not optimal

Providers continue
to understand
problems mostly
in a medical context

Medical interventions
inadequately address
patients' needs

Providers don't learn enough about
patients' lives and experiences

Figure 3b. Dysfunctional learning system

Patterns of living
produce symptoms

Management responds
to market forces,
pressing clinicians
to be more productive

Total health care system
costs increase from
ineffectiveness

Some patients
drop out or
relocate in
the health
care system

People consult clinicians
who are very busy

People experience
symptoms

Office visits are designed
to use clinicians' time
efficiently

Symptoms frequently
continue or return

Patients' stories of their
illness experience are often
not invited because stories are
not deemed medically relevant

Healing and satisfaction
are not optimal

Clinicians continue
to understand
problems mostly
as biomedical

Medical interventions
inadequately address
lifestyle causes and
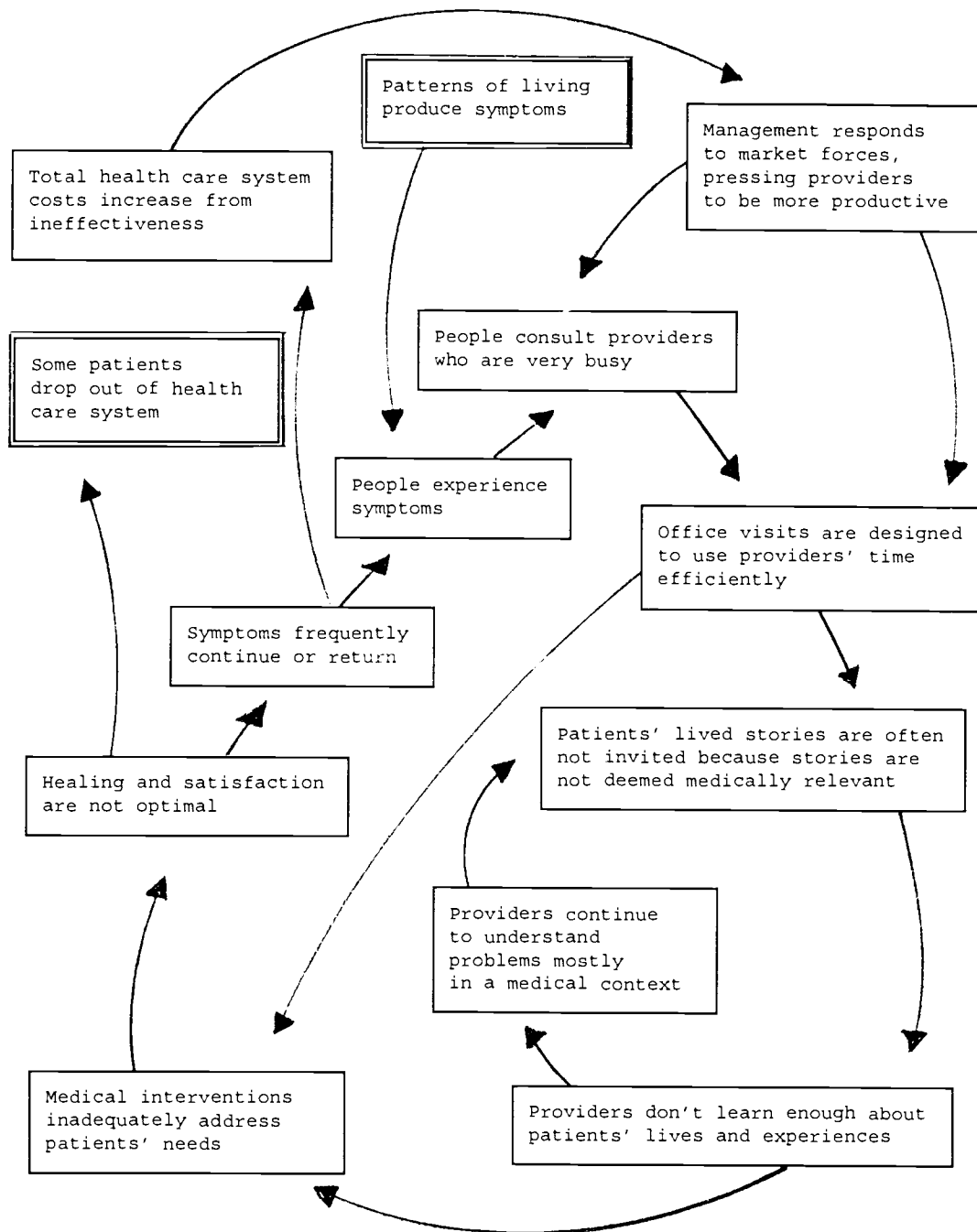many patients' concerns

Clinicians don't learn enough about
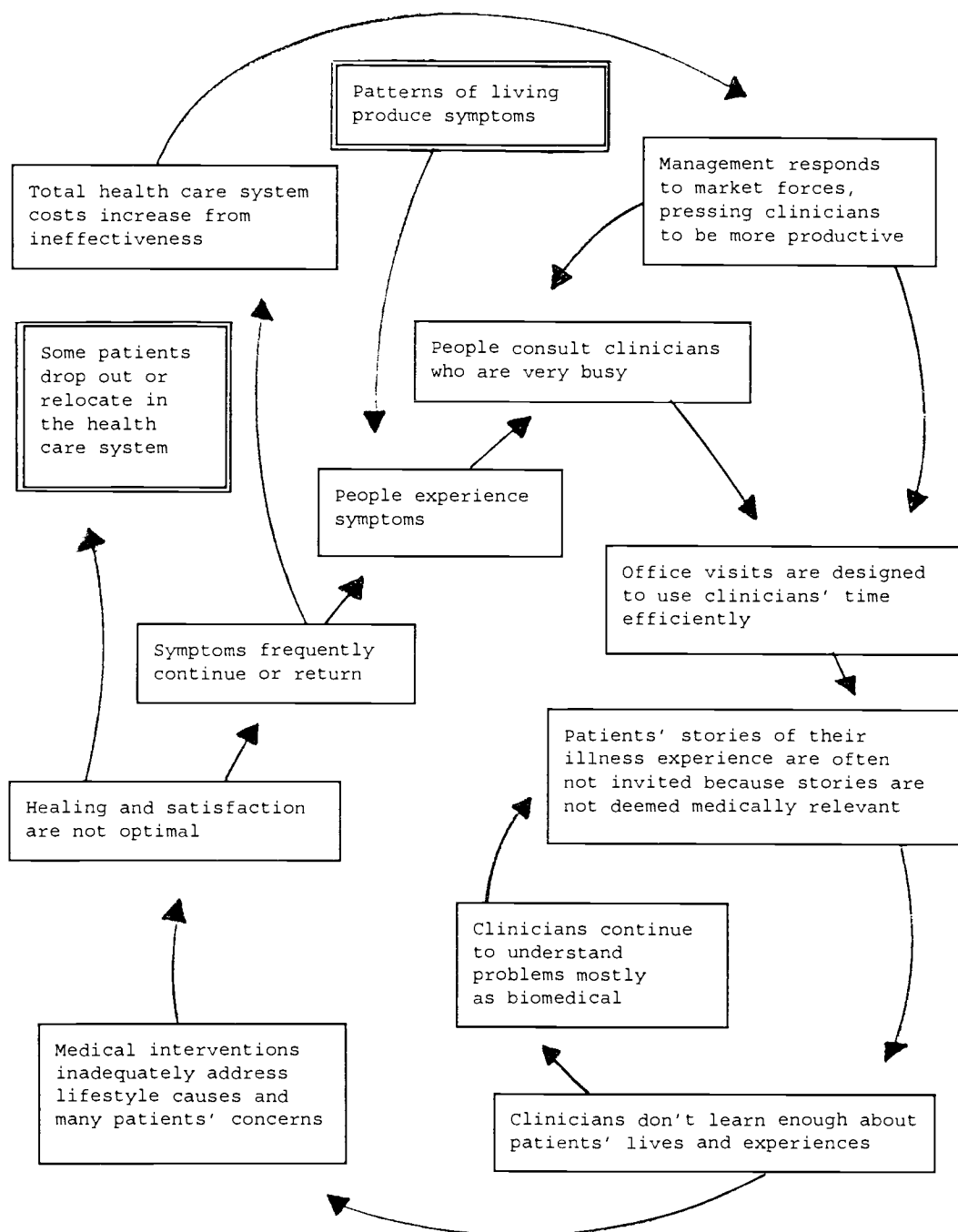patients' lives and experiences
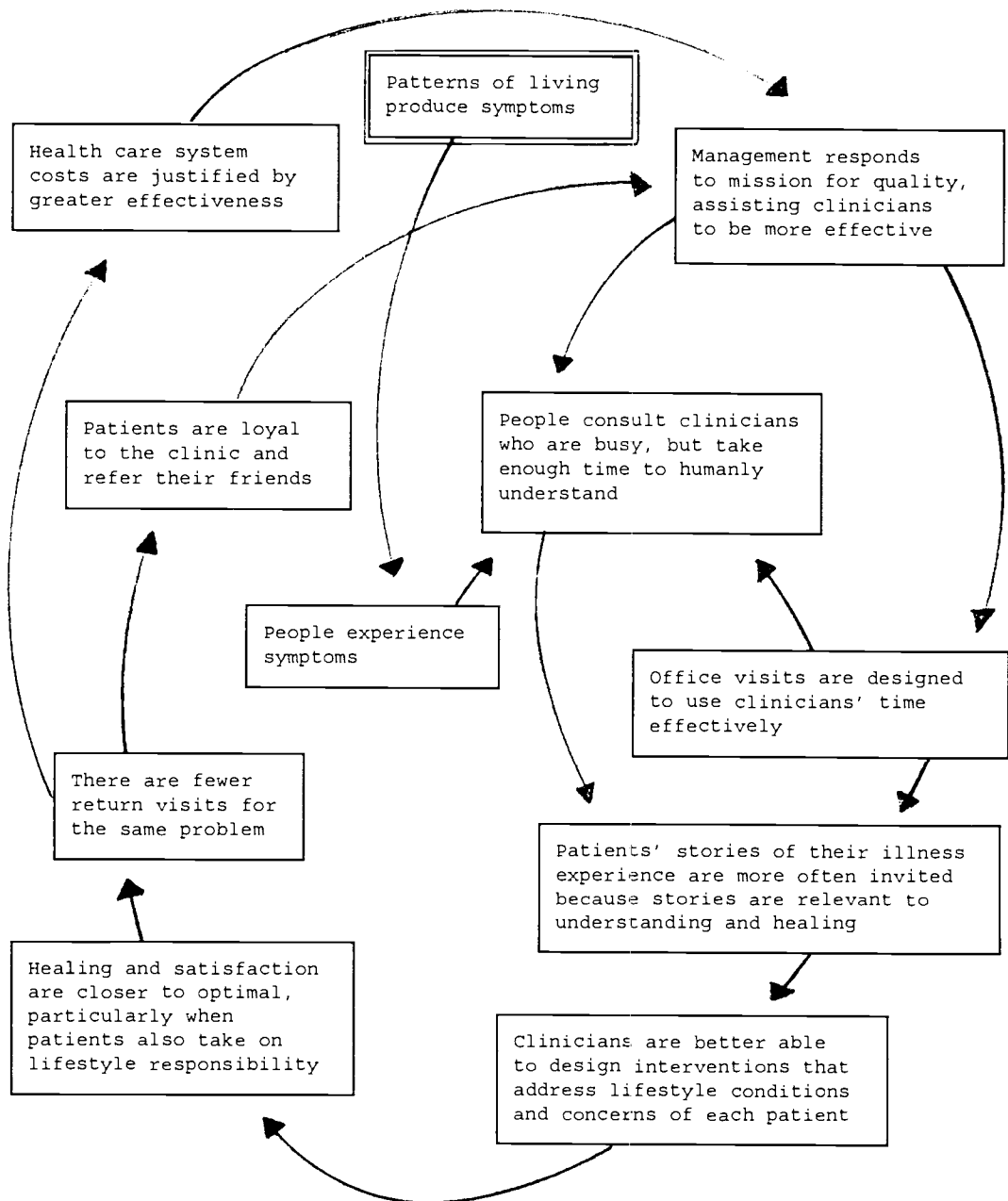
Figure 4. Revised dysfunctional learning system

Figure 5. Quality centered learning system

The diagram displayed a conflict between efficiency, efficacy, and effectiveness in a clinical system. Effectiveness means approaching the overall purposes of health care, the valued ends, the fundamental reasons people seek care. Efficacy refers to producing a desired biomedical outcome, and represents the dominant focus of clinicians. Efficiency refers to attaining an end with the least input of resources, often a prime managerial duty. But note that a focus on efficiency per se does not identify the value of the ends that are to be attained. Inappropriate measures of efficient productivity (e.g. more patients per unit time) can radically distort effectiveness. So it is depicted in Figure 3b., wherein the interests of efficiency and efficacy often leave patients' needs unanswered.

No respondents claimed the dysfunctional pattern was common at the case study clinic. Yet every subject recognized the pattern, either from personal experience or from the stories of others, and most reported actively avoiding it. As Siobhan said, "This is the clinic I used to work for." (730) Recognition of the pattern as similar to personal experience is a test of face validity. The dysfunctional pattern may well be widely experienced.

Subjects provided useful critique leading to improvement of the diagram. Inquiries were made concerning the fairness of the language in the diagram; errors in the diagram; ways to recognize, alter or prevent the dysfunctional situation; and the utility of the diagram. These inquiries brought out a range of suggestions leading the researcher to reconsider the original diagram (Figure 3b.), and to revise it as shown in Figure 4.

The differences between Figure 3b. and Figure 4. are as follows. The term "providers" was changed to "clinicians" throughout, as one physician objected to the use of providers. The statement "some patients drop out of health care system" was altered to include the outcome of relocating within the health care system. This was done following an observation about such relocation by an administrator. The statement "patients' lived stories are often not invited because stories are not deemed medically relevant" was changed to specify stories of illness experience. This was done for greater clarity of meaning. The statement "providers continue to understand problems mostly in a biomedical context" was made briefer without

sacrificing meaning. The statement "medical interventions inadequately address patients' needs" was expanded to include lifestyle causes and patient concerns, as this larger frame was intended. Finally, the linking arrow was removed between "office visits are designed to use providers' time efficiently" and "medical interventions inadequately address patients' needs." This was done on the advice of a physician, who held that lifestyle concerns could often be addressed in the compact time frame of a standard visit.

Neither the original diagram nor its revised version present the dominant situation of learning at the case study clinic. Indeed, the case study clinic appears to be the antithesis of the situation diagrammed in Figures 3b. and 4. It is a site where these diagrams are least true to experience.

It appears that clinical participants are aware of the potential for something like the dysfunctional pattern, and have taken steps to create a different pattern with preferable outcomes. Therefore an additional diagram was drawn (Figure 5), showing the beneficial situation of learning more reflective of this clinic. It

is a system driven by a mission for quality rather than price and quantity.

Sustaining Learning Quality

How can a quality based system survive within the context of a larger price based system? There are three major points of resistance suggested by comparing Figures 4 and 5, and considering the results of the interviews. First, management resists mistaking efficiency for effectiveness, and therefore does not adopt quality-depleted proxies for efficient productivity. Practitioners and staff gratefully cited the lack of production pressures from management at this clinic. This is an example of the first point of resistance.

Second, clinicians resist the biomedical framework of medical education and the procedural bias of reimbursement policy. They sacrifice a certain measure of professional status and income for a quality mission which provides meaning and satisfaction. Practitioners spoke of the adequacy of their income, and of the importance of connecting with patients. Family practice physician

salaries are considerably lower than internal medicine physician salaries. Family practice training is more influenced by the biopsychosocial framework than the biomedical framework. These factors provide evidence of the second resistance.

Third, patients resist the passivity of the quick fix mentality to become more active participants in their health. They are perhaps most able to be recruited in a system that makes time to care. Arnold described a level of patient participation that would challenge any practitioner to engage with. Whit spoke of her readiness to seek out health information, and the responsibility of patients in achieving satisfactory care. Sonia chided herself for being less assertive in asking questions than she should have been. Rodeo was processing the importance of being more committed to his own care. Pete spoke of the importance of having medical information explained, and the value of two-way conversations. These patients either have become, or are becoming, active partners in care, exemplars of the third resistance.

Resistance to the dominant system is not a reactionary driving force, an act motivated against the

system, but the result of a positive quality centered

mission, acting for higher purposes. It is an attempt to

escape distorted emergent purposes and recover core

purposes. The frustration of participants (whatever their

role) in a health care system is to some extent an

expression of desire to reclaim core purposes. Higher

purposes were eloquently spoken for by management,

practitioners, staff, and patients. Siobhan summed it up

this way:

> I do know that all the things that I didn't
> think were possible in a clinic when I came
> here, are possible. I think that whole
> receptive, intuitive, caring for your patient
> really pays off. You know, maybe, maybe you
> don't get your whole patient load in, maybe
> instead of seeing 20 patients in a day you only
> see 12, and maybe the doctor makes less money,
> I'm sure it has something to do with
> production. But when you have those 12
> patients who come in and are repeat customers
> and then they tell 12 friends, and those
> patients are satisfied and continue to stay
> here, I think you have a much healthier base.
> You know, it's not quantity, it's quality.
> (827-838)

Sketching Dysfunctional Systems

Difficulty gaining effective entry at the first

research site deserves some consideration. Approaching a

site, armed with formal research protocols - with consent

forms and tape recorders and publication of results in the offing - is probably somewhat threatening, particularly if the research is aimed at uncovering dysfunction. Defensiveness is all the more likely when dysfunction is already apparent to those in the system. Paradoxically, formal approaches to research may make obtaining reliable knowledge more problematic than informal approaches.

In dysfunctional systems, an informal approach can reasonably be expected to be more effective. Casually converse with participants known as friends or acquaintances, and listen to their accounts of frustration. From these accounts, draw a sketch of the context. Validate the sketch by assent of participant informers. Alternatively, teach the sketching method to participants, and facilitate their sketching, acting not as expert but as scribe. If informal entry is not possible, and blame for dysfunction is at issue, then sketch the context in a way that the behaviors make sense from the perspective of those acting them out, presuming that the individuals are well intentioned (Bella, 2002). This spirit makes the method of qualitative system diagramming more than a tool for visualization of context. It becomes an instrument of change through compassionate

understanding, and a way of moving beyond blame when systems are dysfunctional.

REVIEWERS' COMMENTS

As a gauge of internal validity, three interview subjects reviewed a draft copy of the report on learning quality that was to be given to the case study clinic. The draft report was an abridgement of this dissertation, lacking all reference to the core purposes framework, and without transcripts of the interviews.

Clinic manager Sue, physician Carl, and patient Rodeo, each responded with a brief written review, quoted below. The researcher had inquired if they thought the report was in error in any way; requested feedback on the revised diagrams (Figures 4. and 5.); and invited an overall assessment of the report.

No reviewer found the report in error. Their responses are provided verbatim below. Figure numbers cited in the reviewers' reports have been altered to

correspond to the numbering herein, without changing
meaning.

Sue, clinic manager:

1. I don't find the report in error in any way.

2. I believe figure 5 most accurately describes
the scenario in our clinic. At least through
feedback received from our patients, employees
and through my experience working here, this is
what I believe.

3. My overall assessment of the report is that
each interviewee's perception is biased due to
the "role" they play in the health care system.
As far as overall content, I think it's well
written and accurately describes perceived
learning in primary care (in (city name).) It
would be interesting to compare the same study
in a different clinic, in a different part of
the country with greater varied socioeconomic
diversity. In general I think the quality of
our medical care and patient education in (city
name) is probably among the best in the region.

Thanks for including (clinic name) in this
fascinating study!

Carl, family practice physician:

Thank you for the opportunity to look and read
your report. I found it interesting and did not
consider it to be in error. After practicing
more in our clinic after we had the chance to
talk, and discussing how other clinics work, I
feel that we are trying to do something truly
unique and feel that we fall more into the
Quality Centered Learning System (Figure 5 of
your report). I found the overall assessment of
the report to be clear and concise, and what I
appreciated the most as a practitioner in the
health care field was reading the comments that

other individuals had to say. I also feel that
you very effectively captured some of the
current issues and frustrations from many
practitioners in the current system that we
have. Let's hope for change.

Rodeo, patient:

1. didn't note any errors

2. Figures 4-5 give a better view of the
sometime vicious circle the care giver & the
patient must adhere to.

3. You have a good spread of people you
interview, haven't had a chance to read all and
gave an overall assessment.

Thanks.

P.S. Since your interview I have notice (sic) a
little better attention to me as a patient
rather than just another office call.

PHENOMENOLOGY OF CORE PURPOSES

The third research question inquired into the

identity of the core purposes of primary care. The seven

core purposes (7CP) were derived from a systemic

phenomenological assessment of the intrinsic human

purposes of primary care, couched in non-medical language.

The purposes are: ecological (sustainable biosystemic

balance); <u>societal</u> (good of the body politic); <u>spiritual</u> (quest for meaning); <u>moral</u> (attending to suffering); <u>augmentative</u> (enhancing capacities); <u>corporeal</u> (bodily care); and <u>economic</u> (fair exchange). The systemic perspective includes the mutual negotiation of purposes for all the primary participants in the medical encounter: patients, families, practitioners, society, and Nature.

Systems phenomenology represents a cross between social science and systems science methods. It is both systemic and interpretive, constituting a method appropriate to the problems of organized complexity (Weaver, 1948) typical of human activity systems. Systems phenomenology exposes a more richly human territory than is revealed by methods which define logical hierarchies, such as were employed by von Bertalanffy (1969), Miller (1978), and Engel (1977).

Nor does this method locate the same territory as inquiries based on critical theory, as described in the work of Ulrich (1994); Flood and Jackson (1991); and Flood and Romm (1996). Critical theory has the intent of exposing "false ideology", while systems phenomenology has

the intent of exposing frames of meaning. There is also a subtle but significant difference in the power relations implied by each. It is the difference between critical conflict and mutual negotiation.

Methods of idealized design (Ackoff, 1999, p.122; Gharajedaghi, 1999, ch.7; Ulrich, 1994, p.377) often fall prey to abstractions that lack the textured human qualities located by systems phenomenology. Checkland's (1981, p.225) "CATWOE" (customers, actors, transformation processes, *weltanschauung*, ownership, and environmental constraints) approach to root definition of a problem does not specify a way to discover the crucial frames of human meaning within a worldview.

Systems phenomenology represents a significant innovation in social systems methods. At present it is more of a methodical injunction to attend to frames of meaning than an algorithmic method stating how to do so. Examples are found in the literature of anthropology, mythology, and cultural history (Levi-Strauss, 1969b; Campbell, 1956; Eliade, 1971). Adapting phenomenology to social systems science is an envisioned development.

The phenomenological systems approach, in comparison with the logical systems approach behind the biopsychosocial (BPS) framework, leads to clearer understandings of economic, ecological, spiritual, moral, and augmentative purposes. The 7CP's corporeal purposes are roughly analogous to the BPS's biological category, while the 7CP societal purposes are more broadly inclusive than the BPS framework's social category.

Evidence from the interviews supported the presence of all the core purpose categories, except possibly ecological, although there was no direct line of questioning to draw out the core purposes. Economic, corporeal, spiritual, and societal purposes were spoken of more than moral, augmentative, and ecological purposes. Evidence from the literature supported the existence of all seven purposes as fundamental and legitimate human ends of primary care.

Interest in defining core purposes of primary care is quite recent. Review of publications emanating from the Hastings Center international goals of medicine project finds much to praise in their work to date. However, the

7CP framework explicates aspects of primary care that remain concealed or indistinct in the Hastings Center reports. Among these are the economic, societal, spiritual, and ecological purposes.

CONCLUSIONS

CODA

What constitutes quality of learning in primary care? The first element to consider is what ought to be learned. The answer to this rests on an understanding of the fundamental and legitimate human purposes transacted in primary care. The seven core purposes represent domains of <u>knowledge</u> <u>and</u> <u>practice</u>, and provide the outline of a framework for quality assessment. Core purposes express the enduring and intrinsic dimensions of human value in primary care. Learning, practice, and purpose are closely linked issues.

Quality of learning is a cousin to the quality of medical care (practice). Donabedian (1980) provided the classic framework for practice quality assessment, in terms of structure, process, and outcome. But he proceeded on the assumption that purposes of care were understood and agreed upon. That is a flawed assumption.

Health care organizations, in concert with health professions and communities, develop emergent purposes which redefine, distort, and then conceal transcendent core purposes (as it were) behind an emergent barrier. Typical clinics practice primary care with over-developed corporeal purposes (and with interventions mostly restricted therein to biomedicine). This distortion is not only the source of much frustration and human suffering (Cassell, 1999), but a potent source of safety risks from pharmaceutical and surgical interventions (Kohn, Corrigan, and Donaldson, 2000).

The common distortion of fair exchange into the transfer of monetary wealth adds to a mounting instability in the enterprise of health care in America. The crisis is not fundamentally monetary, but rather a crisis of purposes.

Recovering core purposes may become an essential response for fundamental improvement of quality of learning and quality of practice in primary care. Observing the misfit between local practices and core purposes reveals distinctive opportunities for

improvement. Roter and Hall (1992, p.154-155), citing a nursing home study wherein mortality was reduced by half through a modest non-biomedical intervention, provided an example of neglected opportunities beyond clinical, corporeal, costly, biomedical primary care.

Great opportunities reside in the re-selection and re-balancing of purposes served. This is both a necessary and difficult adjustment. It is not an incremental correction, but a deeper reconfiguration of goods and services offered, based on a redefinition of primary care. How that is accomplished is beyond the scope of this inquiry.

The second element to consider in the question of what constitutes quality of learning in primary care is who ought to be learning. Individual patients are assumed to be the relevant locus of learning in primary care, the passive recipients of education in matters of their health. Quality of learning mutually involves all participants in primary care. Consider, for example, the key relevance of organizational learning.

It is one thing to recognize and correct individual errors within current practices in health care organizations, while maintaining those practices unaltered. That exemplifies single-loop learning (Argyris and Schon, 1996). It is another thing to correct systemic errors, while still maintaining the substance of current practices. But it takes yet another order of learning to recognize that the practices themselves and the emergent purposes are substantially in error. Organizations enter the realm of double-loop and triple-loop learning here, and promptly discover multiple sources of robust resistance to proceeding (ibid). The promise of the transcendent purposes meets durable emergent barriers.

Organizations wanting to procure quality of learning and quality of practice advantages from 7CP primary care must develop the attributes and capacities of learning organizations (Senge, 1990). The 7CP framework is neither panacea, nor magic bullet, nor quick fix for crises of quality. At this point, the 7CP framework is a nod in the direction of humane and transformational change, and an unprecedented guide for constituting quality of learning in primary care.

DIRECTIONS FOR FUTURE RESEARCH

The seven core purposes framework of primary care has received only preliminary development here, and demands further development. Until the constructs of the domains are more clearly articulated, the core purposes cannot be operationalized as an assessment tool.

Identifying core purposes from primary care participants is a comparatively difficult task, requiring an indirect approach to draw out the material without having pre-suggested it. Approaching this from the images of primary care that participants hold is a promising avenue for research (Morgan, 1998).

Systems phenomenology presents an innovative methical injunction to attend to frames of meaning in the assessment of human activity systems. Phenomenology has a rich history in the social sciences, but it has not been previously applied in systems science. It has discernible potential as a social systems science method, and invites further development.

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APPENDICES

APPENDIX A   Executive Summary Of Clinic Report

EXECUTIVE SUMMARY

Overview

This study was an inquiry into perceptions of learning quality, gathered through brief recorded interviews with fifteen diverse participants in a primary care medical clinic. The interview texts provided insights into sources of learning, factors effecting learning, and the dimensions, or scope, of learning.

An additional approach to perceived quality of learning was afforded through use of a qualitative systems diagram. Participants critiqued a systems diagram, developed by the researcher, depicting a learning-deficient clinical system. The critique led to two revisions of the diagram, and also produced insights into conditions for improved learning.

Understanding the dimensions of learning and the complex situation of learning in primary care medical visits are prerequisites to developing finer assessments of learning and proposals for improvement.

Methods

Brief (approximately 45 minute) recorded interviews were held with fifteen participants in the clinic: two administrators, three clinicians, two staff, and eight patients. A purposive sample of patient subjects was selected to include a range of adult generational groups, and for parity in gender. Subjects responded to a list of about twenty questions and additional probes. Following ethnographic methods, the interviews were transcribed, coded, and analyzed for meaning.

The study was approved by the Oregon State University Institutional Review Board, which oversees research involving human subjects. The clinic and all subjects are identified by pseudonym. While selected quotes are provided, full transcripts of interviews are not included in this report, to help preserve subjects' anonymity. Within the clinic, some subjects' identities may nevertheless be apparent. No obviously sensitive material was either discussed in the interviews or reported herein.

Results

Subjects were asked whether their learning and their practitioner's learning had been optimal in medical visits. All but

one assessed the quality of learning for both patients and practitioners at the clinic in positive terms.

The clinic manager, staff, and practitioners, expressed pride in the quality of learning, and the emphasis on education, evident in most patient encounters here.

Both administrators raised the issue of detecting dissatisfaction, and the clinic manager described a practice of reaching out to resolve conflicts and possible dissatisfaction.

Factors in satisfaction expressed by patients included time: taking (or not taking) enough time to take care; long waits in the waiting room; and being (or not being) able to schedule a visit right away. Relational quality and trust in practitioner competency were also mentioned in the context of satisfaction. At times moving beyond experiences with this clinic, patients spoke of lack of medical efficacy, definitive tests not being run, not getting good information, and mis-diagnoses as contributing to dissatisfaction.

Practitioner and staff remarks on satisfaction pointed out the coordination and dedication of the entire team, the lack of production pressure, and the capable facilitation of the clinic manager.

Learning sources mentioned included: formal education programs; meetings; management and organizational culture; media sources; text sources; medical tests; practitioners and staff; patients and their social networks; and intra-personal sources (such as memory, experience, and reflection). They are listed here as an indication of the multiplicity of available channels.

Learning factors included an array of categories (listed in italics) which can be organized as follows: Within a cultural context partially shaped by *mass media messages*, an *organization's management and culture of care* provides conditions (including *time*) and resources that influence learning. However, *cultural and linguistic barriers*, and *educational influences*, highlight the differences among societal, organizational, practitioner, and patient participants. Thus *power and conflict* come to the fore as factors in learning, as seen in *patient clarity and assertiveness* in medical encounters. *Dialogue and relational practices* are the crucible of conveyance, involving *attitudes toward teaching and learning*, and the particulars of personal situation: *gender and generation*, and *emotional loading*. The array of learning factors demonstrates the complex situation of learning, and the potential need to consider several factors simultaneously to effect improvement.

Dimensions of learning are distinct topical areas of interest, the areas commonly of concern in medical visits. The interviews provided evidence for a set of six topical areas: *costs and coverages*; *negotiating the clinic*; *negotiating the visit*; *biomedical constructions*; *relationship and caring*; and *personal meaning*. A finer assessment of learning quality should include inquiry into each dimension of learning.

Subjects were shown a systems diagram of a dysfunctional situation of learning in medical visits. The diagram was intended to be easily comprehensible. The average time elapsed to be ready to respond to questions about the diagram was 47 seconds, with a low of 20 seconds and a high of 130 seconds. Every subject claimed that they could understand the diagram, and provided a correct explanation of the diagram.

All respondents agreed that the diagram showed a pattern that actually occurred. No respondents claimed it was a common pattern at this clinic. Every subject reported that they had experienced the pattern, or knew of it from the experience of others.

A number of suggestions were made for changes in the diagram. These were considered, and a revised diagram was drawn (Figure 3). Also a diagram of a quality centered system was drawn, which more closely reflects the ideals and practices of this clinic (Figure 4).

Conclusions

Several findings of specific interest to the clinic that hosted the research are summarized as follows:

- A sense of organizational mission was ably articulated by administration, practitioners, and staff. Teamwork and coordination were present and valued in the clinic.

- Administrators, practitioners, and staff reported strong support for patient education, reflecting the family practice model of care.

- Every interviewed patient reported a positive assessment of the quality of their learning and their practitioner's learning at this clinic.

- Interviewed administrators, practitioners, and staff expressed satisfaction with their work and pride in their workplace.

- Interviewed subjects reported understanding the diagram of a

learning deficient clinical system. They expressed various experiences relating to such a system, and made clear that the model did not fit their common experience within this clinic.

- Practitioners reported being cognizant of and actively working against the pull of the learning deficient system, guided by personal and family practice ideals, and supported by administration and staff.

With regards to the situation of learning in primary care and the perception of quality regarding learning, this clinic could serve as a model of high performance. This clinic's success reflects the combined interests and efforts of management, practitioners, staff, and patients.

Limitations of the study includes small sample size (n=15) and non-random sample selection. The selection process did not seek outliers in any dimension. All subjects were Caucasian; none were severely disabled or critically ill; none were minors; and most were in good health. For these reasons, the sample does not reflect the clinic's entire patient population. A limited generalizability is warranted, taking into account that the conclusions do not necessarily apply to those portions of the population that were not represented.

APPENDIX B   **Question Schedule And Codes**

SCHEDULE OF QUESTIONS FOR PATIENTS

1.   DEMOGRAPHICS & SERVICE UTILIZATION
1A. Age,   Race   /   Ethnicity,   Gender, Education,
     Occupation.
1B. Self-reported global health status (good, fair,
     poor);
     Number of visits to medical providers in last 12
     months.
1C. Duration of an office visit.

2.   PERCEPTIONS OF PATIENT LEARNING
2A.   I'm interested in the kinds of learning that
         happen in medical visits. Patients learn from
         their providers, and providers also learn from
         their patients. A patient might learn how to
         take better care of their own medical problem,
         or how to cope with a difficulty, or learn the
         correct way to take a medicine.   In your
         experience, has learning in a medical visit
         usually been optimal for you, or has it not?
2B. Do you recall an instance where learning was <u>less</u>
     than optimal for you as a patient? Could you tell
     me about that?
2C.   What do you think contributed to making that
         happen? Can you name any other reasons?

3.   PERCEPTIONS OF PROVIDER LEARNING
3A.   A medical provider might learn about the
         patient's symptoms, learn about the patient's
         ability to cope, and learn about related
         lifestyle conditions, in order to arrive at a
         well-informed diagnosis. The provider might
         need to know about how much or little you
         exercise, or the kinds of exercise you do and
         don't do, as well as about eating and drinking
         habits, and about how you are feeling when
         dealing with a medical condition. Does your
         medical provider adequately learn these things
         from you?
3B. <u>How</u> does your medical provider learn these types of
     information?
3C. Do you recall an instance where learning was less
     than optimal <u>for your provider</u>? Could you tell me
     about that?
3D. What do you think contributed to making that happen?
     Can you name any other reasons?

4. SYSTEMS DIAGRAM REVIEW
    (Present subject with systems diagram of back pain
    and explain how to read it. Then present subject
    with systems diagram of learning in medical visits.)
    Diagrams are sometimes used to model or map complex
    human situations. This is a diagram about learning
    in medical visits.
4A. Would you say you can understand this diagram, or
    not?
4B. In your own words, what does this diagram show?

4C. Does this diagram show anything that seems
    particularly useful or interesting to you?
4D.   What might be wrong about this diagram?
4E. This diagram presents a pattern of insufficient
    learning in medical visits. Do you think it is an
    accurate representation of a pattern that actually
    occurs?
4F. Do you think it shows a common pattern, or a rare
    pattern?
4G. Is the language of the statements <u>fair</u> to patients,
    providers, and administrators?
4H. Has your experience ever put you in the diagram? If
    so, where? Tell me about that.

CODING CATEGORIES WITH SUB-CODES AND FREQUENCIES

```
CODE                FREQS    LINES
Core Problem Identity
                     49        597
Core Purposes
                      8         68
Core Purposes.Corporeal
                     95        572
Core Purposes.Corporeal.Biomed Dom Ovr Other Purposes
                      4         42
Core Purposes.Corporeal.Biomed Dominance Over Alts
                      4         28
Core Purposes.Corporeal.Interventn Dominance Ovr Tchg
                      5         29
Core Purposes.Ecologic
                      1          5
Core Purposes.Fair Exchange
                     59        473
Core Purposes.Fair Exchange.Social Exchange
                     50        370
Core Purposes.Humanistic
                      3         41
Core Purposes.Humanistic.Resilience & Coping Skills
                      2         11
Core Purposes.Humanistic.Social Engagement Skills
                      4         18
Core Purposes.Moral - Allieviate Suffering
                     19        192
Core Purposes.Moral - Allieviate Suffering.Emotional
                      1          9
Core Purposes.Moral - Allieviate Suffering.Mental
                      2         11
Core Purposes.Moral - Allieviate Suffering.Physical
                      1          4
Core Purposes.Moral - Allieviate Suffering.Social
                      2          9
Core Purposes.Moral - Allieviate Suffering.Spiritual
                      0          0
Core Purposes.Societal
                      0          0
Core Purposes.Societal.Equitable Access
                      2          6
Core Purposes.Societal.Minimize Societal Costs
                      7         58
Core Purposes.Societal.Reiterate Societal Order
                      5         59
Core Purposes.Societal.Reiterate Societal Order.Authority & Hierarchy
                     24        183
Core Purposes.Societal.Reiterate Societal Order.Control of Deviancy
                     10         94
Core Purposes.Societal.Reiterate Societal Order.Legal & Reg Compliance
                      6         48
Core Purposes.Spiritual
                      1          5
Core Purposes.Spiritual.Accomodation to Real
                     24        230
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Core Purposes.Spiritual.Hope
                  3        17
Core Purposes.Spiritual.Medicine as Meaning
                  3        22
Core Purposes.Spiritual.Presence Witness Compassn
                 46       362
Demographics & Descriptives
                  0         0
Demographics & Descriptives.Age
                 15        43
Demographics & Descriptives.Duties
                 12       142
Demographics & Descriptives.Education
                 18        99
Demographics & Descriptives.Ethnicity
                 15        17
Demographics & Descriptives.Facilitators & Barriers
                  0         0
Demographics & Descriptives.Facilitators & Barriers.Barriers
                  6        59
Demographics & Descriptives.Facilitators & Barriers.Facilitators
                  6        69
Demographics & Descriptives.Gender
                 15        15
Demographics & Descriptives.Health Status
                 11        61
Demographics & Descriptives.Number of Visits / Year
                  8        40
Demographics & Descriptives.Occupation
                 20        96
Demographics & Descriptives.Patient Learning Optimal
                 17       191
Demographics & Descriptives.Practitioner Learning Optimal
                 17       131
Demographics & Descriptives.Visit Duration
                 14        75
Diagram Reactions
                  0         0
Diagram Reactions.Accuracy
                 14        61
Diagram Reactions.Claim to Understand
                 14        66
Diagram Reactions.Common or Rare
                 16       104
Diagram Reactions.Errors & Amendments
                 30       309
Diagram Reactions.Experienced This Pattern
                 29       370
Diagram Reactions.Fair Language
                 16       151
Diagram Reactions.How to Recog, Alter, Prev
                 21       379.
Diagram Reactions.Occurrence & Locus
                 18       114
Diagram Reactions.Time Elapsed to Understand
                 16        24
Diagram Reactions.Useful or Interesting
                 16       274
Diagram Reactions.Useful or Interesting.New or Clearer
                  4        61
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Diagram Reactions.What Diagram Shows
                15        162
Learning Dimensions
                0         0
Learning Dimensions.Biomedical Constructions
                0         0
Learning Dimensions.Biomedical Constructions.Causes & Prevention
                12        93
Learning Dimensions.Biomedical Constructions.Causes & Prevention.Lifestyle Preventions
                5         33
Learning Dimensions.Biomedical Constructions.Causes & Prevention.Psycho-social Aspects
                7         34
Learning Dimensions.Biomedical Constructions.Diagnostics
                13        91
Learning Dimensions.Biomedical Constructions.Diagnostics.Diagnoses
                15        56
Learning Dimensions.Biomedical Constructions.Diagnostics.History & Physical
                8         20
Learning Dimensions.Biomedical Constructions.Diagnostics.Signs & Symptoms
                5         34
Learning Dimensions.Biomedical Constructions.Diagnostics.Tests & Findings
                15        43
Learning Dimensions.Biomedical Constructions.Outcomes
                9         41
Learning Dimensions.Biomedical Constructions.Therapeutic Interventions
                27        154
Learning Dimensions.Biomedical Constructions.Therapeutic Interventions.Medications
                15        63
Learning   Dimensions.Biomedical   Constructions.Therapeutic   Interventions.Procedural
Interventions           7         54
Learning Dimensions.Biomedical Constructions.Therapeutic Interventions.Wound & Injury
Care            3         9
Learning Dimensions.Costs & Coverages
                28        203
Learning Dimensions.Negotiating the Clinic
                7         41
Learning Dimensions.Negotiating the Clinic.Avenues of Communication
                9         69
Learning Dimensions.Negotiating the Clinic.Legal & Liability Constraints
                9         56
Learning Dimensions.Negotiating the Clinic.Managmnt & Systemic Factors
                15        128
Learning Dimensions.Negotiating the Clinic.Problems of Clinic
                14        123
Learning Dimensions.Negotiating the Clinic.Problems of Clinic.How to improve clinic
                3         33
Learning Dimensions.Negotiating the Clinic.Referral Practices
                8         57
Learning Dimensions.Negotiating the Clinic.Scheduling & Visit Duratn
                32        227
Learning Dimensions.Negotiating the Visit
                4         52
Learning Dimensions.Negotiating the Visit.Decision & Responsibility
                18        163
Learning Dimensions.Negotiating the Visit.Establish Common Purpose
                15        152
Learning Dimensions.Negotiating the Visit.Financial Incentives
                3         20
Learning Dimensions.Negotiating the Visit.Power Differentials
                10        94
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Learning Dimensions.Negotiating the Visit.Re-location
                        1   8
Learning Dimensions.Personal Meaning
                        13   137
Learning Dimensions.Personal Meaning.Gravity of Dx & Prognosis
                        19   100
Learning Dimensions.Personal Meaning.Making Progress or Not
                        4   23
Learning Dimensions.Relationship & Caring
                        32   197
Learning Dimensions.Relationship & Caring.Connection & Common Ground
                        37   229
Learning Dimensions.Relationship & Caring.Connection & Common Ground.Learng & Communic
Styles   23   206
Learning Dimensions.Relationship & Caring.Fitting In
                        10   81
Learning Dimensions.Relationship & Caring.Particularity Person Situatn
                        11   82
Learning Dimensions.Relationship & Caring.Perceived/Perceiving Others
                        20   129
Learning Dimensions.Relationship & Caring.Trust, Safety
                        23   226
Learning Dimensions.Relationship & Caring.Trust, Safety.Competency of Practitioner
                        7   62
Learning Dimensions.Relationship & Caring.Willingness to Particiapte
                        29   227
Learning Factors
                        0   0
Learning Factors.Attitudes To Teaching & Lrng
                        3   12
Learning Factors.Attitudes To Teaching & Lrng.Practitioner Focus on Eductn
                        13   73
Learning Factors.Attitudes To Teaching & Lrng.Practitioner Focus on Eductn.Information
Quality   8   84
Learning Factors.Attitudes To Teaching & Lrng.Willing to Participate & Lrn
                        27   159
Learning Factors.Attitudes To Teaching & Lrng.Willing to Participate & Lrn.Concern
Levels   13   78
Learning Factors.Attitudes To Teaching & Lrng.Willing to Participate & Lrn.Hope vs
Giving Up   1   3
Learning Factors.Attitudes To Teaching & Lrng.Willing to Participate & Lrn.Motivated
                        2   26
Learning Factors.Attitudes To Teaching & Lrng.Willing to Participate & Lrn.Mutually
Receptive   6   25
Learning Factors.Attitudes To Teaching & Lrng.Willing to Participate & Lrn.Mutually
Receptive.Open Mind   7   59
Learning Factors.Cultural & Linguistic Barrier
                        3   35
Learning Factors.Cultural & Linguistic Barrier.Doc & Hosp Culture Clash
                        1   14
Learning Factors.Cultural & Linguistic Barrier.Interpretive Errors
                        2   9
Learning Factors.Cultural & Linguistic Barrier.Interpretive Errors.Not Saying It Right
                        2   29
Learning Factors.Cultural & Linguistic Barrier.Taboo Topics
                        2   11
Learning Factors.Cultural & Linguistic Barrier.Translating Medicalese
                        3   24
Learning Factors.Dialogue & Relation Practices
                        15   96

Learning Factors.Dialogue & Relation Practices.Asking
                    18   78
Learning Factors.Dialogue & Relation Practices.Asking.Breadth of Inquiry
                    10   61
Learning Factors.Dialogue & Relation Practices.Asking.Small Talk, Chit Chat
                    2   11
Learning Factors.Dialogue & Relation Practices.Caring
                    6   48
Learning Factors.Dialogue & Relation Practices.Distractions - Kids
                    1   7
Learning Factors.Dialogue & Relation Practices.Energy Level
                    5   37
Learning Factors.Dialogue & Relation Practices.Engaging Demeanor
                    4   22
Learning Factors.Dialogue & Relation Practices.Feedback
                    3   13
Learning Factors.Dialogue & Relation Practices.Listening & Speaking Up
                    12   66
Learning Factors.Dialogue & Relation Practices.Memory & Reflection
                    2   16
Learning Factors.Dialogue & Relation Practices.Non-verbal, Visual, Commun
                    5   37
Learning Factors.Dialogue & Relation Practices.Open to Responding
                    2   12
Learning Factors.Dialogue & Relation Practices.Recognition of Barriers
                    3   22
Learning Factors.Dialogue & Relation Practices.Relationship Qualities
                    8   68
Learning Factors.Dialogue & Relation Practices.Relationship Qualities.Being Humanly
Understood   8   33
Learning Factors.Dialogue & Relation Practices.Relationship Qualities.Finding Common
Ground   2   11
Learning Factors.Dialogue & Relation Practices.Respect
                    3   18
Learning Factors.Dialogue & Relation Practices.Staying in Touch
                    3   31
Learning Factors.Dialogue & Relation Practices.Staying in Touch.Corresponding
                    1   2
Learning Factors.Dialogue & Relation Practices.Staying in Touch.Making Calls
                    5   22
Learning Factors.Dialogue & Relation Practices.Staying in Touch.Meetings & Visits
                    6   19
Learning Factors.Dialogue & Relation Practices.Trust
                    14   76
Learning Factors.Dialogue & Relation Practices.Truthful
                    10   144
Learning Factors.Dialogue & Relation Practices.Truthful.Denial
                    6   45
Learning Factors.Educational Influences
                    0   0
Learning Factors.Educational Influences.Medical Edu & CME
                    20   116
Learning Factors.Educational Influences.Patient Education Level
                    5   31
Learning Factors.Emotional Loading
                    2   6
Learning Factors.Emotional Loading.Anger, Irritation
                    8   40
Learning Factors.Emotional Loading.Blame & Being (mis)Judged
                    5   63

Learning Factors.Emotional Loading.Defensive
                1   5
Learning Factors.Emotional Loading.Fear, Scared
                7   34
Learning Factors.Emotional Loading.Feeling Burned
                3   9
Learning Factors.Emotional Loading.Frustration
                8   42
Learning Factors.Emotional Loading.Hx Bad Encounters
                6   59
Learning Factors.Emotional Loading.Personal Baggage
                4   18
Learning Factors.Emotional Loading.Problem Patients
                1   14
Learning Factors.Emotional Loading.Rudeness
                1   30
Learning Factors.Emotional Loading.Stressed; Feel Cruddy
                3   23
Learning Factors.Gender & Generation
                5   30
Learning Factors.Gender & Generation.Gender
                2   22
Learning Factors.Gender & Generation.Generational Expectations
                2   30
Learning Factors.Gender & Generation.Hearing Loss
                3   18
Learning Factors.Gender & Generation.Non-Comprehension Concealed
                1   10
Learning Factors.Gender & Generation.Practitioner Age
                2   12
Learning Factors.Mass Media Messages
                1   8
Learning Factors.Org,Mgmnt, Culture of Care
                20   218
Learning Factors.Org,Mgmnt, Culture of Care.Avail Tchg Mtls & Prof Resour
                0   0
Learning Factors.Org,Mgmnt, Culture of Care.Avail Tchg Mtls & Prof Resour.Mtls, Equip,
Jrnl, Bks, Web   14   65
Learning Factors.Org,Mgmnt, Culture of Care.Avail Tchg Mtls & Prof Resour.Specialists
& Prof   11   54
Learning Factors.Org,Mgmnt, Culture of Care.Communications Equpt, Phones
                8   29
Learning Factors.Org,Mgmnt, Culture of Care.Communications Equpt, Phones.Technology
Change Hazard   1   9
Learning Factors.Org,Mgmnt, Culture of Care.Continuity of Care
                9   35
Learning Factors.Org,Mgmnt, Culture of Care.Documentation Quality
                5   27
Learning Factors.Org,Mgmnt, Culture of Care.Red Tape
                2   11
Learning Factors.Org,Mgmnt, Culture of Care.Reimbursement Policies
                5   68
Learning   Factors.Org,Mgmnt,   Culture   of   Care.Reimbursement   Policies.Financial
Disincentives   8   52
Learning Factors.Org,Mgmnt, Culture of Care.Satisfaction, Love Work
                4   55
Learning Factors.Org,Mgmnt, Culture of Care.Selection of Provider of Svcs
                3   62
Learning Factors.Org,Mgmnt, Culture of Care.System Focus on Education
                6   27

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Learning Factors.Org,Mgmnt, Culture of Care.Teamwork
                9       76
Learning Factors.Org,Mgmnt, Culture of Care.Teamwork.Service Dedication
                3       35
Learning Factors.Org,Mgmnt, Culture of Care.Technology Costs
                2       17
Learning Factors.Patient Clarity & Assert Purp
                3       19
Learning Factors.Patient Clarity & Assert Purp.Clear Expectations & Concerns
                10      92
Learning Factors.Patient Clarity & Assert Purp.Patient Assertiveness
                10      100
Learning Factors.Power & Conflict
                19      115
Learning Factors.Power & Conflict.Agenda Conflict
                7       60
Learning Factors.Power & Conflict.Agenda Conflict.Hidden Agendas
                2       11
Learning Factors.Power & Conflict.Agenda Conflict.Narcotics Seeking
                7       72
Learning Factors.Power & Conflict.Noncompliance
                3       14
Learning Factors.Power & Conflict.Noncompliance.Disagree w/Reccommendations
                10      94
Learning Factors.Power & Conflict.Noncompliance.Pattern Hard to Alter
                12      118
Learning Factors.Time
                11      59
Learning Factors.Time.Appropriate Appt Length
                7       49
Learning Factors.Time.Appropriate Appt Length.Keeping Focussed
                5       31
Learning Factors.Time.Prompt Scheduling
                4       19
Learning Factors.Time.Repeated Visits
                2       5
Learning Factors.Time.Taking Time
                18      298
Learning Factors.Time.Telephone Hold Time
                2       15
Learning Factors.Time.Waiting
                8       58
Learning Sources
                0       0
Learning Sources.Formal Education Pgms
                11      32
Learning Sources.Formal Education Pgms.CME & Conferences
                3       5
Learning Sources.Intra-personal
                0       0
Learning Sources.Intra-personal.Life Experience, Habit
                16      74
Learning Sources.Intra-personal.Memory & Reflection
                3       16
Learning Sources.Intra-personal.Self-Knowledge Symptoms & Mng
                3       21
Learning Sources.Management & Organiz Culture
                9       45
Learning Sources.Management & Organiz Culture.Organizational Culture
                2       42
```

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Learning Sources.Media & Mass Media
                 3        12
Learning Sources.Media & Mass Media.Internet & Computer
                11        40
Learning Sources.Media & Mass Media.Video, VCR
                 2         8
Learning Sources.Medical Tests
                 8        26
Learning Sources.Meetings
                 6        14
Learning Sources.Patients & Social Networks
                76       450
Learning Sources.Patients & Social Networks.Relatives & Friends
                 8        30
Learning Sources.Practitioners, Staff & Spclst
               122       704
Learning Sources.Practitioners, Staff & Spclst.Other Prof Resource Indivs
                 7        26
Learning Sources.Text Sources
                 0         0
Learning Sources.Text Sources.Brochures & Handouts
                 3        16
Learning Sources.Text Sources.Correspondence
                 1         2
Learning Sources.Text Sources.Journalst & Books
                10        36
Learning Sources.Text Sources.Medical Records
                 6        44
Learning Sources.Text Sources.Surveys & Questionnaires
                 3         9
Satisfaction
                27       205
Satisfaction.Detecting (Dis)Satisfaction
                 5        35
Satisfaction.Job Satisfaction
                 5        50
Satisfaction.Satisfactn w/Other Settings
                13       229
Satisfaction.Satisfactn w/This Clinic
                28       357
```

APPENDIX C **Human Subjects Documents**

RESEARCH OFFICE

**OREGON
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UNIVERSITY**

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Telephone
541-737-3437
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541-737-3093

IRB@orst.edu

May 24, 2001

Principal Investigator:

The following project has been approved for exemption under the guidelines of Oregon State University's Institutional Review Board (IRB) and the U.S. Department of Health and Human Services.

Principal Investigator(s):   Leonard Friedman

Student's Name (if any):   David Kailin

Department: Public Health

Source of Funding:

Project Title: Perceived Learning in Primary Care

Comments:

This approval is valid for one year from the date of this letter. A copy of this information will be provided to the Institutional Review Board. If questions arise, you may be contacted further.

Sincerely,

Laura K. Lincoln
IRB Coordinator

INVITATION TO PARTICIPATE IN STUDY

Date: September 4, 2001
To: Patients of (clinic name)
Re: Request for volunteers to be interviewed

(Clinic name) is participating in an Oregon State University Department of Public Health study to explore perceptions of learning at medical visits. The research involves brief interviews which focus on the quality of learning as perceived by patients, providers, staff, and administrators. We expect that the findings will be of use to the clinic and its patients by indicating current perceptions of learning quality and potential areas for improvement.

Eight to twelve patient volunteers will be individually interviewed for about 45 minutes. Interviews will be recorded, and participants will be identified by fictitious names. The study will form part of an academic dissertation, and portions may be published in research articles and other formats. A report of findings will be made available to interested participants, and also to the clinic. (At least one patient volunteer will additionally be asked to review and comment on the report of findings.)

We are seeking one male and one female in each of the following age groups: 20-40; 41-58; 59-76; and 77-over. Of subjects meeting these criteria, we will inquire into self-reported global health status (good/fair/poor) to select secondarily for health status diversity.

David Kailin, MPH, a doctoral candidate in Public Health, will conduct the interviews at the clinic. The interview can be arranged for another time and location if more convenient for you. We hope you will consider volunteering to participate for this study. Pilot study participants mentioned that they had an interesting conversation and appreciated the opportunity to share their thoughts.

David will be available in the Conference Room from 8:00AM-2:00PM on these Sept. dates: Thursday 6th; Friday 7th; Monday 10th; Wednesday 12th; Thursday 13th; and Friday 14th. You may schedule an interview time at the front reception desk, or by contacting David at (telephone number)

To volunteer to be interviewed, stop by the front reception desk.

Or, you can contact David Kailin at (telephone number) for more information.

The principal investigator is Associate Professor Leonard Friedman, Ph.D., (541) 737-2323; 315 Waldo Hall, OSU, Corvallis, OR 97331.

INFORMED CONSENT DOCUMENT

Research Project Title: <u>PERCEIVED LEARNING IN PRIMARY CARE</u>

Principal Investigator: Associate Professor Leonard Friedman, Ph.D.

> (541) 737-2323
> Dept. Public Health, Waldo 315
> Oregon State University
> Corvallis, OR 97331

Thank you for agreeing to participate in this study! This form outlines the purposes of the research and describes your involvement. This form also outlines the protections accorded to you as a research subject.

The purpose of this research is to get your opinions and insights about learning at medical visits, so that we might better understand how to improve the quality of medical visits.

The information from this study will be used in a doctoral dissertation, and portions may be published in journals or public presentations of research. The information will also be used to write a report for the clinic. You may obtain a copy of the report on request.

Prior to the study, you will be screened to be sure you are a suitable candidate. We will select three primary care medical providers; two office staff members who have contact with patients; two clinic management employees; and eight to twelve patient volunteers.

Patient volunteers will be one male and one female in each of the following age groups: 20-40; 41-58; 59-76; and 77-over. Of patients meeting these criteria, we will inquire into self-reported global health status (good/fair/poor) to select secondarily for health status diversity.

The study involves a private individual interview lasting about 45 minutes. One medical provider, one management employee, and at least one patient volunteer will additionally be asked to individually review and comment on the report of findings. The interviewer will be David Kailin, MPH, a doctoral candidate in Public Health at Oregon State University.

Here is a sample of the interview questions:
> What contributes to a medical visit in which patients <u>do not</u> optimally learn what they need to learn?

What contributes to a medical visit in which patients <u>do</u> optimally learn what they need to learn?

We will also ask a few questions about yourself, such as age, education, and occupation.

The interview will be tape recorded, and the audio tapes will be used only for this study, and then destroyed. The tapes will be transcribed by David Kailin or by a professional medical transcriptionist who will not know your real name and who will protect the confidentiality of the materials. You will be identified by a fictitious name (pseudonym). Your real name (and the real names of anyone you might mention) will not be used in any verbal or written reports or data summaries. The only list linking real names to pseudonyms will be kept in a locked file with access limited to the investigators. That list will be destroyed after three years.

Your participation in this study is voluntary, and you have the right to withdraw from the study at any time, for any reason, and without penalty of any kind. If you withdraw before analysis of your interview is completed, information collected from you will not be used.

Pilot study participants mentioned that they had an interesting conversation and appreciated the opportunity to share their thoughts. We expect that your experience will be similar. Your participation contributes to making medical care more effective and satisfying.

You are encouraged to ask questions at any time about the study and the methods we are using. Your concerns are important to us. The primary contact for research related questions is:

David Kailin, MPH   (Telephone number)
Plageman Hall 305, Oregon State University
Corvallis, OR 97331

If you have any questions about your rights as a participant, please contact:
IRB Coordinator, OSU Research Office, at (541) 737-3437;
or via e-mail at IRB@orst.edu.

My signature below indicates that I have read and understood the procedures described above and give my informed and voluntary consent to participate in this study. I understand I will receive a copy of this consent form.

Your Name Printed:_____

Your Signature: _____   Date: _____

Your Address: _____

                   _____

                   _____

Your Phone #:   _____

APPENDIX D   **Interview Transcripts**

```
 1: * September 6, 2001 8:10 AM
 2: * YYY conference room
 3: * Admin 1: 'Sue Johnson'
 4:
 5: * I want to start off with just some demographic questions.  Age?
 6:
 7: Thirty-four.
 8:
 9: * Oh, you get to pick a pseudonym for yourself.
10:
11: Oh, really?
12:
13: * Yep, pick a name, any name...
14:
15: How about Sue Johnson?
16:
17: * Oh that's wonderful!
18:
19: It sounds real yet, you know...
20:
21: * Yeah, I like it, okay. Race is Caucasian, gender female...
22: education?
23:
24: B.S. in business management.
25:
26: * Where did you do that?
27:
28: University of (city name).
29:
30: * When?
31:
32: Well I took the very long long road in college education.  I
33: started out at the University of (state name) in communications.
34: I have probably taken enough college courses in my lifetime to
35: have six degrees but I didn't finish and it wasn't a big deal to
36: me. I always thought I was very employable, and I have proven to
37: be very employable.  But culture shock when we moved to (this
38: city), Oregon and learned that lots of people had Ph.D.'s in
39: (this city), Oregon, and gosh if I want to stay in the game I had
40: better finish this degree.  So I finished up which was a very
41: short process because of all the course work I had done through
42: the years, through an online program.  It wasn't ideal learning
43: because I'm a question asker, and I love to communicate, but it
44: served its purpose.
45:
46: * Okay. Your professional title is...?
47:
48: Clinic manager.
49:
50: * And how many years have you been in management?
51:
52: Oh, about six.
53:
54: * And how many years in this position at this clinic?
55:
56: One year.
57:
58: * So that's still pretty fresh in the job here.
59:
60: Yes, I've been in the organization for 10 years, just turned 10
```

61: years.
62:
63: * How would you describe your duties?
64:
65: Well, they vary greatly. I have in my mind two customer bases,
66: for lack of a better term. One would be our group of employees,
67: the other, our external customers, are our patients coming here.
68: So I deal...daily, my day is very varied in terms of, I don't
69: have a grand master plan other than meetings I need to attend. I
70: spend a great amount of time with our employees here. Sometimes
71: with our patients in various capacities. Administrative duties,
72: budgets, paperwork...it's varied.
73:
74: * What it are the types of things that help you, what are the
75: things you perceive as barriers, in terms of accomplishing your
76: job, your mission?
77:
78: Oh, boy, that's a really big question. Well the things that
79: help me are the resources that I've developed over the years, the
80: people I work with, my colleagues, and I guess friends in the
81: business you might say, help me a lot because if I get stuck I
82: know who to call to help get me unstuck, or answer my questions,
83: or bounce ideas off of. Now something that definitely gets in my
84: way is regulations, because health care is a highly regulated
85: industry. And so it gets in my way dealing with patients,
86: because maybe a patient is asking for a certain something, and
87: because we may get sued, or it is not legal, or it is fraudulent,
88: we're just not able to accommodate. I would say that's a big
89: thing that tends to get in my way. Also we're very, dealing with
90: a bunch of red tape, because we are a large health-care system,
91: it's no longer as easy as authorizing something for payment -
92: that goes through many different chains to finally get paid.
93: That's kind of a small example but it used to be you'd handle it
94: at a different level, now it goes through many different
95: processes.
96:
97: * That's a good description - what used to be simple is now
98: complex.
99:
100: Yes. Definitely. Change might be perceived as a barrier, but
101: I thrive on change and it's not too much of an issue for me. You
102: know, today we know it's done this way, and maybe somebody forgot
103: to tell a certain group of people that tomorrow that's going to
104: change! ((Laughter))
105:
106: * Oops! All right, can you describe an ordinary work day?
107:
108: Ordinary work day, I arrive here and usually one or two
109: employees will have something they need to get off their chest.
110: I'll spend maybe the first couple hours of my day working with
111: employees. It's very important for me to kind of do my rounds.
112: There are about 35 of us, just under 35 of us here that I manage.
113: It's really important for me to make my rounds, say good morning.
114: I do that for a couple of reasons but that takes up probably two
115: hours of the early part of my day. From there it is anybody's
116: guess. I may have a meeting to go to, I serve on several
117: committees on behalf of the city based physician groups, so that
118: takes me outside the clinic some days more than others. And then
119: maybe any patient correspondence that I might have. My staff is
120: really well trained in terms of, they detect any frustration,

121: dissatisfaction from our patients, they will come in -- in fact
122: yesterday was a great example of that, somebody came in, said
123: 'just heads up, it seems like when this lady left she wasn't
124: entirely satisfied', so today what I will do is call her and just
125: kind of probe that a little bit. So I do spend a good deal of
126: time, but that depends on the day, and whatever else is taking
127: place here, as far as how long I'll spend on those kinds of
128: issues. I'm making a lot of outbound calls, patients aren't
129: necessarily seeking me out but I do a lot of seeking patients
130: out, if that makes sense.
131:
132: * It makes a ton of sense, and it's really very pro-active
133: management.
134:
135: Oh, well I love it, that's really what I thrive on is that
136: interaction with our patients. They can teach us a lot and help
137: us improve our business greatly.
138:
139: * Yeah, that's just a wonderful sense of management. It's
140: about people first. Could I get a description of the
141: characteristics of the clinic, the number of providers and
142: patient visits.
143:
144: Okay. We have currently eight providers made up of six MD's
145: and two physician assistants. We are currently adding two
146: practitioners, so in the next couple of months we'll have a total
147: of ten, which will equal nine full-time providers. Their patient
148: visits vary depending on their style of practice. One day one of
149: our on-call practitioners hit 34 patients, which was very very
150: busy, very very busy. Our appointment slots are about fifteen
151: minutes on the average, although if somebody needs a longer
152: appointment certainly we will schedule them for 30, 45, depending
153: on what they're coming in for. So I would say on average maybe
154: 25 to 28, somewhere in there, is a full day for each of them.
155:
156: * Yes, those would be full days. In terms of overall volume of
157: patients a week or a month, ballpark?
158:
159: I'm not even sure, we have usually five or so in every day, so...
160:
161: * Five providers, so about 125 patients per day?
162:
163: I would say that's probably about average, give or take. Lots
164: of people come through here every day.
165:
166: * In terms of new patient appointments, how long are those?
167:
168: Again they vary, we have several different kinds of new patient
169: appointments. We have people that are maybe new to the area or
170: are just looking for a change, and maybe they've been burned,
171: what they consider to be burned, in the past, so they want to
172: meet this person that they may choose.
173:
174: * An informational...
175:
176: Right, so what we call that is a get acquainted appointment. We
177: don't bill for that because there is no insurance company on the
178: face of the earth that's going to pay for a new patient
179: appointment, and our providers taking new patients feel it's
180: very important to make that connection. So it's about a five

181: to ten minutes appointment, no medical questions, so you don't
182: mention your aching back, rather maybe how would you handle this
183: scenario, something like that. That's one kind of new patient
184: appointment. The other would be, maybe I chose you two years ago
185: as a provider but I've been really healthy and now I need to see
186: you for a cold, a sprain or something. That's going to be about
187: a 30 minute appointment, because we have never met before so
188: I'm going to have to take a history and a physical and it's going
189: to be a little bit longer appointment.
190:
191: * I want to move into the questions of perceptions of learning.
192: From your perspective, what kinds of things, what types of things
193: does a patient need to learn?
194:
195: Oh, well I think it starts out very basic. At the minimum the
196: patient needs to learn how the office functions, not in great
197: detail but certainly things like how do you handle prescription
198: refills, how are you going to handle referrals, which groups
199: do you refer to, those kinds of things. Because if you educate
200: them on the basics, it cuts out a lot of frustration and -- at
201: least this is what I believe -- we have learned through the years
202: even though it might sound convoluted to our patients, it's still
203: important for them to understand how the whole referral process
204: works. So I think we do, hopefully we're doing a good job at
205: that.
206:
207: * How do you do that?
208:
209: Well it can happen on several different levels. If somebody
210: calls in, it comes into the switchboard -- I need to have a
211: referral to an orthopedic surgeon -- the person who answers the
212: front phone would ask a few questions -- who is your doctor here,
213: have you seen that doctor recently, and if not she would say
214: well, I'll tell you this, the doctor is going to want to see you
215: in the office before he starts a referral for you -- so a little
216: bit of education on the front end. Or sometimes, she knows
217: insurance very well, so she can say what kind of insurance do you
218: have -- well I'm on Blue Cross, it's a PPO plan -- and she will
219: say well you don't need a referral on your insurance plan. So
220: just trying to catch that on the front end, rather than have them
221: go through this long process and learn in the end after two weeks
222: waiting for paperwork to go through that you don't even need a
223: referral for this service.
224:
225: * You don't need one, or it might not be covered...
226:
227: Exactly. And that's another really good point David, what we
228: try to do is put some of that, not a lot because we understand
229: that working with insurance companies can be frustrating on its
230: own, so we try to do most of that here. We do try to put some of
231: the onus back on the insurance companies, so what she might say
232: is, to be safe, Mr. Jones I'd really recommend that you contact
233: your insurance company and find out the particulars -- is this
234: service even a covered benefit, and is Dr. Jones really a covered
235: provider. But education we take very seriously here.
236:
237: * What other types of things does a patient need to learn?
238:
239: Thank you for bringing me back to where we started. Other types
240: of things they need to learn. I think they need to learn -- it's

241: important for them to learn about their diagnoses. Because we
242: try to focus on patient education here, we've got several
243: different ways they can do that. Certainly with their
244: practitioner would be the most popular way. We also are going to
245: be implementing, we have a patient education room in our clinic
246: and we're going to put in an interactive computer in the room
247: which will allow for people that maybe just recently got
248: diabetes, can go in and learn that way. We also have a TV VCR
249: which will also be in that room because some people are more
250: visual, don't want to mess with a computer, just want to pop in a
251: tape. If that's maybe real important for them to be able to
252: learn about their new diagnoses.
253:
254: * Is there a patient educator on staff?
255:
256: Not right on staff but we do have a staff of them in our health
257: care system. Diabetes is a great example of that, we have an
258: outstanding diabetes program and diabetes educator so we can
259: easily connect with her, and she either will come to the clinic
260: or they can go to her office however it works out best. I think
261: it's important for people to learn about the prescriptions that
262: they're taking. We find a lot of times elderly people will come
263: in with shoe boxes full of prescriptions that they've been given
264: over the last 55 years.
265:
266: * A little frightening.
267:
268: Yes, a little frightening. We do have a full-time pharmacist
269: that works here. She very willingly will go through that shoe box
270: or shoe boxes full of medication and get them on a much more
271: appropriate regimen, and oftentimes save them hundreds of
272: dollars a month doing that. So that's another educational piece
273: we have here.
274:
275: * That is good. So in many ways you been answering the next
276: question which is: how do patients learn these types of
277: information?
278:
279: All in various ways, either through brochures, soon, the start
280: of next year, they'll be able to access the online information,
281: or popping the tape in the VCR if they prefer.
282:
283: * And they get a fair amount over the telephone?
284:
285: Absolutely. The medical assistants spend a good portion of
286: their day, and you will have an opportunity to talk with the
287: medical assistants to learn more about that, but they do spend a
288: good deal of their day educating.
289:
290: * What contributes to a medical visit in which patients do not
291: optimally learn what they need to learn?
292:
293: Well, I think maybe the red tape, maybe I'll expand on that,
294: because maybe they've had difficulty in accessing a provider,
295: maybe they've come with some baggage, and so they're very
296: defensive and really don't want to hear what it is maybe that
297: we're saying to them, and have kind of put up a wall, kind of
298: created a barrier for them to learn and to hear what it is that
299: we have to say. I think that's a lot of time frustrating for all
300: of us that deal with patients, when they -- and I'm biased, but I

301: think our group as a whole is very open minded and often we'll
302: take patients that have been discharged from all over the (local
303: area) and when I go and I'll ask a provider -- this is the
304: history, we need to give them a chance. So I would say personal
305: baggage is probably the largest barrier. Maybe they've had a bad
306: experience with a provider, their life experience, what got them
307: to where they are today. The media creates barriers for us.
308:
309: * How does the media creates barriers?
310:
311: Well, you hear about the wrong leg being cut off or accidental
312: overdose of medication or medication that caused horrible
313: outcomes. The media from my perspective blows things terribly
314: out of proportion, and people come here with that.
315:
316: * That's interesting. You know it was occurring to me, I wonder
317: if sometimes maybe the resistance that a patient brings has to do
318: with their own sense of denial of a medical condition. It can be
319: a big impact on how we see ourselves.
320:
321: Certainly, yes, I agree. I think all that, all that, what they
322: come here with can cause a barrier.
323:
324: * What contributes to a medical visit in which patients do
325: optimally learn what they need to learn? The facilitators.
326:
327: Well, I think the people that come here with open minds and the
328: people that maybe don't have that baggage, that could be one
329: group of people that come here that are able to learn. But I
330: think maybe in addition to that, maybe people that just don't
331: really care, you know people that are just here, come to the
332: doctor to be fixed, they don't want to learn. Do you hear what
333: I'm saying? There's a certain group of people who, they don't
334: want to know necessarily in detail what's wrong with them. Maybe
335: they're afraid of it, maybe it's just their generation, I don't
336: know exactly what is, they just want either a pill or fix it,
337: whatever you have to do to fix it.
338:
339: * But they don't want to be too deeply involved in either the
340: knowledge or even necessarily the activities that they might need
341: to undertake. I mean they're enough involved that they're here
342: but there's not necessarily the sense that getting fixed might
343: involve a shift in lifestyle or some deeper change.
344:
345: Right. And so maybe those aren't the people that come here and
346: learn, because they don't wish to learn.
347:
348: * But the ones who do, the ones who learn optimally, that's the
349: ones I want to get at now. What really facilitates optimal
350: learning?
351:
352: Well I think people that want to know about themselves, the
353: people that are learners by nature really, conversely to those
354: that don't want to know, they really want to know, tell me about
355: that, you know tell me more about that -- if I cut out this will
356: it help that? I think the question askers, people that are just
357: engaged by nature will be the ones that learn optimally.
358:
359: * Okay. In your estimation has learning in a medical visit
360: usually been optimal for this clinics' patients, or not?

361:
362: Well of course I'm going to be very biased in my answer.
363: ((laughter)) I would say on average yes, absolutely.
364:
365: * That's something to be proud of.
366:
367: We all are, we're very proud of it. Our practitioner base is
368: very young, we range from 30 to 50, very young, and I think that
369: maybe that plays a part in it. Maybe they're not worn out yet, I
370: don't know exactly what, but I think as people they're very
371: engaging, as people, so my guess is that as medical practitioners
372: the same holds true.
373:
374: * That might be one of the facilitators right there, of patients
375: learning.
376:
377: Absolutely. I think they would love for all the patients to
378: want to come in here and learn, I really do. By and large they
379: spend a good deal of time with their patients. So I would say
380: our learning is good here.
381:
382: * All right, where were we on this wonderful list of questions?
383: Okay, do you recall an instance where learning was less than
384: optimal for a patient? Without disclosing the patient name,
385: could you tell me a story about that?
386:
387: Well, I'll try to think...I'm thinking of a recent incident,
388: this may or may not be relative to learning, but we had a third
389: year resident doing a two-week clerkship here. This husband and
390: wife came and the wife had an appointment, they were established
391: patients here, it was late in the day about 4:30, quarter to 5.
392: The medical assistant that was working with the resident was also
393: working at the same time with a permanent practitioner here, so
394: she was doing the job of two medical assistants. Tremendous
395: barriers at the beginning were set up between both the patient
396: and the medical assistant. The poor assistant was worn down by
397: this time of day, the patient waited about 20 minutes out in the
398: waiting room, and the patient perception was that by the time she
399: was brought back she was frustrated and felt that the wait was
400: too long. So she came to us by the time she was in the exam room
401: irritated. The medical assistant was equally irritated. The
402: medical assistant put the blood pressure cuff on the woman's arm
403: and the woman said 'No, you've got that in the wrong place'.
404: That really irritated the medical assistant, and from there it
405: went from bad to worse. It resulted in this woman getting up out
406: of the exam room before the practitioner made it through the
407: door, and left the clinic. I've analyzed this, I actually did
408: phone the woman the following day, I gave her time to cool off,
409: and it was interesting to hear her perception of it. It was also
410: interesting to hear the perception of the medical assistant. So
411: I would say that learning there was shut off on both ends and
412: both were left feeling horrible about the situation.
413:
414: * What I hear is really a story of emotional loading...
415:
416: On both sides.
417:
418: * ...here you have a medical assistant and a patient both of
419: whom are irritated, tired, and get frustrated.
420:

421: And neither of them were willing to learn from the other one of
422: them. The medical assistant, the last thing she wanted to hear
423: from this patient, how to... There were a number of other issues
424: that took place during that short encounter that ultimately
425: resulted in this person saying, unh-uh, I'm not going to sit for
426: an appointment here.
427:
428: * And what you brought up so well is that learning is a two-way
429: street. Very interactive.
430:
431: Oh, very. If one person is unwilling it's not going to work.
432:
433: * Well let's move along a little, we've looked at patients'
434: learning, now let's look at provider learning, it's the other
435: side of that equation, you led me right to where I need to go. So
436: what types of things does a provider need to learn at a medical
437: visit?
438:
439: Well I think in my opinion the most important thing that a
440: provider needs to learn is how does his or her patient learn. So
441: where I can apply that would be with maybe an elderly person who,
442: well sometimes they're very stoic and would never let on that
443: they either don't understand the terminology being used, or maybe
444: they can't hear, but they do this 'Oh, aha' when they really
445: haven't a clue what it is you've just said. So I think the
446: provider really needs to be in tune with that, and really needs
447: to learn at a glance about their patient and how they maybe
448: learn best. I think that, in my opinion, is huge.
449:
450: * Yes that's a big concept and a very very rich one. There's a
451: tremendous amount of learning that's tacit and it's instantaneous
452: and it goes without words.
453:
454: Definitely. I think that nonverbal is very important to pick
455: up on.
456:
457: * In what ways does a provider learn the information? We've
458: said just before that, that a savvy practitioner sizes up the
459: situation with a certain kind of expertise that's visual, that's
460: very rapid. What other ways do providers learn the types of
461: information they need to know?
462:
463: Well, listening I think is a big thing. Maybe ask one question
464: and people like me will tell you everything you wanted to know
465: without even asking another question. ((laughter)) So I think
466: listening is very important. And asking questions. And getting
467: to know the patient.
468:
469: * What contributes to a medical visit in which providers do not
470: optimally learn the kind of information they need?
471:
472: Well, certainly a non-compliant patient, somebody that is
473: absolutely not willing to participate. Or maybe if there's again
474: - providers, I've learned over the last year, are very human like
475: the rest of us, they come to work sometimes with baggage and
476: maybe they're just not at the prime of their day, or something
477: has contributed to their day to prohibit them from being as sharp
478: and as in tune as they should be.
479:
480: * And prevents them from finding that common ground that really

481: allows learning to happen.
482:
483: Yes, yes.
484:
485: * What contributes to a medical visit in which providers do
486: optimally learn what they need to learn?
487:
488: Well, I think that connection is a big part.
489:
490: * In your estimation has learning in a medical visit usually
491: been optimal for providers, or not?
492:
493: Hmmm, that's an interesting question, I would say so. I would
494: say that the majority of them are going to probe and do what
495: they can to learn something from the patient so I would say yes.
496:
497: * Do you recall an instance when learning was less than optimal
498: for a provider and again without disclosing either the patient's
499: name or the provider's name could you tell me a story about that?
500:
501: I'm not sure that I can.
502:
503: * That's okay. Take time to think about it, if one pops up, it
504: pops up. Now I'm going to show you some systems diagrams. This
505: is a systems diagram on back pain. I'm just going to explain how
506: you read it. You can start anywhere in the diagram you want. A
507: double walled box is either a system input or a system output. If
508: you're following an arrow forward, you say 'therefore'. For
509: example: stress and strong emotions are expressed as muscle
510: tension, therefore back muscles tense up. So you can follow
511: these loops around forward if you want to, or you can follow them
512: around backwards by saying 'because'. So: back hurts when doing
513: normal activities because back muscles become inflamed. I'm just
514: going to give you a minute to look at that one, to sort of get
515: familiar with the idea of how to read this type of systems
516: diagram. It's really a pattern map. There are many patterns,
517: this is not the only cause of back pain, this is actually a
518: representation of a lifestyle loop if you will, or set of loops.
519: And so you might say, this might cause that, it's not the only
520: way, but it says, if we've done it well, this is just a fairly
521: typical pattern. So this is an example of the diagram that shows
522: a pattern. Does this seem fairly straightforward?
523:
524: Yes it does.
525:
526: * It's a pretty simple technique of showing a complex situation
527: that you can grasp pretty quick. Okay, now here's a second
528: pattern map that models a complex situation that I want to give
529: you a minute or two just to look at, that one, and read through
530: it.
531:
532: ((30 seconds of silence))
533:
534: Yep!
535:
536: * I want ask you a few questions about this one.
537:
538: Okay.
539:
540: * Would you say you can understand this diagram or not?

541:
542: Understand it in terms of being able to follow the diagram...?
543:
544:
545: * Well, understand it in terms of being able to follow the
546: diagram and understand what it is trying to show.
547:
548: Yes, sure.
549:
550: * In your own words what does this diagram show?
551:
552: Well, I would just sum it up by saying the patient's health
553: care needs weren't addressed and the patient became frustrated
554: and decided who needs doctors and decided to not seek care.
555:
556: * Okay. Does this is diagram -- it's probably the most
557: important question -- does this diagram show you anything that is
558: particularly useful or interesting to you?
559:
560: Yes, yes. I think it was stated very well that the patient
561: wanted to give some more information and some background on why
562: this was happening, but because it wasn't medically pertinent
563: information the providers don't have the extra time to listen to
564: those thoughts, and speed things up, and therefore don't get all
565: the information, and the patient doesn't feel well taken care of,
566: and it's a big, a long cycle and finally the patient gets
567: frustrated and drops off the radar.
568:
569: * When you see this map, does it show you anything that you
570: might have not seen before? Does it make anything more clear
571: about this pattern?
572:
573: No, I think I've seen all of this. ((laughter))
574:
575: * Is there anything you see in this map or diagram that you say:
576: Oh, gosh that's not right, that's wrong.
577:
578: Nope, I would say it's very accurate, I've seen it before, and
579: hearing from not necessarily our patients but patients in
580: general, hearing some of their concerns, I would say they
581: described this scenario.
582:
583: * Do you think it's a common pattern or a rare pattern?
584:
585: Oh, I would say it's probably more common than we want to know.
586:
587: * Is the language of the statements in this diagram fair to
588: patients and to providers and to administrators?
589:
590: I guess for the purpose of the diagram it is. I don't think
591: anything stands out as absolutely not, that would never. I think
592: it's very accurately stated.
593:
594: * Has your experience ever put you in the diagram and if so
595: where. I'd like to know about that.
596:
597: Not personally, thank goodness I'm very healthy and so are my
598: immediate family members. It would be hard for me to judge that.
599: My 83-year-old grandmother who lives 2000 miles away sort of
600: describes this kind of thing to me but I do not have a whole lot

601: of personal with it I would say.
602:
603: * This is a pattern of deficient learning and it's the kind of
604: pattern we don't want to see happen. What we're aware of is that
605: there are also patterns of very effective learning. We could
606: just as soon map those out, but those are working well.
607:
608: Right, right, exactly.
609:
610: * How do we avoid this kind of pattern, how we break out of
611: this pattern?
612:
613: Well I think being more aware of learning and maybe if we only
614: have 15 minutes to see, I'm getting a little specific here, if we
615: have only 15 minutes to see a patient then I think it makes a lot
616: of sense to use that 15 minutes wisely, and if trying to get to
617: the bottom of this person's medical condition means back to 1962
618: and somehow maybe saying to Mrs. Jones that that's pertinent
619: information but could she sum it up.. or I don't know exactly how
620: that would go. I don't necessarily expect the provider's going to
621: listen for six hours to get all this background information. But
622: I think if you know you have 15 minutes to spend with somebody
623: then that 15 minutes should be used very efficiently and maybe
624: some specific questions that would help get to the root should
625: be asked.
626:
627:   * So there's really that time limit or that time barrier that's
628: contributing?
629:
630: Yes. Yes, which I didn't mention earlier about learning.
631: Absolutely. And I think some providers are much more aware of
632: that time than others, and you may hear from one that is very
633: timely, and maybe he'll articulate how that goes for him. Yes, I
634: think given the time constraints then you should make the most
635: out of that visit.
636:
637: * So there's a fascinating tension between time and learning
638: and efficiency.
639:
640: On the other hand I don't know how you train the patients,
641: especially the older folks, between the 80 and 90-year-old range,
642: how you would train them to answer more specifically or timely,
643: you know that would be difficult. I would love to put together a
644: brochure that talked about how to make the best, the most of
645: your encounter. I think that would be ideal if you could do
646: that.
647:
648: * That could be done. Well that's all the questions. Thank you.
649:
650: Great, it was fun. Thank you.
651:
652: ((end of interview))

1: * September 6, 2001 10:15 AM
2: * YYY conference room
3: * admin2: 'Fred'
4:
5: *First I have just a small set of basic demographic questions.
6: Age?
7:
8: Forty-five.
9:
10: *Forty-five, race Caucasian, gender male, educational background?
11:
12: I have a B. S. in recreation administration from (city name)
13: State.
14:
15: *... who just whomped us! ((Laughter; reference to sports event))
16:
17: And then I have a Master's in health services, actually it's a
18: Master's in public administration with a health services option
19: from the University of (state name).
20:
21: *Wow! All right, professional title?
22:
23: I am chief operating officer for (name of health system).
24:
25: *That's a big job! And it's gotten a lot more complex over the
26: years.
27:
28: Yes, well in my background, I came, I was working in downtown
29: (city name) and moved to (nearby city) in 1992. What I did was I
30: established (name of physician group), so there was nothing, and
31: I was the one that put that together. Then as the hospitals
32: merged, then I took on management of all of the clinics. So
33: there's a physician who is my boss but I am the operating officer
34: for all of the clinic's from (city A) to (city B).
35:
36: *Wow, that's incredible, okay, years in management?
37:
38: Seventeen.
39:
40: *Years in present position?
41:
42: Well, since the merger, a year and a half.
43:
44: *How would you describe your duties?
45:
46: People have described it as driving a nitroglycerine truck
47: ((laughter)). Generally, what I'm responsible for, I'm
48: responsible for the operations of all of the medical office
49: portion of the organization. So it is everything from our
50: involvement in hiring positions to dealing with strategic
51: things...we were just at a meeting on occupational medicine,
52: urgent care type of program development...to wage and salary for
53: employees, budgets and just everything.
54:
55: *Wow. How would you describe the facilitators and barriers to
56: accomplishing your duties? What things make your job a heck of a
57: lot easier to do, what are the brick walls?
58:
59: I think it's interesting, the biggest brick wall that I've faced
60: for years is, though it doesn't seem like it should be, there is

61: a very different world between physicians and hospitals. And
62: there's different cultures, there's different philosophy. The
63: way to describe my view is, you look at hospitals as a restaurant
64: which is a low volume high price type of entree, where the
65: clinics are more of a McDonald's, where you are serving fast,
66: high-volume low price type things. Though you think hospitals
67: and doctors work together, the cultures are very different and
68: they clash significantly. Physicians, in the old world
69: physicians were solo practitioners, cottage industries, and
70: whatever they didn't spend on their practice they took home.
71: Hospitals, high-volume,((note: meant low volume)) no one really
72: taking home the profit, different different different cultures.
73:
74: *That's really so interesting to have to work with that. How do
75: you mesh these?
76:
77: You try to find common ground.
78:
79: *Common ground, that's the stuff that makes it go. How would you
80: describe an ordinary workday?
81:
82: I had a meeting this morning at 7:30 and we went through a new
83: wage and salary program at one of the offices, and what I said is
84: that I go to meetings all day.
85:
86: *Okay, okay ((laughter)). Wow, so you're covering a lot of
87: different clinics. Overall do you have a sense of the volume, of
88: the number of providers?
89:
90: In the group it's something in the neighborhood of 20 offices and
91: about 110 providers.
92:
93: *That's incredible to try to coordinate that. I want a get some
94: of your perceptions about patient learning. A little set of
95: questions about that. What types of things does a patient need
96: to learn?
97:
98: I can kind of go of bunch of different ways, I think I'll give
99: you kind of different perspectives. One is, patient has a bias
100: that I have the insurance and everything should be covered. And
101: I know growing up or when I was younger, the doc would say well
102: your insurance will cover it, let's go ahead and order those
103: tests, and that's changing now. Patients don't understand that,
104: they think, there's a mind set, a mentality of more tests, more
105: studies is better quality when not necessarily that's true. So
106: that's one.
107:
108: *So patients have to learn about limits.
109:
110: Yes I would call it, we're hearing a lot, issues are that,
111: responsibility and cost sharing is being back to patients when
112: historically it's been a blank check. And so I think that's one
113: thing you have to learn. Second area that I think they have to
114: learn is that, I don't know how to describe it, you get one
115: component of complaint that the doctor didn't spend enough time.
116: I think the patient would do better if they managed their visit.
117: I think the patient comes in not managing it, knowing sort of
118: intuitively what they want out of a visit but not really making
119: that clear, and I think they could get a lot more if they kind
120: of manage the visit with a physician, saying here's what I really

121: want to get out of it.
122:
123: *Could you think of any way we could help patients learn how to
124: manage a visit better?
125:
126: I've always thought it would be kind of interesting almost to
127: have a questionnaire for the patient, you know - what are you
128: here for, what are you expecting. I had a doctor, I'll stay on
129: the line, it's because the nurse says what is your visit for,
130: and they'll say something, now a doc will always tell you is,
131: they get you in the room and they say oh by the way I've got this
132: and this and this. But I think he would be nice to say okay what
133: is your expectation. One of the physicians talked about dealing
134: with a sick kid and it was pretty cut and dried what the kid had,
135: but going to the mother saying okay what are your concerns about
136: this, so that they can address the concern, and everything else
137: goes away. I think somehow the touchy-feely kind of concerns
138: need to be drawn out of the patient somehow or other. And no
139: real indictment, but I also think that physicians coming out are
140: compassionate, but they're scientists. Because if you look at
141: the criteria to get into medical school, it's a scientific
142: criteria not a compassion criteria, and their training is all in
143: the scientific side of it, and you hopefully get a compassionate
144: person but there's no guarantees.
145:
146: *There may actually be things in the training that tend to dull
147: or not reward that side.
148:
149: Yeah, and I think the system sort of fosters itself because who
150: tends to stay in academia are the academic docs, and it sort of
151: just feeds on itself where you get more and more of the
152: scientific side. Now it's a bias, I've never been to medical
153: school. But just seeing docs and talking to them, and talking to
154: people about their complaints, I've sort of come to that
155: conclusion.
156:
157: *That's a fine observation. What contributes to a medical visit
158: in which patients do not optimally learn the kinds of things they
159: need to learn?
160:
161: I think there's not a, well I don't think there's a real emphasis
162: on education. I think there's an emphasis on - I'll give you a
163: personal example: I run okay, and I get injured, so I go in and I
164: want to find out -- my hamstring is sore and I want the pain to
165: go away, but I want to find out what caused it. So what can I
166: do preventively to stop from causing it. If you go to an
167: orthopedic surgeon, they're trained on telling you: I can solve
168: the problem and I can cut on this and I can fix it. Okay, but
169: educate me on what caused it. That's not part of their training.
170: So I think there needs to be more of a focus on an educational
171: component to (a) the patient needs to ask for it, but (b) I think
172: providers need to feel comfortable in explaining more to the
173: patient.
174:
175: *So in some senses patients aren't necessarily going to learn the
176: information that they need because providers are captives of
177: their education.
178:
179: Yes, they're trained at solving a problem, they're not trained...
180:

181: *As a medical problem, a biomedical problem...
182:
183: ...not a psycho-social problem
184:
185: *And not a psycho-social problem or a lifestyle problem.
186:
187: Mmh-hmm.
188:
189: *Good, okay. Maybe the flip side of that question. What
190: contributes to a medical visit where patients do optimally learn
191: what they need to learn?
192:
193: I think a patient is actively involved in asking questions, I
194: think the questions are asked in the way that doesn't threaten
195: the physician, but actually can be done so that the physician is
196: comfortable doing some explanation. I think that threatening may
197: not be the best word but something like that where it's not an
198: attack but like okay, can you explain this to me. But I think
199: most patients have a mind set of, I don't feel good, give me a
200: pill. Or do some, fix it fix it, don't give me all that stuff,
201: just fix it. And maybe even in society, people are excited to
202: get out of school - why? Well because they don't have to learn
203: anymore, they don't have to extend themselves.
204:
205: *So it takes something, you have to be actively involved as a
206: patient and not to show up but also to say, oh, this might
207: require something more of me.
208:
209: Yeah. It's like a student, if I went to class and didn't ask any
210: questions, would I learn? I think it's almost the same type of
211: situation.
212:
213: *That's good, okay. In your estimation has learning in a medical
214: visit usually been optimal for patients within this health care
215: system?
216:
217: No, I don't think so. I think that you hear more and more
218: stories about - in fact my wife does it - goes on the Internet
219: and pulls off pages and then comes in and asks the docs about it,
220: and that was never done years ago. Then the doc was on a pedestal
221: and told you what to do. Even your older patients, rarely did
222: they challenge a physician or ask why, they just quietly did what
223: the doc said. And now you have more people coming in and trying
224: to negotiate. Okay doc, here's what I think I have. And some of
225: that depending on the physician again, some of them are, you know
226: you are challenging my authority, I'm not going to do that. And
227: then you have others that are willing to sit down. But where your
228: fundamental problem in all of it is, is the physicians are paid
229: on a piece work basis. And by sitting down and giving the people
230: as much time to answer the questions, a physician can't charge
231: for their time and so there's a loss of revenue. So the system
232: is completely upside-down, because it's designed to go in, take
233: care of a problem, and go to the next one. It's not designed to
234: be educational.
235:
236: *We're in good alignment on that ((laughter)). That's great,
237: that's great. Let me ask a few questions then about provider
238: learning. I think in many ways you've already addressed them.
239: What types of things does a provider need to learn?
240:

241: And I would, I'll give you a bias again, if you divide providers
242: out from physicians and mid levels, and mid levels would be nurse
243: practitioners, physician assistants, or nurse midwives. I think
244: those people in a broad generalization probably are more in tune
245: in answering questions than physicians.
246:
247: *It's a different training.
248:
249: Yep, it's a different approach. Now they all sort of want to
250: gravitate back toward being a physician, so they move back to the
251: science of the physician to evaluate them on the scientific
252: basis. And to a degree, their way to take time and answer
253: questions is probably a financial disincentive. But they have a
254: propensity to doing the education as opposed to where physicians
255: are more, I'm to going to fix a problem. And so I think the
256: physician needs to be aware of that mind set -   part of fixing
257: the problem is giving the answer to the question.
258:
259: *Let me ask this same question about providers that I asked about
260: patients. Do you think learning for providers has generally been
261: optimal?
262:
263: I think the learning, well the learning you're using I don't
264: think it has. I think the education, the physician has
265: requirements to continue their learning, to do the medical. And
266: what are they learning? They continue to learn technical
267: information. If you have two courses, here's a course presented
268: by Oregon Health Sciences on CF, and here's a course on
269: interacting with your patients, the vast majority are going to go
270: to the CF one as opposed to the interaction one, the scientific
271: rather than touchy-feely.
272:
273: *I want to move now to a systems diagram. The first one is just
274: sort of instructive about, an example of how to read this type of
275: systems diagram. A double walled box is either a system input, or
276: a system output. And if you read forward from an arrow, you
277: would say 'therefore': back muscles tense up therefore back
278: muscles become inflamed. And it works really in loops... or you
279: could read it backward and say 'because': back hurts when doing
280: normal activities because back muscles become inflamed. I want
281: you to spend a minute just sort of going through this one just to
282: get a feel for it. It's a systems map and it's a pattern. It's
283: not the only pattern for back pain, there are other patterns.
284: This happens to be a lifestyle pattern, a pattern where the
285: emotional state feeds into a whole set of lived behaviors that
286: become self sustaining without anybody particularly organizing
287: them this way.
288:
289: Right.
290:
291: *So it's just an example of a pattern map, or a simple systems
292: diagram. Here's a little bit more complex one. And I'd like you
293: to spend just a little time reading through this one. I want to
294: ask you some questions about it.
295:
296: Okay. So here's the input box, okay.
297:
298: *And again this is not the only pattern that happens, you might
299: say this is the pattern we don't want to happen, so I've sketched
300: it to try to understand it.

301:
302: Mmh-hmm. Okay.
303:
304: ((40 seconds elapsed since first seeing diagram))
305:
306: *First of all would you say you can understand this diagram or
307: not?
308:
309: Mm-hmm. ((affirmative))
310:
311: *In your own words what does this diagram show?
312:
313: Well it pretty much talks about what we were talking about
314: earlier, I mean that the system is set up so that people come in
315: and have a focused appointment, the providers stays on the
316: focused appointment, and people don't feel satisfied. When I was
317: reading it, thinking about, those thoughts go off in your head,
318: that you're doing this analysis, and I've always been fascinated
319: where you hear stories about millions and millions and millions
320: of dollars people pay out-of-pocket to go to alternative type of
321: providers, chiropractors, naturopaths, those types of things,
322: well why do people do that? Are they getting... where are they in
323: essence doing it right, and where is the traditional medicine
324: doing it wrong.
325:
326: *What need have we missed?
327:
328: Right. That's an excellent way to put. We're missing something,
329: we should be able to learn. Is it that the chiropractor, is the
330: touch that they appreciate, that they feel like something's being
331: done as opposed to just a cognitive exercise? Are they able, in a
332: negative sense, to manipulate those people to get what they want
333: as opposed to not in health care? I don't know that.
334:
335: *And it's a really rich question, and I'm starting to look at
336: that in some of the studies I'm doing.
337:
338: I've always been fascinated by that, I don't have any, I've never
339: been to a chiropractor.
340:
341: *When you look at this diagram is there anything in terms of my
342: depiction of this pattern that stands out as being wrong?
343:
344: This one I thought is interesting - that some patients drop out
345: of the health care system. No, they do to a point, but they're
346: always going to come back into the system, either through the ER
347: or something. So drop out kind of caught me, maybe take a leave
348: of absence, I don't think anybody ever drops out of health care.
349:
350: *Yes, at some point it becomes an essential.
351:
352: Right.
353:
354: *Maybe a temporary drop out. That's a wonderful observation.
355: Thank you, that's very helpful.
356:
357: Even if you go to chiropractors, you still somehow go back into
358: mainstream.
359:
360: *So maybe leave of absence, some patients taking a leave of

361: absence from the health care system.
362:
363: Right. That's the first one that...
364:
365: *That's a wonderful refinement.
366:
367: Yeah I mean, this is a strong - total health care system costs
368: increase from ineffectiveness - it's a strong statement but I
369: think for the most part I can agree with it. Other than that I
370: don't have any trouble with it.
371:
372: *All right. The diagram presents a pattern of insufficient
373: learning or ineffective learning. Do you think it is an accurate
374: representation of a pattern that actually occurs?
375:
376: Yes, I wouldn't say 100 percent, but I think it's accurate for a
377: majority of the patients.
378:
379: *Do you think it shows a common pattern or a rare pattern?
380:
381: Oh, I think it is more common than rare.
382:
383: *Is the language of the statements fair to patients, to
384: providers, and to administrators?
385:
386: Umm, not necessarily, for instance I read another statement,
387: let's see if I can find it here...providers don't learn enough
388: about patients lives and experiences. A couple things triggered,
389: because I have kind of off the key conversations with docs all
390: the time. I was talking to a doc who's been practicing 23, 24
391: years in (town name), not in this community, and he told me, what
392: he was trying to do was to figure a way to start slowing down,
393: and he does a specialty, he does pulmonology, and he also does
394: general internal medicine. And he said the easiest way to do it
395: would be to just jettison my internal medicine practice and just
396: do pulmonology. But these are my friends, I've been seeing them
397: for 25 years, I just can't do that. I have in other times
398: talking to physicians that in a meeting they'll say, well you
399: know, so-and-so didn't look good. And so I have to go back and
400: give them credit, they may not, you know, don't learn enough,
401: they may not verbalize, but they're real good at picking up cues.
402: The patients didn't look right, there was something about them
403: they didn't like.
404:
405: *Any good provider picks up a vast amount of information tacitly,
406: and you can't necessarily say why, but you know, the alert light
407: goes on, something's wrong here, I need to keep close tabs.
408:
409: Yeah, and I've heard it, I just for some reason felt I needed to
410: order this. And I've heard it more than you can imagine.
411:
412: *I've heard that as well, and have experienced that. That
413: intuition level is there. That's good, so that may be not quite
414: absolutely perfect or perhaps not quite fair to the amount that
415: providers really do take in given the time that they have with
416: patients.
417:
418: Mmh-hmm. Yeah, and I think you have an input and then you have an
419: output, and I think my view is the output is where the deficiency
420: is, that they're not explaining, talking as much, as taking all

421: this stuff in.
422:
423: *Has your experience ever put you in this diagram...
424:
425: Oh, yeah, I'm a patient.((laughter))
426:
427: *...and if so, where? Tell me a story about it.
428:
429: Well I mean, just different, I'll give you one from a long time
430: ago. When I was running, I was a distance runner, and I landed
431: one day on my arch, I hit a rock and I could feel something pop
432: in my arch. So I went in, got up the next morning and my arch was
433: just absolutely killing me. So I went, and I went to an
434: orthopedic surgeon and he did some analysis and the sense I came
435: away with, the fact that he felt, you know, I could do surgery on
436: this. So then I went to a podiatrist and the podiatrist said oh
437: yeah, planter fasciitis, here's what happened, I think you need
438: orthotics, and your gait pattern. Looking at the two, it's like I
439: clearly didn't feel like the orthopod took me as a, he took me as
440: an arch, as an injured arch, as opposed to a human being with a
441: sore arch.
442:
443: *Mmh-hmm.
444:
445: And so that, I go through there, you know, medical interventions
446: inadequately addressed my need, the healing wasn't optimal,
447: ((spoken while tracing from loop diagram)) so what I did is, I
448: moved to a different location in the system.
449:
450: *There you go...
451:
452: I went to a different system as opposed to the one I was in.
453:
454: *So a leave of absence, or a relocate...
455:
456: Yeah.
457:
458: *Finally does this diagram show you anything that is either
459: particularly useful or interesting, any 'a-ha', any insight that
460: it particularly provokes?
461:
462: The question, that's why I went sort of back here, is I would
463: love to know right here, the healing and satisfaction aren't
464: optimal and so now the patient has to make a choice, I'd like to
465: know what's going through their mind, to say I'm going to
466: relocate, or I'm going to stay here even though I'm not real
467: happy. Can I come back and manage it? So how I tend to be, if I
468: go to a store and I'm not real happy, yeah, okay, if they screw
469: up once fine, if they screw up twice, no. I don't make a fuss, I
470: just don't go back. Now other people will make a fuss, and I
471: will sit here and say okay, how can I manage this differently.
472: Do we need to put a loop in here, we being the health care
473: system, to say okay, if people aren't satisfied, how can we (a)
474: get that information, and (b) what can we do.
475:
476: *Yes, you bet, those are both good questions and very very rich
477: questions. And its right at that node isn't it.
478:
479: Mmh-hmm. ((affirmative))
480:

481: *How do we get the feedback on performance that we need?
482:
483: Well traditionally, we do patient satisfaction surveys, it's
484: superficial stuff you know. Were you pleased with your visit? Is
485: it easy to park? Was the place clean? How did you like your doc?
486: Did they answer your questions? And most of the docs place out
487: very well, but that's in the group that's coming here. So
488: they're happy. How can you get the ones... so you assume the
489: people that eat at Burger King are happy with Burger King, but
490: you have a percent of population that don't ever come to Burger
491: King.
492:
493: *And you have to try and understand them...
494:
495: Mmh-hmm. ((affirmative))
496:
497: *So its understanding that broader community of expectations.
498: How do we get to that? I think that some of the way that I am
499: working at understanding that is through medical anthropology,
500: and history, and just really looking deeply across cultures,
501: saying what are the enduring, fundamental, and legitimate
502: purposes that health care serves. And that's, I'd talk your ear
503: off about that, I won't do that today. But that brings me right
504: to where we need to get. Very rich, very interesting, and you've
505: just got a wonderful grasp of the situation.
506:
507: ((end of interview))

1: * September 7, 2001 1:15 PM
2: * YYY conference room
3: * prov1:'Carl Quinn'
4:
5: * I want to start with just a few demographic questions. Age?
6:
7: Age, thirty-five.
8:
9: * Thirty-five. Race is Caucasian...
10:
11: Race is Caucasian.
12:
13: * Gender male; professional training?
14:
15: Professional training is a medical physician.
16:
17: * Okay, and title?
18:
19: Title? Family practitioner, M.D.
20:
21: * Years in practice?
22:
23: Years in practice would be seven.
24:
25: * All right, and years in your present position?
26:
27: Present position, three.
28:
29: * Okay. How would you describe your duties?
30:
31: The duties are general medical care for patients of all ages
32: ranging from newborns to the elderly.
33:
34: * What brought you to family practice?
35:
36: Choosing family practice was a journey. I knew I wanted to go
37: into the medical field, but I liked every distinct part of
38: medicine going through different rotations, so I wanted to do
39: pediatrics, I wanted to do obstetrics, I wanted to do counseling,
40: psychiatry, and then I realized I could do all of that with a
41: family practice. But I think ultimately the need to connect with
42: humans on an individual basis was first and foremost.
43:
44: * What would you say are the facilitators and barriers to
45: accomplishing your daily duties? What are the things that really
46: make your job a lot easier to do, what are the things that are
47: just brick walls?
48:
49: Things that make my job easier are...the knowledge that a person
50: is speaking on the same wavelength, or that I am speaking on the
51: same wavelength with them. It's getting that sense of 'I
52: understand' in their eyes. Those are definite pluses. Barriers
53: on the other hand are when you know that what you're trying to
54: present just isn't coming across, either just in the way that
55: it's been presented, or in the feeling that the person you're
56: talking with or a patient you're trying to counsel or educate,
57: doesn't want to have the information presented... because it may
58: interfere with their health in a negative fashion, or they just
59: refuse to hear a different thing ((?)) on it. Other barriers at
60: times is just purely cultural too, and that can be linguistic and

61: cultural just in terms of, oh, different thoughts about medical
62: practice, or things that you should and should not share with
63: your family physician.
64:
65: * How would you describe an ordinary work day?
66:
67: An ordinary work day....um, time is of the essence. It starts a
68: little earlier especially if you have patients to round on in the
69: hospital. But if you're in the clinic setting, I have, myself
70: and my assistant really strive to stay on time for patients. And
71: I think that that's one of the number one barriers again, when
72: you talk about, is the perception that you're always waiting for
73: the doctor, and the doctor is always behind. What I try to get
74: across to people, well, if I am behind it's probably because I
75: spent more time with somebody that needed that time. But that is
76: one of the number one mis-perceptions that I try to correct. The
77: day ((?)), just a normal starting time, kind of get on with the
78: day with routine visits or complete physical examinations. They
79: do get spaced out pretty frequently, every 15 minutes you're
80: starting up with a new patient, you may be double booked because
81: you needed to see them, and usually the cycle goes on until the
82: end of the working day. A lot of phone calls, which sometimes
83: get pushed off until the end part of the day, so you can phone
84: patients back with this or that. And that sometimes is the most
85: frustrating thing, when you've already put in a whole day of
86: seeing patients, you're not completely done yet because you may
87: have to re-live the entire encounters again with dictating. And
88: 20 years ago we didn't have to worry about dictating and
89: documenting everything that you do with a patient, and now with
90: the medical legal environment you have to document, document,
91: document. So on the one hand it's frustrating because you have
92: to then re-live the whole encounter, and sometimes you just want
93: to turn it off and go home. But on the other hand medico-legally
94: you have things to help cover you in what you've discussed with
95: patients, which is a good reminder for the next time they come
96: in, but also to insure that they've understood things that you
97: want to do with them. And if they've given you consent to do
98: that with them, so that's a good way of documenting. But it's a
99: frustrating thing at the end of the day when you just want to go
100: home and relax. And then if you're on call on the weekend,
101: evenings or weekends, you still have the constant always knowing
102: you could be called out to admit the patient or to see somebody
103: urgently. I think most physicians see that as part of the
104: lifestyle, but I feel a lot of the time that patients may not see
105: the fact that it does interfere with that physician's own
106: personal family life.
107:
108: * It's the job that doesn't go away.
109:
110: That's right, that's right.
111:
112: * Married to your career.
113:
114: That's right. I'm part of a younger generation of physicians
115: though that do understand that, and I'm really going to try to
116: set limits, because especially if you have a family, if they grow
117: up too fast, and... so I think there's a younger generation of
118: physicians knowing that work is work and home time is home time,
119: and you try to protect that as much as possible.
120:

121: * Wow, wow. How many visits a day do you end up seeing, how many
122: patients?
123:
124: It ranges depending on how many physicals you're seeing in that
125: day, to how many quick emergent things. Ranging for a routine
126: day between 20 to 30.
127:
128: * Those are busy days. Yeah. Roughly how, say a new patient
129: visit, how much time does that...
130:
131: A new patient, which I like to see 30 minutes for a new patient
132: so I can go through their medical history with them, if it's the
133: first time they've been in our clinic, I guess to educate them a
134: little bit about how our clinic works, what you can expect from
135: us as your practitioners, what our on call system is like, that
136: we are always available for phone advice, but that we have
137: physician assistants that may work with us as well. But for those
138: very acute things, that I as a family doctor like to see them.
139: ((?)) is available. Also a way to explain to them what our
140: concept of open access is at our clinic, which is trying to see
141: people the day that they need to be seen, rather than phoning in
142: for a sore throat that day and being told that they have to wait
143: until two weeks later. So that's why I like to spend 30 minutes
144: in a new patient encounter, and then usually after that it's
145: fifteen minutes.
146:
147: * How does the clinic reimburse you for your services?
148:
149: How we get paid is through an RVU system. RVU's are a relative
150: value index. So for the type of coding according to the Medicare
151: guidelines for ((?)) coding, would be, circle what type of a
152: patient visit it was, and then based on that code is how we get
153: generated RVU's for a full month. But we are fortunate in our
154: group setting that we get the same rate of pay for a six month
155: period, depending upon what our production was in seeing patients
156: from the previous six months. So it's very reassuring when you
157: take two weeks off or a vacation that you don't get penalized in
158: your take home pay. You get that same take home pay but its
159: spread over six months of your production.
160:
161: * Is there a differential in terms of reimbursement for cognitive
162: interventions, time spent teaching and explaining, as vs.
163: procedures?
164:
165: All procedures pay higher, so if you are a physician who likes to
166: do a lot of procedures, you'll generate more RVU's. Traditionally
167: there haven't been good payment systems for the discussion and
168: the counseling. Now that was all part of medical practice
169: anyway, so it is built into, when you're talking about high blood
170: pressure, you're checking their blood pressure, but you're also
171: telling them why is it important to be treated in the first
172: place. So that is always part of the game, the discussion. But
173: if you have a patient come in purely to have some counseling
174: aspect done because of stressors in their life, sometimes without
175: a medical diagnosis to code, it's very hard to get any payment
176: back from insurance companies for that. They a lot of the time
177: will want just pure medical diagnoses, and that's what you get
178: paid on. But you know there is some leeway, and you try to build
179: in, let's say you do have a documented medical diagnosis, to talk
180: about that, to discuss other factors that could partially play

181: into a medical diagnosis. That's how it often can be brought
182: into a whole discussion.
183:
184: * Okay, I want to move to some questions about your perceptions
185: of patient learning. A broad question - what types of things
186: does a patient need to learn?
187:
188: They need to learn that this is a partnership. My concept of
189: medicine is, gone are the days where the doctor sat on an ivory
190: tower and said you shall do this. So I have with my patients a
191: partnership built in, that I'll be their, hopefully, medical
192: expert, and gathering information for them, making decisions
193: based on clinical data, talking about pros and cons of therapy
194: and coming up with a formulation of a game plan. So I see that
195: more as a partnership with me. I understand that there are other
196: medical advisers, and people that play roles in this partnership,
197: and I'm very comfortable with the team concept of approach to
198: medicine. So I think that's what I expect out of my patients,
199: first and foremost to know that I'll be there to advise them, but
200: I want to make decisions with them, and that I want them to have
201: buy in with the decisions we have made together. So that they're
202: fully aware if they have any bad outcomes, that we were aware
203: that this could happen, and that they are not falsely, falsely
204: comforted with me making every decision for them. I make a
205: decision with them and not for them.
206:
207: * I wonder if you find patients who find that partnership model
208: unpalatable to them?
209:
210: A few. And I would say, mainly in maybe the, the individuals that
211: are age 65 and older that are used to the physician making the
212: decisions for them, and that would be a role model of medicine
213: that they knew. But I think the feeling at my practice is, 35
214: percent pediatrics and a lot of young families, and we're seeing
215: a lot of young families that are very well educated, and pros and
216: cons of types of treatments, they want to know beforehand any
217: adverse outcomes.
218:
219: * So there's some real generational differences amongst the
220: patients.
221:
222: Definitely.
223:
224: * Both expectations that physicians are bringing into the room as
225: well as the expectations that patients are bringing.
226:
227: I would agree, yeah. Another expectation I think is having the
228: patient tell me if they are confused or upset about any
229: interaction. I'd rather know that so that it can be fixed rather
230: than have the feeling there that I would be uncaring to their
231: condition.
232:
233: * Mmh-hmm. What contributes to patients learning the types of
234: information they need?
235:
236: Background knowledge and I would say education definitely
237: contributes. Ease to have computer access. Here in (city name)
238: we have a lot of people who are computer savvy and a highly
239: educated population. People often come into my office with some
240: background research they've already done, and then we can discuss

241: that. Then we have the other segments of the population that
242: might have educational barriers, whether it be language, because
243: English isn't their first language, or whether it be the fact
244: that they weren't able to complete high school education and go
245: on with further post-secondary education. So that generally
246: speaking could impact some of the patient's ability to learn and
247: take home a positive message. I think all practitioners always
248: have to understand that it's important to talk to their level,
249: that your patient can always understand, and you get very quickly
250: accustomed to doing that, at least I do. Not all practitioners
251: might, but I think that's of first and foremost importance.
252:
253: * So you can translate between Medical-ese and English.
254:
255: Yep, definitely, all the time.
256:
257: * Job title - translator. I like it!
258:
259: I like it!
260:
261: * Okay. In your experience has learning in medical visits
262: usually been optimal for your patients or not?
263:
264: Very often, yes.
265:
266: * Do you recall an instance when learning was less than optimal,
267: and without disclosing patient names, could you tell me a story
268: about that?
269:
270: A situation with a middle-aged female with a lot of life
271: stressors, a history of post traumatic stress disorder, spousal
272: abuse, chronic anxiety, depression, chronic use of wrong type of
273: medications, where in my clinical setting I wanted to almost
274: start from scratch and re-address things that had been maybe just
275: the norm of treatment for this person for upwards to 10 years.
276: When there's a lot of resistance maybe from her perspective, to
277: try something new because it would mean leaving the safety of
278: what she already knew. But also on the other hand the types of
279: medications that were being used had a lot of negative side
280: effects and would continue over the long-term to not be effective
281: anymore, or to lead to a higher dependence on these medications.
282: That definitely was a learning curve for both herself and myself,
283: and that we still kind of had to get to a partnership of what was
284: I willing to let go of in terms of what I wanted to do, but to
285: also let her come forward a half step in what she felt
286: comfortable enough to let go of, a certain type of medication, a
287: few very small steps. But that was the educational process for
288: this individual because the previous medical system had coddled
289: her and allowed her to continue in what she had been doing. And
290: now when you had somebody that wanted to make a change because
291: they could see potential adverse, there's a big barrier to
292: learning.
293:
294: * That's a very good one because it points out, people, all of
295: us, we all have baggage.
296:
297: Especially when you start up a new practice, you'll have people
298: that will come to your practice from an established practice
299: because you're new and they think that maybe you'll be able to
300: help them. But in essence maybe all that they were wanting is a

301: new face to continue the same types of treatments and not explore
302: any alternatives.
303:
304: * That is illuminating. Now I want to move to questions of
305: provider learning, physician learning. What types of things do
306: you need to learn in a medical visit?
307:
308: In just a medical visit alone, and I'll expound on just what we
309: need to keep learning in terms of the profession. Professionally
310: medicine is always changing and so continuing with medical
311: education, going to seminars, learning from specialists that may
312: come around and may give discussions and talk, knowing what new
313: and improved medications are around, always first and foremost
314: because you have to keep on top of things. If you get out of
315: medical school or even after 10 years of practice, and think that
316: you've learned it all, you know, you can just keep doing what
317: you've been doing, you're going to fall behind, and it's going to
318: show with your patients as well. Learning personally on a daily
319: visit is, even on those patient encounters when you haven't been
320: the happiest, or that you had a patient encounter that made you
321: really frustrated, is try to look back and see, well, how did I
322: still help that person for that visit. And I think it's better
323: in the long-term, the end result of why we're doing medicine in
324: the first place. I think you always have to go home and try to
325: disregard some of the more negative aspects of that day, and
326: still focus on what was positive from that encounter, because
327: that is how you'll continue to thrive and grow in this practice.
328: If you held every negative it would decrease your willingness to
329: keep going to work and it would be a very short career.
330:
331: * If you dwell on the negatives, all the conflicts that have
332: happened in the day, the unresolved issues, that can gnaw at you.
333:
334: Right.
335:
336: * How do you learn the types of information you need to learn?
337:
338: Myself, I'm a big learner by listening, by hearing something once
339: I usually retain it. I usually can go from patient contacts
340: knowing that I've seen them before, so by seeing one of my
341: patients, I'm very visual, I'll remember their medical history,
342: what I was doing, without opening the chart. So first and
343: foremost it's, you know, it's kind of listening as my number one
344: retaining system or education. And secondary of course is
345: reading, and so, and that will continue from medical journals
346: that I'll flip through at night when I'm watching TV, as well,
347: different computer work that will go on in the ((?chair)), this
348: and that. There is a source of learning through some of the
349: pharmaceutical representatives that come out talking about their
350: products, but that can be a double edged sword, you have to watch
351: that, but there still is some medical information from studies
352: that can be gleaned from that. And, um, feedback from patients.
353: Our clinic has patient questionnaires they send out, and learning
354: in that perspective from, well how did we meet our agendas and
355: our objectives and were people happy with the end result. So
356: it's a daily process.
357:
358: * What contributes to a medical visit in which say you do not
359: optimally learn what you need to learn?
360:

361: Speed, in thinking that I have to stay on time for the next
362: patient, for me to be rushing.
363:
364: * Time pressure.
365:
366: Yes, time pressure would be a barrier to learning. Thinking that
367: gee, there's three more people that are waiting now and I have to
368: make up time with this patient encounter to get me back on track
369: with the ones that are left behind. So rushing, you know rushing
370: through an encounter, would be probably my biggest barrier to
371: learning. But outside of that I still try to do that connection
372: on the human basis, and that's why I went into medicine in the
373: first place. So I don't know if that answered the question
374: completely, but the biggest barrier on a one time patient
375: encounter is making sure I'm going to have enough time to do what
376: I want to do, educate them the way I feel they need to have the
377: education, and to hear back from them how they felt, did they
378: receive that educational advice.
379:
380: * Okay. I want to move now to some systems diagrams. I've put
381: together sort of an ethnographic approach and a systems approach,
382: and there's a lot of different ways of doing systems. I'm trying
383: to draw some very simple diagrams, and they're really maps of
384: patterns, pattern maps is perhaps the best way I could put it.
385: This is a sample diagram that simply has to do with lifestyle
386: contributions to back pain. There's lots of other ways to get to
387: back pain, there's lots of other patterns, this is just the
388: diagram of one pattern. A double walled box is a system input or
389: a system output. And if you read from a box following an arrow
390: forward, you would say 'therefore'. Back muscles tense up
391: therefore back muscles become inflamed therefore the back hurts
392: when doing normal activities, and you can follow the loops
393: around. Or you can follow the arrows backwards by saying
394: 'because'. I want to give you a minute just to go through that
395: little diagram and see if that makes sense in terms of how to
396: read them.
397:
398: ((9 second pause))
399:
400: It makes sense.
401:
402: * Good. Good.
403:
404: It definitely makes sense.
405:
406: * Generally I would say in systems thinking, we're thinking in
407: circles or in loops, more than in chains.
408:
409: Right.
410:
411: * So it's looking at interdependencies and mutual ....((?))
412:
413: Unfortunately what I see happening, people will consult the
414: health care provider too late.
415:
416: * Yes, yes, it could be very late in there.
417:
418: There should be the contact hopefully well before we get into
419: this chronic cycle.
420:

421: * You bet, absolutely. This is a little bit more complex diagram
422: that I want to show you now. And I just want you to read through
423: that one, look it over and I'm going to ask you some questions
424: about it. I'd really like to get your input on it.
425:
426: ((37 second pause))
427:
428: * It's one pattern out of many patterns, I'd say it's the pattern
429: we want to avoid. And we need to learn more, and so what I'm
430: going to try and do is learn how to avoid it. But first I'm going
431: to ask some real simple questions about it. First of all would
432: you say you can understand this diagram?
433:
434: I can understand it definitely.
435:
436: * In your own words what does this diagram show?
437:
438: Well, when we see the top upper right hand box about management
439: responding to market forces, unfortunately we're practicing in a
440: field that has never been listed as a consumer based product.
441: We're consumer driven, we bring in costs. I think traditionally
442: medicine was meant to be those healers, those touchers, and help
443: people and guide them along to better health in their whole life,
444: and so we saw patients more globally, and saw them more as what
445: they did with their community, and how they interacted with them.
446: And then as medicine became more technologically advanced, the
447: costs of medicine started to go up. The people that managed
448: medical costs dictated amounts of patients that needed to be
449: seen. That put more stress on physicians to meet the bottom line,
450: especially with the increasing costs of technology of medicine.
451: Patients would expect the highest technology because it was
452: available, but not as willing to pay for those added costs. So
453: ultimately the insurance companies, hospital systems, physician
454: groups, and then later on patients with their own insurance costs
455: and deductibles, all started to pay into that. So that in my
456: mind created a system that wasn't truly treating patients as
457: people anymore, but patients as the problem that needed to be
458: fixed. Makes sense?
459:
460: * That makes good sense, you bet, you bet. As you look at this
461: diagram, is there anything that you see that might be wrong about
462: it, any statement in there, any you might say set of implications
463: or conclusions that you think 'Ooh, that's not right'?
464:
465: Patterns of living produce symptoms, I definitely agree with
466: that, but we've become a fast food generation, and we want quick
467: fixes, and patients today when they look at, and I know this is
468: generally speaking, when they look at our fast food environment,
469: our fast way of living, we want a quick fix but we're not willing
470: to put in any of the extra work it would take to change our
471: lifestyles, first and foremost, to help prevent disease
472: processes. And if we look at the rate of obesity, and it has
473: skyrocketed in just children over the last 10 years due to
474: increased inactivity, increased fast food, that's going to be a
475: problem for us twenty years down the road in even higher rates of
476: diabetes, higher rates of hypertension, higher rates of heart
477: disease, and then that will produce even more strain on the
478: medical system and the resources available. And that's a way of
479: thinking that's been occurring over the last couple generations,
480: quick fix, quick gratification, no work into making changes, and

481: expecting the physician or practitioner to give a pill to make
482: everything better, when the bulk of our chronic disease states,
483: we still have to look from a lifestyle venue. I'm sure there are
484: medications to help a lot, and augment the person, but if they
485: can't change their lifestyle, i.e. smoking, then the problems
486: will continue to exist. And we can't sit down and judge a person
487: because we don't know what it is like to be in their shoes. We
488: have to try to understand and try to be their medical advisers,
489: and stating but if you continue doing these types of lifestyle
490: things, this may occur for you, when you're going to be more at
491: risk of having this occur. But I hope we don't get into a
492: judgmental phase because then I think that works against what
493: we're trying to achieve with patients if we're being judgmental.
494:
495: * That's very interesting, if I were to extrapolate from that, I
496: would say that given that this is just a pattern that starts with
497: a lifestyle problem, that I've drawn here, what you might be
498: suggesting is that in order to shift or change this pattern, to
499: not get stuck in, in terms of the overall ineffectiveness and the
500: increase in costs and hence the drive of time pressures, to get
501: out of this pattern, and to focus on lifestyle medicine, is going
502: to face resistance from patients who want the quick fix.
503:
504: Definitely. And it's going to face resistance from the insurance
505: companies, because there aren't diagnoses to cover lifestyle
506: modifications. So it's a double edged sword, where exactly do
507: you make the pressure and the changes? And I think that that's
508: why the insurance companies that maybe cover those yearly annual
509: preventative medicine examinations, you can incorporate a lot of
510: lifestyle medicine into that. But I think it starts right from
511: small, it starts right from bringing in your children for their
512: newborn examinations, and asking about lifestyle issues then, and
513: activity and exercise. And you may be able to bring up a
514: lifestyle change with a young patient, but the same time it's an
515: overweight mother or father is hearing those same things. And I
516: talk about obesity a lot, but that's because we see it a lot.
517: There are a lot of other disease states that are definitely
518: lifestyle associated.
519:
520: * Change isn't going to come easy, and I agree with you 100
521: percent on that.
522:
523: Change is not a quick fix, you have to keep at it every single
524: day.
525:
526: * That's right, that's right. This particular diagram presents a
527: pattern of insufficient learning in medical visits. And I guess
528: my question would be, is it an accurate representation of that
529: pattern?
530:
531: It's an accurate representation of that specific pattern, if you
532: feel that you're spinning your wheels with particular patients
533: where things never really change or get better, they continue to
534: come in and see you, you continue to see them, you talk about
535: therapies, they talk to you about their issues or problems, but
536: then the whole thing gets revisited the next time that you see
537: them. And not primarily in changing lifestyle, just that the
538: fact that you have a certain client or a certain amount of
539: individuals that no matter what they or you try to do they're
540: just probably not going to get a whole lot better in the way that

541: they are feeling. And that may be due to, I see this more in the
542: people that have chronic pain, chronic daily pain. I think it's
543: very hard once they get to that point to ever feel completely
544: well again, without doing almost a complete make over, of their
545: psyche, of their lifestyle, of their relationships with others,
546: letting go of emotional baggage, and then of course using
547: manipulation with medications, with exercise etc. And I think
548: first and foremost, I think we can document and state that a lot
549: of our medical problems result from pain. Pain not only from
550: muscular or skeletal, but emotional pain. And why does a patient
551: go see a doctor in the first place, they're having pain
552: somewhere, it could be pain from depression, pain from anxiety,
553: it's a different type of pain, or too, maybe a painful cut finger
554: that they need sewn up. I guess in, we have to get better at
555: understanding the role of pain and how it affects the persons'
556: whole well-being. And trying to decrease that pain, whether it
557: is just by listening to them and they feel like their pain has
558: been better, or whether it is by doing the other traditional
559: medical approaches.
560:
561: * To be listened to well has amazing impact on patients.
562:
563: Mmh-hmm, yeah.
564:
565: * I think it's its own therapeutic intervention, but there's no
566: code for it, right? ((laughter)) No CPT code for that! Well. Do
567: you think this shows a pattern that actually occurs, perhaps not
568: so much in your practice, but in the general field of medical
569: practice?
570:
571: Umm.
572:
573: * ...and if so, would you say that's a common pattern or a rare
574: pattern or somewhere in between?
575:
576: I think it's more, I mean we see it, but I think it's more of a
577: rare pattern, where the healing and satisfaction are not optimal,
578: where patients drop out completely from the health care system.
579: They may choose to go to other alternatives, or do they drop out
580: completely, I don't see that as a constant. But I do see a
581: pattern emerging in what we're doing today, in where the total
582: health care system costs increase from ineffectiveness, leads to
583: more and more pressure, then we go to that looping, going around
584: and around with use of providers time, and then the symptoms keep
585: continuing and returning, which gives even more increase in the
586: ineffectiveness. So there's definitely a larger, it's like a
587: smaller loop within the larger loop on the diagram.
588:
589: * Mmh-hmm. Would you say that the language of the statements is
590: fair to patients, to providers and to administrators?
591:
592: I would say so. I would say it's very valid.
593:
594: * Yeah. You know one of the things I'm trying to show is that
595: everybody's doing their job here as, in many ways as they are
596: expected to under the constraints that they're charged with, and
597: yet we get outcomes that we don't want. How do we avoid that? At
598: one level it's nobody's fault, at another level it's everybody's.
599: And to really say, now how can we first of all become aware of
600: this pattern when it occurs, and second of all - where's the

601: leverage, how can we change it?
602:
603: One thing I just thought of, when my brain was thinking forward a
604: little bit, and one thing that it doesn't bring into this is the
605: fact that physicians, I don't like the word providers, I like the
606: word practitioners because we all practice medicine, but
607: providers has been the buzzword of the insurance companies and I
608: didn't go to provider school, so that's for the record.
609:
610: * There you go.
611:
612: But as practitioners, we're still human, and I don't know in this
613: whole diagram, was there the space that, into patients view
614: practitioners as still being human, and still being infallible.
615: And while this whole system may get very busy with health care
616: costs and trying to do the best good for the best patients, I'd
617: say by and large practitioners are here and doing their job
618: because they want to help people. We're not in the position
619: because we want to make a lot of money, or to rip off the system,
620: or to cure everything, because sometimes even though you're doing
621: everything that you hope you can do, bad things still happen.
622: And I guess I would like to see worked into this whole model is
623: that practitioners still are seen as being human beings, or
624: not being infallible. But still mistakes happen, and bad things
625: happen, and that unfortunately I see that over the last, you know
626: 20, 30 years, there's been more and more focus on shifting blame
627: to somebody. And I think everybody should take care in
628: positioning anybody, outside of negligence. If there's pure
629: negligence that occurs, that's very different, but I think that
630: if you get patients to buy in with you, and getting a better
631: appreciation of a team approach to medical help, then you will
632: get less problems in putting blame on, when results aren't met.
633: Because you have had a team approach to discuss the different
634: options. And still that's where the medical field has to change,
635: and ultimately not see themselves as being infallible, or being
636: the hierarchy, the only advisers to medical help.
637:
638: * And yet some of that willingness, let's just call it
639: forgiveness, that you would like to see from patients when things
640: don't turn out well, which is a reasonable expectation, I think
641: that comes from having had the time to create the human
642: relationship, rather than the strictly medical diagnostic
643: intervention relationship.
644:
645: Right, right. And hopefully what I would see is that people who
646: want to develop that human relationship went into primary care,
647: because that's where we need it. We can leave all of the other
648: stuff with specialists, if they're not as concerned, but the
649: human contact, I think that the basis of primary care has to be
650: seeing each other as humans.
651:
652: * And that's really what family practice has championed,
653: pioneered, and nurtured.
654:
655: Definitely. Right.
656:
657: * I probably couldn't indicate that, this is as complex a map as
658: I can make, and still have it... and so it's too simple, it
659: misses lots of things, it misses the input of medical education
660: for example, and you know, the regulatory web...

661:
662: Right, right.
663:
664: * ...you know, the impact of TV on people's health in terms of
665: being sedentary. Has your experience ever put you in this
666: diagram, and if so where, tell me a little story about that.
667:
668: I can see parts of my medical practice and career in every
669: single, every single box.
670:
671: * Mmh-hmm.
672:
673: Not only being part of the medical community, even being as a
674: patient and having to wait on the other end for different tests,
675: and you know, so I've seen myself in every part of this, except
676: for the dropping out of the health care system.
677:
678: * And that is just one avenue, some will opt out, and some will
679: go back into the loop.
680:
681: Right, right. But every single box, I could see that I've
682: experienced that.
683:
684: * Is there anything in this diagram that seems particularly
685: useful or interesting for you or that pushes an insight? An a-ha?
686:
687: Um, one thing that I, when I initially read through, that jumped
688: out at me, that I really liked seeing, but that's because I
689: strive to do that anyway, is the fact that patients lived stories
690: are often not invited, because stories are not deemed medically
691: relevant. But as I stated earlier, my new patients, so I talk to
692: them about, so where did you grow up, and what do you do, and so,
693: I think that's such an important part of having a good
694: relationship with a practitioner, is knowing how do their life
695: circumstances affect why they are here today. But at the same
696: time I can see where sometimes it's not medically relevant
697: because if they're just seeing me for a sore throat, I don't feel
698: that I need to talk to them about what their experiences were
699: growing up in the fourth grade.
700:
701: * That's right, that's right.
702:
703: Not that I ever think so, but I'm glad that was in there because
704: I think that overall we need to get back to that and get back to
705: that connection and see people as others that can give us
706: experience and feedback. And I think maybe as I'm growing older
707: and now have a young family I'm raising, and my wife and I are
708: seeing that connection as even more important to pass on maybe
709: what we've learned to our children, and I can now more see what
710: my parents have lived through, and what they were trying to pass
711: on, and try to appreciate that in any patient then, regardless of
712: age, to still see that they are a valued member of society.
713:
714: * So if I understand right, you feel all these market pressures,
715: the time pressures...
716:
717: Mmh-hmm.
718:
719: * ... and you might say the directiveness of biomedical training,
720: scientific training, and at the same time you also find a space

721: to resist that...
722:
723: Mmh-hmm.
724:
725: * ... to bring another set of values to the table.
726:
727: Yeah. Because if I didn't have that human contact and really
728: knowing that I've touched a person, they've touched me back
729: emotionally on that level, I wouldn't be able to continue doing
730: what I'm doing, because that wouldn't get me any satisfaction.
731: So I would say personally, I have definitely bucked that trend,
732: and while things become busier time wise, and you do get a time
733: crunch, you know when you've touched somebody and affected them
734: in a good way. And so hopefully you can have more of those
735: encounters than lesser in a day, and it all makes it worthwhile.
736:
737: * So regardless of the cost of bucking those pressures, I'm sure
738: there are some costs involved, it's worth it.
739:
740: Yeah, because you could schedule patients every seven minutes,
741: but then is your patient population going to decline over the end
742: because they don't feel you as taking active interest in them as
743: people. And I think that's what would happen. But the other
744: thing when it comes to primary care, I think that our medical
745: associations have to do a better job informing the public at
746: large that primary care physicians do not make tons of money.
747: That when we look at high costs of medicine it's not because
748: primary care physicians are paid a lot. It's because of the
749: advancement of technology, the skyrocketing costs of medications,
750: but the general perception is you only go into medicine because
751: you want to be rich. That's far from the truth. I think family
752: physicians get paid well for what they do, but we've seen a great
753: reduction in the past 10 years in any type of income and I don't
754: feel that people have really noticed that, because they see their
755: health insurance premiums skyrocket, and they see that as that
756: money going to the physician. So I think that we need to do a
757: better role too of just saying yes, I'm happy with what I'm doing
758: and I do get paid well for it, but if you feel that I'm getting
759: rich from doing this, people are being mistaken.
760:
761: * ((laughter)) I know, I know that's an easy mistake to make.
762: Those are all the questions I have.
763:
764: ((Invitation proffered to review report, and accepted.))
765:
766: Thank you so much, a delight!
767:
768: ((end of interview))

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 1: * September 12, 2001  12:00 PM
 2: * YYY conference room
 3: * prov2: 'Cindy'
 4:
 5: * The first thing I want to do is just a couple of demographic
 6: questions, real simple stuff. Age?
 7:
 8: Forty-eight.
 9:
10: * Race Caucasian, gender female, professional training?
11:
12: I'm a physician assistant, umm, do you need more than that?
13:
14: * Yeah, sure, tell me anything about your training.
15:
16: Physician assistant is a program that most medical schools now
17: have.  The training varies between, it's usually around three
18: years after college, so my undergraduate education was at
19: (state name) State and then I went to the University of (state
20: name) health sciences center for my P.A. training.
21:
22: * All right, professional title?
23:
24: Physician assistant.
25:
26: * Okay.  Years in practice?
27:
28: Twenty-four.
29:
30: * Wow!  Years in your present position?
31:
32: With this group?
33:
34: * Yeah.
35:
36: Well, that's kind of hard to say, and because the group has
37: evolved, '94 I guess is when this group first started, about
38: seven years.
39:
40: * All right, all right.  How would you describe your duties?
41:
42: I see patients, I see them independently with, (name) is my
43: supervising physician, meaning that if I have questions or
44: concerns he would be available for consultation.  I do physicals,
45: I do acute illnesses, I do acute injuries, I order appropriate
46: lab or x-ray, prescribe medications and treatment.
47:
48: * What would you say are some of the things that make your day,
49: make your work easier, what are some of the facilitators, and
50: what are some of the real barriers to you accomplishing what you
51: need to accomplish?
52:
53: The biggest facilitator is (name), my CMA.  She's excellent
54: with patients in terms of organization, having things ready for
55: me so that I can do what I need to do, and she takes care of a
56: lot of the ((?)), and so she's the biggest facilitator.  We have
57: other staff members who are also very good, schedulers and so
58: forth, scheduling patients appropriately, allowing enough time
59: for certain situations, and they do a very good job of that.
60:
```

61: * That makes a big difference in everybody's day!
62:
63: It does. Yeah, yeah. And we've struggled with that from way back,
64: but we're doing well right now.
65:
66: * What's an ordinary work day like?
67:
68: I usually start around, between 8:30 and 9:00. I see roughly
69: 20 patients a day, a variety of problems, a variety of patients.
70: Basically it's spent seeing patients. There's some meeting
71: responsibilities and so forth but that's maybe once a week or so.
72:
73: * How does this clinic structure reimbursement?
74:
75: That's... with the practitioners? It's changing. It used to be
76: pretty much each practitioner had their own negotiating and
77: different contracts. Some people were compensated straight
78: salary, some people had kind of a salary range depending on how
79: productive they were, and some people are moving to a straight
80: productivity, in other words you're compensated directly based on
81: what we call RVU's, roughly how many patients you see and for
82: what complexity of problem.
83:
84: * Okay, I want to ask a few questions about your perceptions of
85: patient learning. First the real broad question, what types of
86: things does a patient need to learn?
87:
88: I guess it depends a little bit on what type of visit they're
89: here for. If it's from an acute illness, they need to learn what
90: their diagnosis is, what's going on, why they're sick. And they
91: need to learn what they can do about it, whether that's simple
92: things of rest and nutrition, or whether it's more complicated
93: with medications. They need to learn what those medications are,
94: what kinds of problems they could see, how to take them. They
95: need to learn what things to watch for, if more serious
96: complications are developing.
97:
98: * Well, maybe another question, one back question that just
99: occurred to me: how do you see your role or even perhaps your
100: mission as coinciding or different from that of other types of
101: providers?
102:
103: In our practice I don't think it is different. I think in some
104: practices, PA's and nurse practitioners may have different roles,
105: and that role may actually be more of an educational role, in
106: other words they may see the patients who need an hour of
107: education regarding their diabetes or whatever, and they would
108: take on that function as opposed to the physician. In our
109: practice that's not how we practice. We all see our own patients
110: and do the educating ourselves.
111:
112: * How do your patients learn the types of information they need
113: to learn?
114:
115: I think most of it comes from face to face conversations, I mean
116: me telling them what I feel it is important for them to know.
117:
118: * Mmh-hmm, mmh-hmm. What contributes to a medical visit in which
119: patients do not optimally learn what they need to learn?
120:

121: Thinking back to some research grants in the past couple of days:
122: language can be a huge barrier. If their understanding and their
123: expression in English is not as good, there's obviously a huge
124: barrier there. I just saw a lady this morning who spoke very
125: little English, but her husband was fairly fluent. But at the
126: same time we were discussing some very sensitive personal issues,
127: and there is because of the ethnicity involved some
128: embarrassment. So it was difficult communicating through the
129: husband to the wife from the problems she was having. So it was
130: a language problem, it was also a cultural problem, in that
131: neither he nor she felt real comfortable discussing it. There's
132: ((?)) small children are a problem, when you have a couple of
133: toddlers in the room screaming, it's very difficult to
134: communicate with the parent,((?)) be expressed, you know you just
135: need to get the key points, and it's not a discussion, it's just
136: very quick and very brief and because sometimes the noise level
137: ((laugh)) doesn't allow anything more.
138:
139: * Yeah. Yeah, those are very vivid, well relayed. Um, to tease
140: out the other side of that question, what contributes to a
141: medical visit in which patients do optimally learn what they need
142: to learn?
143:
144: I think for me when I have a sense of a really successful visit,
145: the communication has been very good and the exchange, you know
146: the patient has understood what I tried to say. You're
147: connecting at a certain level, whether it's a patient that you've
148: known for a period of time and you have a relationship, or
149: patients that identify with me. I think then the communication
150: is easier back and forth and I think the learning is probably
151: better.
152:
153: * So something about common ground... it's a real key.
154:
155: Sure.
156:
157: * And if I understand, some of that common ground comes from
158: time.
159:
160: It can, it can. Certainly the patients you've had over the years
161: get a connection. It happens very quickly too. And again just
162: today I had that expressed to me by a patient who I've only seen
163: a couple of times, but we were dealing with a difficult issue,
164: you know kind of making a choice of where we were going to go
165: from here, and she expressed that point exactly, I haven't seen
166: you that long but I would trust what you recommend. So you can
167: get that connection in a very short period of time.
168:
169: * It's a good piece of art, isn't it?
170:
171: Umm, it is, yeah ((spoken with some reservation)) I think there
172: can be some skill involved, but sometimes it's just the
173: personalities involved I think as well, and the perception that,
174: similarly minded helps.
175:
176: * In your experience, has learning usually been optimal for your
177: patients, or not?
178:
179: Umm, I guess maybe I'd back off a little from optimal because
180: things can always be better. I think acceptable and

181: satisfactory. If you leave out of that equation the folks that
182: are never going to agree with you or accept what you recommend,
183: it doesn't necessarily mean there's a failure in learning.
184: There's different ways to approach the same problem and maybe
185: they're coming at it from a different perspective. Does that
186: mean their learning failed? I don't think so.
187:
188: * So the teaching may have been there, the interest in
189: learning...
190:
191: Or acceptance.
192:
193: * ...or acceptance, might not have.
194:
195: Yeah, an example of that might be the whole immunizations issue,
196: parents who elect not to immunize. And we try to teach them the
197: benefits of immunization, and they still elect not to. Is that a
198: failure of learning? Perhaps, I don't know. Or is that then
199: choosing another source to learn from, i.e. the Internet or other
200: health, alternative providers?
201:
202: * Good, that's a real nice point. Excellent. Okay, what types
203: of things does a provider need to learn in a medical visit?
204:
205: In a visit? Umm, well, real basic things of why the patient is
206: there, understanding of what their symptoms are, what disease
207: process if any is going on, what the patient's expectations are
208: for that visit.
209:
210: * How do you learn these types of information?
211:
212: You ask.
213:
214: * You ask, ask, ask. ((laughter)) All right. What contributes
215: to a medical visit in which you do not optimally learn what you
216: need to learn?
217:
218: Sometimes patients I think come in, umm, there can be hostility
219: on the patient's part, there can be a reluctance on their part to
220: answer certain questions or to reveal certain things. Sometimes
221: if their expectation is, you know this problem is simple, I just
222: want such and such, and let's not get into it in depth, you know.
223: And my expectation is well maybe there are issues here that I
224: want to explore. They don't want to so they are less forthcoming
225: with information.
226:
227: * So that level of participation of patients is a tremendous key.
228:
229: Sure.
230:
231: * In your experience has learning usually been optimal for you as
232: a provider?
233:
234: Most often, not always. I mean there are some encounters that
235: are just, you just feel didn't go well.
236:
237: * Of course. Do you recall an instance where learning was less
238: than optimal for you as a provider and without disclosing patient
239: names could you tell me a story about it?
240:

241: Well I guess I would go back to the lady I saw this morning,
242: because of the culture and language barriers. She was dealing
243: with a couple of concerns that she has, and she didn't know the
244: words to explain them, and the husband tried, and I don't feel
245: like I have a real sense of what they had been told by another
246: physician in their home country, of something, and I don't have a
247: real good understanding of what that something was, like his
248: diagnoses. Because they had difficulty conveying to me what the
249: issue was.
250:
251: * So it might be a diagnosis that was in different terms
252: altogether than what you're used to.
253:
254: Yeah, and there was concern of some type of a lesion, and you
255: know, but they didn't know anything beyond that, and they in
256: fact, they described it as a wound. And you know that could be
257: many things. And again I didn't see anything, which is
258: reassuring, and it's likely it wasn't anything, but the
259: recommendation was to have it rechecked. I don't know exactly
260: what I was supposed to be looking for.
261:
262: * Yeah. All right, I want to show you a couple of diagrams.
263:
264: Okay.
265:
266: * I like to draw maps, and these are like pattern diagrams, a
267: systems map. And this one I want to use just to show you how to
268: read this kind of map. It's a pattern of back pain, really a
269: lifestyle pattern of back pain. There's a lot of other patterns
270: of back pain, so when you draw a pattern map you're not trying to
271: show every pattern that exists, you just trying to say, well
272: here's one pattern, trying to link it together. A double walled
273: box is a system input or a system output.
274:
275: Okay.
276:
277: * And you can read it by following the arrows forward and saying
278: 'therefore', or following the arrows backward and saying
279: 'because'. So you might say back muscles become inflamed
280: therefore the back hurts when doing normal activities. Or you
281: could read that just backwards, the back hurts when doing normal
282: activities because the back muscles become inflamed.
283:
284: Mmh-hmm.
285:
286: * And it shows a pattern. These are really loop diagrams,
287: interlinked behaviors.
288:
289: Right, it's all, it is all very circular.
290:
291: * Yeah, does that makes sense?
292:
293: Mmh-hmm.
294:
295: * All right. I want to show you another one, it's a little bit
296: more complicated, and I want you to look at it for a minute or
297: two, and I want to ask you some questions about it, okay?
298:
299: Oooph! ((laughter, and an exclamation of being overwhelmed))
300:

301: * Yeah, it is a little more daunting.
302:
303: ((40 second pause))
304:
305: * Is that one, is that one understandable?
306:
307: Mmh-hmm.
308:
309: * All right, in your own words what would you say it shows?
310:
311: Umm, a potential for a kind of vicious cycle where people coming
312: in with concerns and because of time constraints that is
313: sometimes placed on providers, those concerns are not adequately
314: addressed, and perhaps the problem is treated more superficially,
315: because the problem doesn't get any better and the patient
316: becomes more and more frustrated, the symptoms persist and
317: re-occur, requiring repeated access to the health care system,
318: which continues to be ineffective.
319:
320: * You got it. This is again one pattern of many patterns. This
321: is the pattern that we want to avoid; you know, there are also
322: very healthy patterns. So I'm sort of focusing on this one
323: because this is the one I want to prevent if possible.
324:
325: Mmh-hmm.
326:
327: * And does this diagram show anything that seems either
328: particularly useful or interesting?
329:
330: Umm, I think it diagrams what we see a lot, although I would, the
331: exception being I don't think we have management pressures on us
332: in terms of time constraints, I really don't, I think our
333: practice is very fortunate at least at this time. That if we
334: have a patient coming in, that we know ahead of time is going to,
335: if we want to block out two hours to see that patient, we have
336: the ability to do that. So, but yes, I can, I know this happens.
337:
338: * Okay...umm, you've actually just answered a question ahead,
339: that's perfect, yeah, I know this happens. I was going to say is
340: this an accurate representation of a pattern that actually
341: occurs?
342:
343: A pattern that can occur, sure.
344:
345: * Do you think it shows a common pattern or a rare pattern. And
346: let me put that in two ways - let me put it first of all, say in
347: terms of this clinic, but second more generally in health care.
348:
349: I would say it's common generally. I guess I would hope, and I
350: do think in our office, it's not as common. Certainly there are
351: visits that occur, you know this type patient could come in at a
352: time when you are backed up and feeling some pressure, and that
353: particular visit may not be satisfactory. But I think we're all
354: sensitive to the issue. You know back pain and chronic pain and
355: that type of thing is a time consuming process and if time is not
356: available that day I think we're all intuitive enough to say okay
357: let's bring that patient back at a time when it can be addressed.
358: So where that one visit may not be satisfactory, hopefully that
359: can be ((?)).
360:

361: * Has your experience ever put you in this diagram?
362:
363: Sure.
364:
365: * Tell me a story about that.
366:
367: Umm. ((laughter)) Well, I'm not sure if I can think of one
368: specific but, there is this, you know, frequently a patient will
369: come, let's say a new patient, then the problem list, you know we
370: keep a page in the front of the chart with all of the diagnoses,
371: you get five or six diagnoses, and many of them have chronic
372: pain, maybe fibromyalgia and arthritis and obesity, and all
373: things that are kind of inter-related. And you do always look at
374: that before you go into the exam room, you need to take a sigh,
375: you just feel overwhelmed before you go in. That happens, that
376: does happen, all of those things can't be addressed at that first
377: visit, and so sometimes you do have to break things down, and say
378: we need to focus on this and then we'll get to the bigger issues
379: later. Again, I think our practice, and I think it's good in
380: recognizing lifestyle and social factors and so forth to play a
381: huge role, and if you don't address those issues you're never
382: going to fix the ((?)).
383:
384: * And my sense is again, it's also a very, a truly exceptional
385: clinic in that regard. And that some of the family practice
386: focus has come through very well.
387:
388: Well and if you, the reality is, you know this model doesn't work
389: for anybody. And if you can break this ((reference to the
390: diagram loops)), you know not only is the patient happier, but
391: the reward is yes, that patient will be back less, and that's
392: success.
393:
394: * Not only does it not work for anybody, but it's also nobody's
395: fault.
396:
397: Mmh-hmm.
398:
399: * So one of the things I want to ask you, is the language of
400: these statements fair to patients, to providers and
401: administrators?
402:
403: I guess of the management, in our case I don't think that's fair
404: because we don't have any pressure in that sense. Umm, office
405: visits designed to use providers time efficiently, I think that's
406: true, but that's a benefit to the patient as well. You know if
407: we're two hours behind, that doesn't help the patients in the
408: waiting room. Umm.... Providers don't learn enough about
409: patients lives and experiences... I would say over visits they
410: do. Umm... mostly in a medical context - that's probably true,
411: but that's not necessarily a bad thing, I mean it can still be in
412: mostly a medical context with other things brought in, that's not
413: necessarily a bad thing. Umm.. Yeah I'd say overall it's fair.
414:
415: * Mmh-hmm, mmh-hmm. And those are good pointers, I appreciate
416: them. Well I guess my big question is how do we recognize this
417: loop when it's happening, how do we get out of it when it's
418: happening, and how do we prevent it?
419:
420: I think it's pretty easy to recognize, I think all our CMA's

421: would recognize it. They know the chronic pain patient who's
422: always coming back or always calling in, and express their
423: frustration you know, with so and so, you know, why do they keep
424: coming in, you know. I mean there can be a little bit of a
425: backlash in that, and so I think that people who fall into this
426: are very easy, it's very easy to recognize it.
427:
428: * But what I hear you saying is that also at some level the CMA's
429: are providing feedback, and really almost patient advocacy as
430: well.
431:
432: It can go both ways, sure, sure.
433:
434: * Uh-huh.
435:
436: They can be advocates, they can also kind of tip you off to, you
437: know, there can be other motivations behind patients ((?)) as
438: well, and they can be very intuitive ((? rest of sentence trails
439: off)). And reminding you, you know this is the third time this
440: person's been in for this problem, oh yeah, okay maybe we need to
441: kind of look at this more. I mean yes, they can be very helpful
442: in that sense. So I think these people come to the surface, and
443: then breaking the cycle is probably a matter of, of looking at it
444: more in-depth at that point, okay, what are we not accomplishing
445: here and why.
446:
447: * Good, very good. I mean one of the things I hear you talking
448: about is the teamwork that occurs in this clinic, and that's an
449: important part...
450:
451: Mmh-hmm.
452:
453: * ... for good medical care and for breaking out of the pattern
454: if it occurs, when it sort of threatens to occur.
455:
456: Mmh-hmm. Well it's also, you know as practitioners we all have
457: our strengths and we all have types of patients that we are more
458: successful with, based on experience and personality and a lot of
459: different, and gender, you know a lot of different things. You
460: know as an example ((another clinician here)) had a patient who
461: was coming in for chronic pain. ((clinician name)) didn't get a
462: real good feeling about this patient in terms of maybe being
463: narcotics seeking. But then at one point she kind of wanted to
464: step back and say maybe I'm not being fair, maybe I really am
465: missing something, and she asked the patient to schedule an
466: appointment with me, and she told me about it ahead of time, she
467: said I want you to go in with an open mind, see objectively what
468: you really think, and let me know. Because she felt like she
469: wasn't being successful with this patient, and wondering okay, am
470: I not being fair to the patient, am I missing something, or if
471: this really is narcotics seeking. So yes, we can bounce off of
472: each other, we work well on that.
473:
474: * All right, well those are all the questions I have.
475:
476: ((laughter)) That's easy!
477:
478: * Thank you so much.
479:
480: Sure, sure.

481:
482: ((end of interview))

1: * September 13, 2001   1:30 PM
2: * YYY conference room
3: * prov3: 'Joyce'
4:
5:
6: * Okay, I want to start with just some demographic questions.
7: Let's start with age?
8:
9: Forty-two. ((spoken hesitantly, as if trying to remember))
10:
11: * Well okay, thereabouts. ((laughter))
12:
13: Yeah. ((laughter))
14:
15: * Race is Caucasian, gender female, professional training?
16:
17: Medical Doctor.
18:
19: * All righty, and that is professional title as well?
20:
21: Mmh-hmm.
22:
23: * Okay, years in practice?
24:
25: One.
26:
27: * All right, and years in present position?
28:
29: One.
30:
31: * Okay. How would you describe your duties?
32:
33: Taking care of people's health, more towards the preventative
34: medicine side. You are interested in education, and I'm not
35: saying this just because of that. I was a teacher for 10 years,
36: and so I think a huge part of my duties is educating people about
37: their own health. You know, when is a cold something you should
38: come in for vs. wait it out, and why we do things like Pap smears
39: and colon cancer screening, you know, and why it's important for
40: their health. So preventative medicine, education, you know,
41: certainly part of my duties is acute care, you know, urgent care
42: sort of stuff. But probably less of that - I talked to a friend
43: from Portland the other night, and she said, hey, saving lots of
44: lives? - well, no, I've seen lots of rashes though. ((Laughter))
45: I don't go out and save a lot of lives, I'm not shipping out to
46: New York or anything, that kind of, those kind of duties.
47:
48: * Yeah. But what a magnificent background to bring, particularly
49: to family practice. You did a specialty in family practice?
50:
51: Mmh-hmm.
52:
53: * Perfect.
54:
55: Yeah.
56:
57: * What would you say are some of the facilitators to
58: accomplishing your duties, and what are some of the barriers?
59: What are the things that make your tasks a whole lot easier, and
60: what are the things that are the real brick walls?

61:
62: You know there are remarkably few brick walls. Come in, you know
63: just finished training, you know at big ((medical college name)),
64: you know, I guess, facility a year ago just before I started
65: practice. And, uh, they'd do everything, they would put up brick
66: walls, you know in terms of administration and paperwork and
67: medical records, you know hoops and you know problems, and coming
68: down here is just a real sigh of, a breath of fresh air.
69: Everybody works together well, that's what facilitates things.
70: We've got a clinical, a clinic manager, you know, who kind of
71: like works behind the scenes to make things work well. The
72: medical assistants facilitate things real well, that, partners,
73: who every time I am not clear on something, they're happy to help
74: me, or recommend a referral, you know who you send for, who's a
75: good neurologist in town ((?)) you know her, do you go to ((one
76: neighboring city)) or to ((another neighboring city)) for tests,
77: you know, things that are real helpful there. Umm, other things
78: that make things easy... I guess the patient population generally
79: makes things easy. People are real educated about their own
80: health care. I have more people you know come in with web pages,
81: you know have already researched something on their own. You
82: know I can actually say to a woman, and you can do a long
83: discussion about whether she wants to use estrogen or not, and
84: say okay but we're not going to start it today, you go home, you
85: know here's some web sites, you know here's some books, and
86: she'll come back a month later and will have made her decision.
87: And it's very rare do I, do I get, you know maybe ((physician's
88: name)) does, because he's got an older population, but it's
89: pretty rare that I get people who just say, you know, I don't
90: know, you're the doctor, tell me what to do. People are much more
91: invested in their own health care.
92:
93: * That's nice to see.
94:
95: Yeah! I like it. ((laughter)) I mean I know there's doctors who
96: don't like that, you know, but that's the way I practice, and you
97: know I tell people that, I'm not going to make a decision, it's
98: your body. ((laughter)) Some of them like that and some of them
99: will go look for doctor that'll just tell them what to do. So
100: it's sort of a match of practice styles.
101:
102: * Mmh-hmm. So it's almost a mutual selection happens there.
103:
104: Yep.
105:
106: * If the patients really can't handle shared decision-making in
107: that sense, and they want paternalistic decision-making done in
108: their stead, they go someplace else. ((laugher, a few missed
109: words)) How would you describe an ordinary work day?
110:
111: Um, well I'll often, if I have a patient in the hospital I'll go
112: up to the hospital, find my way in in the morning, and then I
113: start seeing patients at 8:30. I have usually a couple of
114: patients a day who have like 45 minute appointments, Pap's, or
115: new patients, and then a whole bunch of, you know 15 minute, you
116: know blood pressure problems or, you know, sprained my eye
117: ((laughter)) sprained my ankle or got something in my eye. I
118: usually get you know 15, 30 minutes behind somewhere in the
119: morning. Often we have conferences at lunchtime, drug reps talks
120: downstairs, continuing medical education speakers up at the

121: hospital. One day a week I go to yoga during lunch, and come
122: back, do dictating, the charts that I saw of patients in the
123: morning, and then do the same thing in the afternoon.((laughter))
124:
125: * All right. About how many patients a day do you end up seeing?
126:
127: Well on a normal day, about 15 to 20. Call days, in the winter,
128: I think I've seen up to 35 patients. That can be, that's about
129: the worst I've ever had. I've worked over at, more, when I was
130: trying to decide which practice I was going to join, I worked
131: over at ((name of a group practice)). And boy I just got through
132: seeing like 50 patients a day, it was pretty incredible, but
133: anyway, that's about why I didn't join it. ((laughter)) One
134: reason.
135:
136: * Do you feel there's financial pressure to see more patients
137: than you see?
138:
139: No, here? No, there isn't. We're kind of paid on production, so
140: there doesn't seem to be any pressure.
141:
142: * There would be the pressure that you want to take on,
143: basically.
144:
145: Yeah, if you don't want to see more patients, that just means
146: you don't make as much money. And I figure we're already
147: shamefully paid. You know I don't need, I did, did the over
148: working thing already, and now I'm happy to just sit back, enjoy
149: my family, and you know take a day off a week, now enough money,
150: now ((?)).
151:
152: * This is just sort of a side question, but the transition from
153: teaching to medicine, for many people medicine becomes a career
154: that swallows them, you end up married to your career, married to
155: your profession. It must have been a very difficult decision,
156: first of all to go through the training, and second of all to
157: ((?)).
158:
159: Yeah. Well we kind of talked about it as a family, and decided
160: it was worth doing, you know and, you know moved up to ((city
161: name)), I've got two kids, 13 and 15 now, and they, it was a
162: little bit hard on them, you know, but we did it. ((laughter))
163:
164: * Yeah that's great. We really are at a point where we have to
165: think of, you know two career and three career lives.
166:
167: Yeah, yeah, and you know med school does not have to be all
168: consuming. It is for people who haven't done other things in
169: their lives, and it's all they've known, go straight through, you
170: know college, medical school, residency, practice. But you know
171: I wasn't 21 when I went into medicine, and I already had some
172: life experiences. You know I mean I guess I, that was a concern
173: actually in the decision-making, like ooh, you know it could be
174: all consuming, I don't want that. But, uh, you know, been able,
175: I mean, you know, just practice. You know I joined this practice
176: and not another one because it's, it doesn't, you know, they
177: support that people have families and lives outside of medicine.
178:
179: * Good. Okay, get back on target here.
180:

181: Yeah.
182:
183: * It's just such a rich question, I just couldn't pass it up!
184: ((laughter)) What types of things - this is a broad question-
185: what types of things does a patient need to learn?
186:
187: Um, I kind of touched on that a little bit... the things that are
188: going to keep them healthy, um, you know in terms of preventative
189: medicine, lifestyle stuff, I think you know in America, the
190: biggest problem we have is obesity and smoking, alcohol and most
191: patients you know who have chronic life long conditions, have one
192: of those problems. You know the diabetes, the hypertension and
193: all of that. So I harp on that, pretty much on every visit, I
194: educate. ((laughter)) I mean sometimes it is, I painted a
195: picture for a guy, you know about his smoking, and kind of told
196: him about you know being an older gentlemen pulling an oxygen
197: tank, you know behind him in the street everywhere he went. And
198: that was enough of an image for him, to get him to quit smoking.
199: So sometimes you're just kind of letting them know where their
200: particular lifestyle is going to lead them, is educational.
201: Other things I think are real important in terms of education are
202: new moms and babies and you know, and these are the things to
203: look for, things to expect, things to panic over, things not to
204: panic over ((laughter)), I do a lot of education in that area.
205:
206: * How do your patients learn these types of information?
207:
208: You know that's an interesting question, so much you know like
209: the new moms, you know so much of it is passed down from mother
210: to daughter. And I've got a couple of families, you know Hispanic
211: families who are usually really good about passing that kind of
212: stuff down, and the grandparents just aren't around you know,
213: they're in Mexico or wherever. So I have some real young Spanish
214: speaking moms who don't, who are lost, you know they don't have
215: anybody in the area to share this information with them. So they
216: usually get it from family members, and... where else? I think
217: we're getting there.
218:
219: * Well you've already suggested that the Internet is a real
220: avenue.
221:
222: The Internet, yeah, and there's some you know definite
223: misinformation out there too. People are coming in with Internet
224: information, and I need to you know, redress. But they also come
225: up with some good stuff. I've had people cut out ads from
226: magazines, they think they need this medication. They talk to
227: friends.
228:
229: * Yeah.
230:
231: I had one guy who came in about two weeks after suffering a gout
232: attack, he said all of his friends told him that there was
233: nothing they could do, he could do, so he never came in. But then
234: a friend yesterday told him there was something that could be
235: done, so he came in ((laughter)), you know that, both ends of
236: that one.
237:
238: * What contributes to a medical visit in which patients do not
239: optimally learn what they need to learn?
240:

241: You mean, contributes to that, what makes it so they don't..
242:
243: * What contributes to an outcome that we don't want, which is to
244: say the patient is not learning?
245:
246: One would be time, definitely you know, you get this you know, 35
247: to 50 patient days, you just don't have the time to sit and talk,
248: because you know you've got three people and you're already an
249: hour behind, and... Uh, the other is preconceptions, I think when
250: patients come in knowing that they need an antibiotic, they've
251: always gotten an antibiotic for this, and it doesn't go away
252: unless they get an antibiotic, and you know you try and have the
253: discussion with them of why that doesn't work.
254:
255: * So sometimes learning takes unlearning.
256:
257: Yeah, good, that's a shorter way of putting it. ((laughter))
258: Yeah. Sometimes. You know I mean gosh, you've been told something
259: by, you know, doctors and your parents all your life and then,
260: you know, some upstart comes in and tries to tell you that that's
261: all wrong. It's not going to happen in one visit. ((laughter))
262:
263: * And what contributes, maybe the flip side of this, what
264: contributes to a medical visit in which patients do optimally
265: learn what they need to learn?
266:
267: You get the same - time, taking the time to do it. The desire to
268: do it on the part of the practitioner. Them feeling comfortable.
269: Sometimes having, them having a friend or family member along as
270: well, it's going to make them more open to listening and less
271: closed down.
272:
273: * In your experience has learning in the medical visit usually
274: been optimal for your patients or not?
275:
276: Yeah, so far, I mean I've only been here a year. ((laughter)) I
277: don't have a lot of complaints, and I do you know on occasion get
278: some feedback from, you know, patients.
279:
280: * All right. Do you recall an instance where learning was less
281: than optimal for a patient, and without disclosing a patient's
282: name could tell me a story about that?
283:
284: ((laughter)) Where learning was less than optimal... sure.
285: Recent woman who actually just fired me, who I started seeing
286: three months ago, she came to me after actually having had
287: patient-doctor relationships with everybody else in town as well.
288: I think I might have been one of the last ones in town that she
289: hadn't tried yet. She had been started on a boat load of opioid
290: medicines for fibromyalgia and chronic fatigue, which I don't
291: really agree with. On the other hand I couldn't do much about it
292: other than continue it at this point, you know see if I could you
293: know talk her into coming down off of them. She wanted to go up
294: on them, and that's been her pattern all along, is to escalate.
295: And I mean there was no education, she, you know would come in
296: frequently with you know a migraine headache or something and
297: need more medicines. I mean this isn't, you know, I mean she
298: wasn't selling them or doing anything, I mean she truly seemed to
299: think she needed them. And just very manipulative. And I, I
300: called her on it, I said you know, you're being manipulative.

301: And she'd get to the point where she would you know, I would say
302: I will not go up on your medications, she would then call and ask
303: if she could go up on her medications, I would say no, I will not
304: let you go up on the medications, so she'd go up on the
305: medications and come in and say she's out. It's like wow what
306: can I do? I can't not give you the medications and watch you
307: withdraw, you know, and so basically she fired me right before I
308: could fire her. ((laughter))
309:
310: * Yeah, yeah.
311:
312: Which is fine, but you know there's no educating her and there's
313: no helping her, you know nobody will be able to maintain or even
314: establish a relationship with her to be able to help her.
315:
316: * So she's in a cycle that she's committed to both
317: physiologically and psychologically.
318:
319: Umh-hmm. Yeah. And you know I think about her when I think about
320: starting somebody on pain medications, because somebody started
321: her on pain medications, you know and somebody started her on a
322: low dose, you know thinking it would help, and now she's in
323: trouble. ((laughter))
324:
325: * Yes. And you can see the reasonableness of starting her on
326: pain medication, and yet it comes out to where nobody wants it to
327: come out, of course.
328:
329: Mmh-hmm.
330:
331: * All right. What types of things does a provider need to learn
332: at a medical visit? Another big question.
333:
334: I think often we just see, you know the one thing the patient is
335: coming in for, not look at a holistic picture of the patient, all
336: the other things that could be contributing to that complaint, so
337: often you know somebody will come in with stomach problems and
338: then the next visit they're coming in because their neck hurts,
339: and you finally you know learn more and more about the patient,
340: and you know which takes time, I mean I can't learn everything
341: about a patient in the first visit or the second visit. But you
342: end up you know spending enough time with them over, over time,
343: you find out it's all, you know depression, or you know their
344: husband lost their job, or you know, something. So you need to
345: you know educate your self about the patient. I'm not sure I
346: answered your question you posed.
347:
348: * You know, I think you answered it very well.
349:
350: About the patient, I think he needs to learn about the patient, I
351: mean you know sometimes you've got to educate yourself about, you
352: know go back and read the book about the disease or something
353: like that.
354:
355: * Mmh-hmm. No, you made a real key distinction there between
356: getting what you need to understand a biomedical problem and
357: understanding the psycho-social context of a problem, of a
358: person, not of a problem but of a person who's got a problem.
359:
360: ...who's got a problem. Right.

361:
362: * There we go. Okay. Well how do you learn the types of
363: information that you need?
364:
365: I learn about patients by you know taking the time to listen to
366: them. If I don't feel like we've had you know a good long visit
367: I'll often have them come back, you know do that, spend some more
368: time talking about these things at another visit. You get you
369: know different information after a couple of weeks from them. I
370: use the Internet, I have things like you know CDC, web page in
371: family medicine, web page in Medline, up on the Internet all the
372: time, and so I can you know real quickly access information. You
373: got a couple books, a couple computer programs. I've got some old
374: files from residency that I never tend to go to. ((laughter))
375:
376: * It's so fascinating how Internet use has just blossomed. When
377: I was first logging on to Medline in 1986, it would tell you how
378: many people were logged on at that time, and it was in the teens
379: of users, worldwide access, and it would be, you know say 17
380: users logged on.
381:
382: Oh my gosh.
383:
384: * Yeah, and it was like how come? And I'm sure that they don't do
385: that any more.
386:
387: They don't even do that anymore. ((laughter))
388:
389: * But there's so much more people...
390:
391: Other information comes from conferences and CME's, I get very
392: little of my information from drug reps.
393:
394: * Yeah. What contributes to a medical visit in which you do not
395: optimally learn what you need to learn?
396:
397: Um... hidden agendas. Cute old guy I was seeing this morning,
398: his wife was with him and she said I come along because he
399: doesn't always tell you what you need to know. And he chuckles
400: and he says well that's, I was raised up where you don't
401: complain. And she said, well honey you know you're at the
402: doctor's ((laughter)), you're where you're supposed to complain.
403: And he said, says ((?)) it's okay she should know it all. A
404: misconception.
405:
406: * Oh, okay. In your own experience has learning in a medical
407: visit usually been optimal for you as a provider?
408:
409: Uhh, no. Sometimes I, I mean, not; ... most of the time, yeah.
410: But there's, I think usually when I feel like I didn't do a good
411: job, it's because I didn't get to the bottom of, of what's going
412: on with the patient.
413:
414: * Do you recall an instance where learning was less than optimal
415: for you as a provider, and again without disclosing a patient
416: name, I'd love to hear a story about that.
417:
418: Yeah, one just actually popped into my mind about this gal who
419: took a double, took an extra dose of Erythromycin, you know
420: which shouldn't really do anything, and has been vomiting for the

421: last eight months straight. She went to ((another practice in
422: town)) and you know they haven't been able to do anything for
423: her. They referred her to gastroenterology, who scoped her,
424: didn't find anything wrong with her, I think she's maybe had
425: barium studies. She saw one of my partners, who couldn't really
426: figure it out, but she was going to be my patient anyway so, then
427: I saw her, and you know I can't figure it out, and I've seen her
428: with her, with her and with her mom, both now, and it just none
429: of it makes sense. She didn't like the gastroenterologist, I'm
430: going to have her see a different gastroenterologist. They've
431: been on the Internet all over the place and they come up with you
432: know one diagnosis after another. So there's something going on
433: that I don't understand, and I think it's a family dynamics sort
434: of thing, rather than you know something actually going on in her
435: gut, but I just don't know what it is. I don't feel fully
436: educated on that one.
437:
438: * What contributed to making that situation happen? That
439: particular one, that where you, look I didn't get to the bottom
440: of this?
441:
442: Well either she's not telling me the whole story, you know
443: there's other things she doesn't want to talk about, although
444: I've talked with her you know individually and with her mom in
445: the room. You know it could be some preconceptions on my part,
446: you know gee this kind of problem is such a pain to deal with,
447: she must be not telling me something, you know.
448:
449: * It's difficult, I mean human problems are so complex.
450:
451: Yeah, there's a lot of background there.
452:
453: * So it's like sleuthing in many different dimensions.
454:
455: Mmh-hmm.
456:
457: * Yeah, yeah, that's not easy.
458:
459: And sometimes it's just waiting for more information to finally
460: bubble loose and present itself. Sometimes digging for it
461: doesn't get you anywhere, and you just have to sit back and wait.
462:
463: * Yeah, the history is always unfolding.
464:
465: Yeah, yeah.
466:
467: * It's not done, you don't take a history and it's over.
468:
469: Yeah. Well that's why you know like I'm in my first year of
470: medicine, and then these guys have been doing it for a long time,
471: and have seen patients, you know the same patient over 17 years,
472: you know and watched their kids grow up, and they know a lot more
473: about their patients than I do now.
474:
475: * That kind of continuity is beautiful to have.
476:
477: Mmh-hmm.
478:
479: * I'm going to move to some questions about some diagrams. All
480: right, I've been drawing pictures. And this is basically a

481: pattern map. We could call it, you know with fancy technical
482: jargon names for it, we don't need those, it's just a map of a
483: pattern. Now I want to show you how to read this kind of pattern
484: map. And then I'm going to go on to another one that I'm going
485: to have you read, and then the I'm going to ask you some
486: questions about the other one. In this is a pattern diagram, a
487: pattern map. It's about back pain, and it's really sort of a
488: number of lifestyle components of back pain. And the first thing
489: to point out, is it's just one pattern, there's many other
490: patterns of back pain. So when we draw pattern maps, we're not
491: trying to draw every pattern all at once, it's to really break
492: out one fairly typical pattern. When you read this map, a double
493: walled box is either a system input or a system output. And you
494: can read foreword on the arrows, and you say 'therefore' - back
495: muscles tense up therefore back muscles become inflamed... and
496: you can follow that around. You can read them backwards by saying
497: 'because' - the back hurts when doing normal activities because
498: back muscles become inflamed, because... I want you just to spend
499: whatever time you'd like to just reading through that one, just
500: to see if it makes sense to you.
501:
502: Mmh-hmm.
503:
504: * It's a way of diagraming a situation... and also that it makes
505: some real, that one, some real life sense, about.
506:
507: Okay, just this one though? ((laughter))
508:
509: * We'll get to the other one about real life sense too! Is that
510: okay?
511:
512: Yeah, no, I get it now I think.
513:
514: ((Note: has grasped the diagram during explanation, without any
515: additional time needed to process it.))
516:
517: * It's a fairly simple diagram. Now I want to move on to one
518: that's a little more complex. I want you to take again a minute
519: or two or whatever time you need to read through that one, and I
520: want to ask you some questions about it. Again this is a pattern
521: map and it is one of many patterns, it's the one that we don't
522: want to have happen, or one of the ones we don't want to have
523: happen. There are also very virtuous patterns.
524:
525: ((27 second pause))
526:
527: ((Cough)) Sorry, I hope you don't get whatever I have.
528:
529: ((13 second pause))
530:
531: Okay.
532:
533: * All right, would you say you can understand this diagram or
534: not?
535:
536: Mmh-hmm.
537:
538: * In your own words, what would you say this diagram shows?
539:
540: Umm, how not listening to our patients and fully understanding

541: them hurts the health care system, and overloads it, whereas
542: we're thinking we are being more efficient, we're actually being
543: less efficient, driving more patients into the system...
544:
545: * Precisely so.
546:
547: ... and out of the system.
548:
549: * Precisely so. And I guess what I'm trying to show in here is
550: that everybody is doing their job, in some senses right. It's
551: not because anybody is incompetent, or it's anybody's fault, but
552: we are all doing things that lead us to outcomes that we don't
553: desire. Is there anything that this diagram shows you that
554: seems either particularly useful or interesting, does it clarify
555: anything for you, or help you see anything better that you didn't
556: see before?
557:
558: Well it seems like if you could take out this loop right here,
559: that providers don't learn enough about patients lives and
560: experience, take out that box right there, you could, it kind of
561: all branches out from there, and you could, solve a lot of
562: problems right there.
563:
564: * So that's a way of interceding.
565:
566: Mmh-hmm.
567:
568: * Good, you're several steps ahead of me, and that's perfect,
569: just what I'm looking for, because ultimately what I want to get
570: at, we may as well get there because we are there, is to say how
571: do we recognize this loop, how do we get out of it, how do we
572: prevent it? And I don't know the answers to those questions, but
573: I sure hope you do. ((laughter)) And you've really contributed
574: something by saying, well if we had more time with patients, that
575: might be one component there, you know, as well as the focus of
576: the need to do it, both of those are components.
577:
578: Mmh-hmm.
579:
580: * Do you think this represents a pattern that actually occurs?
581:
582: Oh yeah.
583:
584: * Oh yeah. ((laughter)) Would you say this is a common pattern or
585: a rare pattern? I'm going to ask that question actually in two
586: ways. One of them is say in this clinic, and the other is say in
587: the wider world of medicine.
588:
589: Well I don't know if everybody says that their clinic is perfect,
590: and all the rest of the world sucks, but I don't think it happens
591: in our clinic much. And, you know we've kind of talked about
592: self selection, and you know patients and providers' styles. You
593: know like I said I'm only a year out of training, and I was in a
594: training program that was very into the bio-psycho-social model,
595: maybe that comes across, up at ((name of medical college)). But
596: then I also did some moonlighting at ((name of a large regional
597: HMO)), and I would find a remarkable difference between, you know
598: the patients that I was used to seeing you know in our small
599: family practice clinic, you know with the bio-psycho-social
600: model, and then I'd go over to the ((HMO's name)) system, and

601: those people are used to, you know they're trained, one problem
602: and you're out of here ((laughter)) you know and I don't want to
603: hear about anything else. And you know when I would start to ask
604: them more ((laughter)) about the stressors in their life or
605: something, they were shocked, they move on, you know it was like,
606: no, you know, these bruises didn't come from my husband you know,
607: ((laughter)) or whatever. So there is some self selection there,
608: I think not, and you know some people choose ((name of HMO))
609: because it is like that because it's, you know, fast, it's
610: efficient, and they don't ask you personal questions. So there's
611: some self selection that goes on there, and there's, we sit down
612: in our own office, you know one of the providers is always an
613: hour behind, because she takes the time to just sit, listen,
614: talk, to these complex problems, I mean she's on leave right now,
615: you know we're all seeing her patients, and her patients are kind
616: of used to that. ((laughter)) You know I think she's over
617: checking ((?)). ((laughter))
618:
619: * There goes your day, right! Uh-huh.
620:
621: So I forget where that all started but you know it's not, it's
622: not for everybody, but, oh, I know, if it's really hurting the
623: medical system, anyway.
624:
625: * Yeah, I think what we were trying to nail down on that one, is
626: that: is it a common or rare pattern in this clinic, and is it a
627: common or rare pattern in, more generally in medical practice.
628:
629: It's a fairly rare pattern in this clinic, and it's probably
630: somewhere in between in the rest of the world.
631:
632: * Yeah, somewhere in between. All right. Do you think it's a
633: fairly accurate representation of a pattern that actually occurs?
634:
635: Of a pattern, yeah. There's lots of different patterns out
636: there.
637:
638: * Sure. That's right there's also virtuous patterns. I'm
639: looking at this one, the vicious cycle pattern, because I want to
640: know how we get this to not happen.
641:
642: Yeah.
643:
644: * Is the language of the statements fair to patients, to
645: providers and administrators? And by fair I think, you know what
646: I'm trying to get at is that I don't want to point a blaming
647: finger to say oh, this is, you know, this person's fault.
648:
649: ((28 second pause))
650:
651: Well the only problem I think is this statement. ((points to
652: statement in diagram.))
653:
654: * 'Medical interventions inadequately address patients needs'.
655: Yeah.
656:
657: It kind of depends upon these statements before - patients lived
658: stories not invited because not deemed medically relevant, and
659: providers don't learn enough about, um, but when you draw this
660: arrow that says office visits are designed to use providers time

661: efficiently, straight to medical interventions inadequately
662: address, I mean that's not... ((reference to and critique of an
663: inner link across the diagram, from 'office visits are designed
664: to use provider's time efficiently, to 'medical interventions
665: inadequately address patient needs'))
666:
667: * Not a given?
668:
669: ...not a given there.
670:
671: * There are times when a very brief visit for an acute problem is
672: right on target, and addresses the need?
673:
674: Yeah.
675:
676: * A point that is very well taken. Thank you. Has your
677: experience ever put you in the diagram, and if so where?
678:
679: I wish it weren't. Sometimes you get patients who kind of are
680: their own worst enemies, that want to go on and on about all
681: sorts of stuff.
682:
683: * Mmh-hmm.
684:
685: Don't, I mean, you know, we all have friends like that too.
686: ((laughter)) It's just a personality trait, and you do tend to
687: try and redirect and cut those people short, and it may not end
688: up learning enough, you know and may end up perpetuating the
689: whole cycle.
690:
691: * Mmh-hmm. I want to bring out, partly to jog my own memory, but
692: also just to clarify this, this correction or, that you suggested
693: here, because I think it's so good. This pattern might be true
694: when we have a pattern of living producing the symptoms, where
695: you might say a lifestyle problem, as vs., in terms of a chronic
696: problem is a lifestyle problem, vs. an acute problem.
697:
698: Mmh-hmm.
699:
700: * Would that perhaps clarify this? ((referring to line linking
701: across the diagram, from 'office visits are designed to use
702: provider's time efficiently, to 'medical interventions
703: inadequately address patient needs'))
704:
705: No, I still don't like it. ((laughter)) ((referring to same line
706: across diagram)) Just because you know, gosh, most problems are
707: lifestyle problems, and they can become acute problems, you know.
708: But even if it is a lifestyle problem it could be dealt with in,
709: occasionally in just a, a very simple way, very direct, and
710: doesn't really require a great deal of educational knowledge.
711:
712: * Yeah. All right, those are my questions. I'm so thankful.
713:
714: Cool, sure, glad I could help.
715:
716: ((end of interview))

1: * September 7, 2001 10:00 AM
2: * YYY conference room,
3: * Patient1: 'Megan'
4:
5: * The first question that I want to get to, what is your job
6: description here? Your job description, or patient?
7:
8: Well, I'm a patient, but I'm also, I work in here.
9:
10: * Lets... in this clinic?
11:
12: Sort of. I occupy an office but I don't actually work for the
13: clinic. ((laughter)) It's kind of odd, but we needed space, I
14: needed an office, and so they let me come here. I work for
15: community relations, in the physician referral line, so I am
16: currently occupied over here.
17:
18: * That's fascinating, now I've got to figure out how we're going
19: to, I'm to interview providers, staff, administrators, and
20: patients.
21:
22: It doesn't matter to me, I can be a patient or whatever, it's
23: fine with me.
24:
25: * Patient is just fine.
26:
27: Okay.
28:
29: * Now this is interesting, because we all have sort of mixed
30: roles, all of us get to be patients at some point, like it or
31: not.
32:
33: Yes, that's true.
34:
35: * Okay, well, so the first thing you get to do as a patient is to
36: choose a pseudonym for yourself, you get to pick a fictitious
37: name.
38:
39: Oh, lets see...I have no idea...let's do Megan.
40:
41: * Megan, excellent. How do you spell that Megan?
42:
43: That would be M-e-g-a-n.
44:
45: * Excellent, okay, what I want to do first is ask a few
46: demographic questions. Age?
47:
48: Thirty-one.
49:
50: * Race is Caucasian, gender female, education?
51:
52: Twelve years of high school a year and a half of ((name of local
53: community college)).
54:
55: * Okay, and occupation?
56:
57: Physician referral line representative.
58:
59: * That's an interesting job, physician referral line
60: representative. So people call in...

61:
62: Kind of a mixture, I help patients find physicians that are open
63: and taking new patients, and help them, if possible answer any
64: insurance questions they may have, or you know, just the general
65: outlook of ((name of hospital clinical group: X health
66: services)), helping them get to the right place they need and
67: stuff.
68:
69: * All right, that's interesting. Okay, self reported global
70: health status - would you say your health is good, fair, or poor?
71:
72: I would say good.
73:
74: * Number of visits to a medical provider in the last 12 months,
75: ballpark?
76:
77: Umm, probably three.
78:
79: ((Note: around here, subject's voice begins to sound tentative,
80: not self confident, not sure and at ease.))
81:
82: * Okay. And when you have an office visit with your provider,
83: about how long does an office visit last?
84:
85: I would say 15, 20 minutes, depending on what I'm here for,
86: that's about the average, yeah.
87:
88: * Now I want to get into your perceptions about learning in a
89: medical visit. Patients learn from their providers, providers
90: learn from their patients. A patient might learn to take better
91: care of their own medical problem, or how to cope with
92: difficulty, learning the correct way to take a medication. In
93: your experience has learning at a medical visit usually been
94: optimal for you or has it not?
95:
96: I would say that I have learned...you mean from the provider
97: themselves, is that what you are saying?
98:
99: * Yes, well, perhaps even just the whole experience, it's sort of
100: a global question. I mean have you learned what you needed to
101: learn, as much of it?
102:
103: I would say, I would say yes. There may be one or two questions
104: that I may not understand but, otherwise I would say yeah, I
105: would say yeah.
106:
107: * Do you recall an instance in your own experience when learning
108: was less than optimal for you as a patient and could you tell me
109: about that?
110:
111: I don't know...
112:
113: * We can come back to that...
114:
115: ...let me think about that one.
116:
117: * ... because I am going to then ask you what contributed to
118: making that happen, to figure out the reasons why, those are the
119: things we don't want to happen. So that's why that one's there.
120:

121: Okay.
122:
123: * Let me just ask a little bit then about your perceptions about
124: provider learning. What they learn and what they need to know. A
125: provider might learn about symptoms, about your ability to cope,
126: about lifestyle conditions, in order to arrive at a well informed
127: diagnosis. A provider might need to know about how much or little
128: you exercise, about eating and drinking habits, about how you're
129: feeling when dealing with a medical condition. Does your medical
130: provider adequately learn these things from you?
131:
132: Is this like a global thing, or is this just specifically your
133: own provider that you're...
134:
135: * Oh, your own provider. Yeah.
136:
137: Okay. I would say yes, they do find out that information, and
138: they're good at asking those questions.
139:
140: * How does your medical provider learn these types of
141: information?
142:
143: Umm, definitely asking, I mean I don't think you're ever going to
144: know anything unless you ask a question, so... I think just
145: asking the questions and getting to be comfortable with you, you
146: know, the provider and you, the relationship you have.
147:
148: * Do you recall an instance where learning was less than optimal
149: for your provider, and could you tell me about that?
150:
151: Hmm... not really, I had, I have back problems, but sometimes, I
152: don't know, maybe I have gone in sometimes, and I've had
153: continuous problems with it and don't feel like I've gone out of
154: there with a good explanation I guess. I guess maybe wanting more
155: information on why my back is like that. So sometimes, maybe on
156: that, on that problem I would say, I don't always feel like I get
157: the best information.
158:
159: * I think that's a good example. That's sort of the first one,
160: saying your own perception of learning, here's an experience I've
161: had where I've come in, and I don't come away with a clear sense
162: of why I should have back problems.
163:
164:
165: Right. Right. Yeah, I would definitely say that that's a big
166: one. Because of being so young, I'm not, you know, I try to do
167: everything that they, you know, suggest to do, and then I still
168: feel like I'm not getting the right information sometimes.
169:
170: ((Note: subject moving into a more confident voice here.))
171:
172: * Now why, what's contributing to not getting the right
173: information?
174:
175: Hmm. Umm, honestly I think it's sometimes, the providers get
176: busy, and I think maybe just not taking the time to really, you
177: know, go further with the examination, or we've already tried
178: these things, okay now let's do this. Sometimes I think it's
179: just, not putting complete blame on them, because maybe I'm not
180: contributing everything I should to the visit itself, sometimes I

181: think it's just in and out, you know, well, you've got back pain,
182: so deal with it, kind of thing. So I don't know, I just
183: sometimes, I think they don't take the time to want to find out
184: that information.
185:
186: * And I think that gets at the other question that I was asking
187: about provider's learning. The provider might not take the time
188: to learn that information.
189:
190: Umm-hmm.
191:
192: * But you also brought out a real interesting side to that, and
193: that is, you say well, I might not be contributing what is needed
194: to make that happen.
195:
196: Mmh-hmm, mmh-hmm, yeah, I think sometimes we as patients don't
197: maybe voice it well enough, you know, or we're not saying the
198: right things to get our point across, or giving them all the
199: information that they would need, you know, and stuff like that,
200: so.
201:
202: * Yeah. I want to probe a little just about that. I'm wondering
203: whether part of that problem is that as patients we, you might
204: say, have one language, and providers have another language, and
205: it's difficult to bridge them.
206:
207: Mmh-hmm, mmh-hmm. Right.
208:
209: * Would that be a fair description of what you...
210:
211: Mmh-hmm, yeah, definitely. Right. They may interpret what you're,
212: you know, thinking, and they may interpret it a different way, or
213: vice versa. You're not using, yeah, your languages are kind of
214: butting heads, you're not getting understanding exactly from each
215: other.
216:
217: * Very good. I want a show you...if you think of more things
218: along that line, throw them in at any time.
219:
220: Okay.
221:
222: * I want to show you a systems diagram, I want to show you how to
223: read a systems diagram, and actually this one is very appropriate
224: because this one is about back pain. Basically this is a map of
225: a pattern. There are many different patterns, this is just a
226: pattern of back pain that is really a lifestyle set of loops, you
227: might say. And when you're looking at this type of map, a double
228: walled box is a system input or a system output. And if you were
229: to follow an arrow, any arrow forward, you would say 'therefore'.
230: For instance, back muscles tense up therefore back muscles become
231: inflamed. And you can work your way through these loops. Or you
232: could follow your way around backwards by saying 'because'. Back
233: muscles become inflamed because back muscles tense up because
234: pain induces stress... and so you could work your way through
235: this in either direction. I want to give you a minute just to
236: look at that and read through it as an example of how to read
237: this kind of pattern map.
238:
239: ((38 second pause))
240:

241: I keep looking at that one because that happens to me a lot -
242: back muscles get weak, and range of motion decreases.
243:
244: * Mmh-hmm. So that one fits with your experience.
245:
246: Mmh-hmm. Yeah, when it happens, ((referring to diagram
247: statements)) lifestyle becomes more physically inactive, back
248: muscles weaken. Hmm.
249:
250: * So this is just one pattern of, you might say a sustaining set
251: of intertwined causes and effects, and so we have to show them in
252: loop diagrams rather than lines.
253:
254: Right.
255:
256: * Does that makes sense?
257:
258: Mmh-hmm, it does, yeah.
259:
260: * And if I understand, it might make lived sense as well, your
261: experience happens by chance to fit that model.
262:
263: Mmh-hmm, right.
264:
265: * Now I want to show you a slightly more complex diagram. This is
266: one, I want you to read your way through this and spend a minute
267: or so, until you say, 'Oh, I've got that one'.
268:
269: Okay.
270:
271: ((95 second pause))
272:
273: Hmm. This one was challenging.
274:
275: ((35 second pause))
276:
277: I think I understand it.
278:
279: * All right, in your own words what does this diagram show?
280:
281: ((27 second pause))
282:
283: Hmm. I'm not quite sure, I don't know how to say it. Umm, it's
284: very structured... I don't know I don't even know if I'm going to
285: get it right but, to me it's, if you go, they are trying to
286: describe how an office would work I guess. ((Note: very tentative
287: voice)) That if you go in to see somebody, um, they have it very
288: structured that you go in for this amount of time, that you tell
289: them exactly what you are there for, you don't have time to
290: elaborate on, you know, other things or what's happening in your
291: life, or...um, I don't know, hmm.
292:
293: ((8 second pause))
294:
295: I guess if you go there you go through, even you've seen the
296: doctor for what you want to see them for, but you're still having
297: the symptoms, like this direction says some patients drop out of
298: the health care system, and that's probably because they're not
299: getting anything within that diagram, they're not feeling that
300: they're being listened to, feeling rushed maybe, which is, I

301: don't know. That's I guess what I see.
302:
303: * Yeah, that's good. This is basically a diagram of insufficient
304: learning that occurs really for both the provider and the patient
305: and the system administrators all at once. It's the pattern that
306: we don't want to happen, so I'm trying to understand this pattern
307: better, saying how do we recognize it and how do we prevent it.
308:
309: Mmh-hmm, I see.
310:
311: * Because there are other patterns that happen that are very
312: healthy, very good ones. There are times when a patient comes in,
313: their symptoms will very much match a medical model, and the
314: resolution is quite good. But in this particular case, when a
315: pattern of living produces symptoms, which is not so uncommon,
316: the system might not function as well for anybody involved.
317:
318: Right, I see, yeah.
319:
320: * That's sort of what I'm trying to show in this picture. As you
321: look at this diagram, is there anything about it that you say,
322: 'Oh, that's wrong, the pattern doesn't unfold that way', or 'That
323: doesn't belong there'?
324:
325: ((59 second pause))
326:
327: I don't know, this part might be, 'symptoms frequently continue
328: or return', and then it goes 'people experience symptoms'.
329:
330: * Therefore people experience, would continue to experience
331: symptoms.
332:
333: Mmh. I don't think so, I don't see, I mean one way or another
334: they all seem to tie into each other. I wouldn't say one doesn't,
335: one shouldn't, it doesn't go that way, I wouldn't say.
336:
337: * So there's nothing you see that says 'Oh, that's wrong'?
338:
339: No, not really, no.
340:
341: * Do you think that this is a representation of a pattern that
342: actually occurs?
343:
344: Mmh-hmm. I would say yes.
345:
346: * And would you say that it is a fairly accurate representation
347: of a pattern that actually occurs?
348:
349: Mmh-hmm, mmh-hmm.
350:
351: * Would you say that's a common pattern or a rare pattern?
352:
353: Well, I would hope it would be rare, but I don't know, it's kind
354: of, it's in between. Because I'm thinking as a patient, but then
355: I am also thinking, as my job, what I hear from patients, because
356: they have to switch doctors because they're not finding what they
357: want from those physicians. So it seems like I hear it a lot, but
358: then as a patient, for myself I don't think so.
359:
360: * So as a patient you've had actually fairly good experiences,

361: and this hasn't happened much, if at all.
362:
363: Right, right, yeah.
364:
365: * But as someone who refers patients to health care providers
366: you're going to get a sample that naturally is not satisfied with
367: their current or previous situation, who has experienced this,
368: and perhaps has relayed some of this type of frustration to you.
369:
370: Mmh-hmm, right, right, exactly.
371:
372: * Is the language within these statements fair to patients, to
373: providers, and to administrators? Have I stated it in a way that
374: I haven't maligned anybody, and I think even more to the point,
375: haven't blamed anybody?
376:
377: I don't think so, I think you hit on, coming from
378: administration, how it goes down the ladder basically, and you
379: know, I don't think you're hitting on, picking on, any particular
380: person whether it be a patient, administrator or provider.
381:
382:
383: * So it seems relatively fair?
384:
385: Yes it does.
386:
387: * Good. That's important to me. Has your experience ever put
388: you in the diagram, and if so, where?
389:
390: ((34 second pause))
391:
392: Hmm, I don't think so, I don't think that there's anything.
393:
394: * So your professional experience in terms of referring patients,
395: again, so you have the experience of listening to people who have
396: had this experience.
397:
398: Yeah definitely.
399:
400: * Okay. And I guess the next question is, does this diagram show
401: anything that seems either particularly useful or thought
402: provoking or interesting to you?
403:
404: ((8 second pause))
405:
406: I go back to that one a lot. ((Referring to a diagram statement))
407:
408: * 'Patients lived stories are often not invited because stories
409: are not deemed medically relevant'.
410:
411: Mmh-hmm. I don't know why but I just feel kind of these two tying
412: together.
413:
414: * That and 'providers don't learn enough about patients lives and
415: experiences'.
416:
417: I know that the providers are busy and, you know, have to be on
418: track on seeing patients but sometimes I don't think they take,
419: they're there to help you have a better healthier life and
420: sometimes I don't think that they...they make their judgments

421: before getting really to know you better. I don't like that, I
422: have to say, I don't agree with that at all, I think that someone
423: saying it's all in your head, you know, whatever your symptoms
424: are, I think that if someone says it's just all in your head, I
425: don't think that's a fair diagnosis...because I think then it
426: goes back to being pushed to be more productive, being more
427: productive makes them more busier, so they don't take the time to
428: get, you know, to know you and what your symptoms are really
429: relating to.
430:
431: * And that's also partly being a captive of their training. If
432: you're trained to see symptoms that fit disease models, then it's
433: very easy to discount all the things that don't fit that model.
434: And much of life doesn't fit that model.
435:
436: Right, right, that's true.
437:
438: * And what I've tried to show actually is this, a linked system
439: where management would like to see greater productivity, and that
440: puts pressure on physicians to seek medical efficacy in as short
441: a time as possible, but overlook a great deal of the other
442: essential and contributing causes of symptoms. Which ends up
443: putting people back into the health care system loop, and putting
444: more pressure on it. And so it becomes a vicious cycle.
445:
446: Mmh-hmm. Right, right.
447:
448: * And so I'm trying to puzzle out how do we become aware of this
449: cycle, and every bit as important, how do we prevent it, how can
450: we prevent this from happening, or fix it if it is?
451:
452: I don't know, it's easy to say, you know to a provider, you may
453: need to give someone a fair chance before you just judge them. I
454: don't know, I don't know how easy an answer it is to say, to get,
455: to break out of that habit or training or whatever they have gone
456: through that makes them that way.
457:
458: * My sense of it, my personal sense, I realize you're shaking
459: your head saying I don't really know the answer to that
460: question...you're in good company, I don't know the answer to
461: that question either. ((laughter)) But that doesn't stop me from
462: asking it.
463:
464: Yeah.
465:
466: * But my own thoughts on that, is that it really takes everybody
467: involved sitting down together, because it is nobody's fault. And
468: so if people can come together and look at a pattern like that
469: and say, 'Oh, we are all doing sensible things from our own
470: perspectives and getting outcomes we don't want'. At that point,
471: then you can put all different minds together to say how can we
472: coordinate.
473:
474: Mmh-hmm. Because I think if you just got management in one camp,
475: in one group, and you got providers in one group, they're all
476: going to look and say, yeah it's there, we're doing what we think
477: is right. But like you said if you get to look at this and you
478: see really it's a combined effort, and everybody is contributing
479: to this, maybe we all have to change, you know, our ways, I
480: guess. I don't know. That's how I would look at it. ((laughter))

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481:
482: * Yeah, yeah. Well, those are all of my questions and I thank
483: you.
484:
485: Oh, you're welcome, I don't know if I answered them very well
486: but...
487:
488: * You did great! ((laughter))
489:
490: ((end of interview))
```

1: * September 7, 2001 2:15 PM
2: * YYY conference room
3: * patient2: 'Sonia'
4:
5: * First I want to ask a few demographic questions. Age?
6:
7: Fifty-seven.
8:
9: * Fifty-seven. Race is Caucasian, gender is female, education?
10:
11: Nursing, registered nurse.
12:
13: * And that's your current occupation?
14:
15: Mmh-hmm.
16:
17: * Okay, in terms of education: bachelors, Masters...?
18:
19: A diploma.
20:
21: * A diploma in nursing, okay. Your health status in general,
22: global health status, good, fair, or poor?
23:
24: Good.
25:
26: * In good health. A ballpark number of visits to a medical
27: provider in the last year?
28:
29: Mainly my annual, and actually like this would be a third and
30: fifth, but usually it is just my annual, maybe once more for
31: something.
32:
33: * Okay, and when you go for an office visit, roughly how long
34: does that visit last?
35:
36: For an annual I'd say 20 minutes. For something like today I'd
37: say more like 10.
38:
39: * You were checking in today for a cut on the scalp?
40:
41: Right, from having a concussion and just some questions that I
42: had.
43:
44: * I want to ask a little bit about your perceptions about
45: patients and what patients learn. Patients learn from their
46: providers and providers also learn from their patients. A patient
47: might learn how to take better care of their problem, how to
48: cope, the correct way to take a medicine. In your experience, has
49: learning in a medical visit usually been optimal for you as a
50: patient, or not?
51:
52: Usually, yes.
53:
54: * Do you recall an instance where learning was less than optimal
55: for you as a patient, and could you tell me a story about that?
56:
57: Well, actually just when I had my head sutured up, as far as, I
58: think the focus ended up being on getting it sutured up, which is
59: the reason for part of my follow-up today. Because even though

60: I'm a nurse and I kind of know what to expect and all of that,
61: when it happens to you, I knew that I hadn't had a neurological
62: exam and I knew that I wanted that to complete the process and to
63: make sure that how I'm feeling is okay. But there was no
64: discussion about that, but I got that today, but it's a week
65: later. So the problem was taken care of nicely and I really
66: enjoyed the person that saw me. But the bigger scope of, you
67: know, you might feel this, don't do this, or, you know, that
68: wasn't really reviewed, which even though you know, I think it's
69: helpful still to be told. Even though professionally you know, I
70: still think it's important to be told.
71:
72: * Yes, and also your concern with, saying perhaps the
73: neurological exam should be undertaken.
74:
75: That would have been a reassurance to me, because even though I
76: know that I was obviously alert and doing well, and I answered a
77: lot of the questions just like I was visiting or whatever, for me
78: later on then, I felt, I would have felt better had she looked at
79: my ears and my eyes, check the pupils, you know.
80:
81: * Mmh-hmm. Okay. Let me move into some questions about provider
82: learning. A medical provider might learn about symptoms, the
83: patient's ability to cope, lifestyle conditions, to arrive at a
84: well informed diagnosis. The provider might need to know how
85: much or little you exercise, about eating and drinking habits,
86: how you feel when dealing with a medical condition. Does your
87: medical provider adequately learn these things from you?
88:
89: I guess I feel like my primary provider does, yeah.
90:
91: * Good. How does your medical provider learn these types of
92: things?
93:
94: Just by chit-chatting some during the visit mainly. I feel like
95: he remembers who I am, and what I do, and basically about my
96: husband and I, that he has somewhat of a picture. And it's just
97: by talking, by spending that time.
98:
99: * Do you recall an instance where learning was less than optimal
100: for your provider, and could you tell me a story about that?
101:
102: Well, I'll go back to the person I saw who sutured my head
103: injury, because I thought about that later. I thought part of the
104: responsibility could have been myself, to say you know what, to
105: just ask for what I needed, except I didn't think about it until
106: later. Because I thought about that. I have a responsibility as a
107: patient also to, if I have a concern, to state that, you know.
108: So it just made me think more about asking for what I think I
109: need, although in that case you're stunned and all of that, and I
110: honestly didn't think about it until later. But I would have said
111: just do you mind checking my, doing these things. Or to just
112: outright ask for... so can you just tell me as my husband sits
113: here, so he too knows what to look for, what to expect and all
114: that. So I think to ask or to not, I think a patient, it's
115: important that we don't take what our provider says, and not
116: question it, or not to be assertive, because you need to be.
117:
118: * But sometimes it's difficult to have the presence of mind in
119: the midst of crisis.

120:
121: Right, right.
122:
123: * To really prompt all of the information we need.
124:
125: Right.
126:
127: * I want to ask some questions about systems, about a diagram, a
128: couple of systems diagrams. And so I'm going to show you first a
129: systems diagram that has to do with back pain. And this diagram
130: is about, you might say a set of lifestyle loops that contribute
131: to sustaining back problems. There are other patterns of back
132: pain, but this is just a diagram of one pattern out of many. In
133: order to read a diagram like this, you would say a double walled
134: box is a system input or a system output, an entry or exit from
135: the system. And when you read an arrow forward, you say
136: 'therefore': back muscles tense up, therefore back muscles become
137: inflamed. Or you could read around these circles backwards by
138: saying 'because': back muscles become inflamed because back
139: muscles tense up. I want you to take just a minute to read your
140: way through that, to familiarize yourself with how to read this
141: type of diagram.
142:
143: I'm not sure: so, stress and strong emotions...
144:
145: * That's just a system input, therefore back muscles tense up.
146: This would be an emotional cause of muscle tension.
147:
148: Right. But I don't understand the therefore and the because.
149:
150: * Well, when muscles tense up, they cut down circulation, and it
151: tends to make inflammation. So chronic tension in a muscle can
152: lead to inflammation.
153:
154: Mmh-hmm. Okay.
155:
156: ((23 second pause))
157:
158: Okay.
159:
160: * Does that one make sense?
161:
162: I think so.
163:
164: * You can spend some more time with it, there's no hurry on it.
165: ((10 second pause)) In systems diagraming we usually think in
166: terms of loops rather than in straight chains. So in many ways
167: causes you might say become effects, causing itself, and you
168: could get virtuous cycles or vicious cycles.
169:
170: Mmh-hmm.
171:
172: * Here's a little bit more complex diagram, and I'd like you to
173: spend some time reading through that, see if it makes sense to
174: you, and then I'll ask some questions about it, get your input on
175: that one.
176:
177: ((20 second pause))
178:
179: Mmh-hmm.

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180:
181: * Would you say you can understand this diagram or not?
182:
183: I can understand it. ((This is spoken tentatively))
184:
185: * In your own words what does this diagram show?
186:
187: Well, that when people are not satisfied with their medical care,
188: they'll dropout of the health care system.
189:
190: * This is one pattern of many patterns, this is the kind of
191: pattern I think we want to avoid, but there are also some very
192: very healthy patterns, some very good patterns. But I'm exploring
193: this one. Do you see anything that might be wrong in terms of
194: this diagram? Have I somehow not been correct in showing this
195: pattern?
196:
197: Nothing stands out.
198:
199: * Nothing stands out as being wrong.  It presents a pattern of
200: insufficient learning at medical visits.  Do you think it
201: represents a pattern that actually occurs?
202:
203: Oh, I think so, definitely it does.
204:
205: * Do you think it accurately represents that pattern?
206:
207: Some components of it... I mean, those different things.
208:
209: * So at least in a general way?
210:
211: Right, in a general way.
212:
213: * Do you think it shows a common pattern or a rare pattern?
214:
215: Common pattern or a what?
216:
217: * A rare pattern.
218:
219: ((23 second pause))
220:
221: Probably a common pattern.
222:
223: * Is the language of the statements fair to patients, to
224: providers, and to administrators?
225:
226: I think so.
227:
228: * Has your experience ever put you in the diagram, and if so,
229: where? Your experience as a patient.
230:
231: Right.  Maybe when the medical intervention inadequately
232: addresses patients needs, right there.((tracing on the diagram))
233:
234: * So that's led to this cycle of returning back into the system?
235:
236: Well, it leads back into maybe getting another opinion.
237:
238: * So there's a certain inefficiency or ineffectiveness that
239: occurs, that makes the system somewhat busier, and also somewhat
```

240: more expensive?
241:
242: Mmh-hmm, right.
243:
244: * Does this diagram show anything that seems particularly useful
245: or interesting or insight provoking to you?
246:
247: Well, probably the biggest thing is, there's not a whole lot of
248: time to take care of people... like at (college clinic name) we
249: have a lot more time to spend with our patients than in a clinic
250: like this. Or when I compare going, I went and visited a
251: naturopath in (neighboring local city) last year to get a second
252: opinion on hormones, there was just a lot more conversation that
253: happened. It makes a huge difference in care, in trust, in
254: relationship.
255:
256: * What I've tried to depict here is a pattern where
257: administrators are doing their job as its defined, providers are
258: doing their job as they are trained to do, and patients you might
259: say are doing their job. There's nobody who intends a bad
260: outcome, so everybody is doing just right, and yet at the same
261: time we are producing outcomes that we don't desire. And so at
262: one level it is nobody's fault, and at another level... I guess
263: my next question would be how do we recognize this pattern and
264: how do we prevent it from happening?
265:
266: I don't know.
267:
268: * I don't know either, and the best I can do at this point is
269: just to help, to put it as simply as possible on a single piece
270: of paper so that everybody involved in the system can at least
271: see this set of behaviors together and begin to discuss them at a
272: level that's beyond blame.
273:
274:
275: Right, exactly.
276:
277: * Well those are all the questions I have. Thank you for doing
278: the interview, I'm glad that worked out!
279:
280: ((end of interview))

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 1: * September 12, 2001  9:45 AM
 2: * YYY conference room
 3: * patient3: 'Whit'
 4:
 5: * I want to start out with just some demographic questions. Age?
 6:
 7: Sixty-four.
 8:
 9: * Okay, gender female, race Caucasian, education?
10:
11: High school and an A.A., two years of college.
12:
13: * What did you study?
14:
15: All, I just studied, a little bit of everything.
16:
17: * All right, and occupation? What did you work at?
18:
19: Well, I retired from a tax office having worked eleven years.
20: I've been retired six years, six and a half years.
21:
22: * Yeah.  And how would you overall rate your health, good, fair,
23: or poor?
24:
25: Excellent.
26:
27: * Okay, that's good to hear. Roughly the number of visits to a
28: medical provider in the last 12 months?
29:
30: I go once a year.
31:
32: * That's good.  When you go to visit your health care provider,
33: roughly how long does that visit last?
34:
35: Oh, I'd say about 30 minutes.
36:
37: * Okay I want ask a few questions about patient learning and
38: about how you think about learning.  I'm interested in the kinds
39: of learning that happen in a medical visit. Patients learn from
40: their providers and providers learn from their patients. The
41: patient might learn how to take better care of themselves in
42: terms of prevention, how to take care of a problem, how to cope
43: with difficulty, the correct way to take a medicine.  In your
44: experience, has learning in a medical visit usually been optimal
45: for you or has it not?
46:
47: Well, to be very honest with you, I'm probably ahead of the game
48: on most of the things because I try to be very knowledgeable
49: about what might be wrong, or if I incur something with my body,
50: in a way that I can look it up in a medical book of some kind. I
51: do that, I try to come prepared with any of the information ahead
52: of time to ask the doctor about, or if I have concerns about
53: something.  The opposite side of that is that I am aware that
54: they are under an obligation to inform their patients of certain
55: things depending on what our medical experts have discovered. And
56: if you're a certain age you need to be informed that you need to
57: do so and so. And you need to think about taking certain
58: medications or having mammograms or whatever. So by the same
59: token I know that doctors and, their obligation is to inform
60: their patients, and thus informed, then it's up to the patient
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61: whether they go along with what the doctor has told them or not.
62: But it relieves the doctor from any liability so to speak, in
63: saying well I didn't tell my patient. So there are some things
64: they're, I do not agree with, and personally I've taken my own
65: route to do...because I felt I have been in excellent health for
66: so many years...and we'll probably get to some of those later.
67:
68: * But have you learned what you've needed to learn, and have you
69: come away thinking 'I've learned what I needed to learn' in a
70: medical visit?
71:
72: From just the visit itself, or relating with blood tests and
73: follow-up and things like if you have to have...
74:
75: * Well, let's just take the bigger picture of it. If I
76: understand you correctly, you're saying that you really do a lot
77: of your own research, if you will, or study, to learn about
78: various problems on your own before really contacting the health
79: care system or while being engaged with them. So your personal
80: learning, that's what you are telling me, is that has been an
81: important thing for you, yes?
82:
83: Yes.
84:
85: * But what about everything else that you learn, say from your
86: providers and the staff, has that been optimal?
87:
88: Well, since I am in the category of excellent health, I don't
89: have a problem area so to speak that I would need to look up
90: something afterward after being told something through the
91: medical profession. But if it is anything related that way I
92: will be the first to go home and look it up and just see what the
93: books tell me, what alternatives are already used, or what to do,
94: something like that. I think with your question, it would be a
95: very different answer with someone who really has a health
96: problem, just coming in to the doctor. You see, I'm just coming
97: in for a routine physical, and knock on wood I've not needed
98: anything more than that.
99:
100: * We're going to need a pseudonym for you, what name are we going
101: to call you in this report?
102:
103: Whit. W - H - I - T.
104:
105: * You got it! ((laughter)) Do you recall an instance where
106: learning was less than optimal for you as a patient, and could
107: you tell me a story about that?
108:
109: Meaning?
110:
111: * You haven't gotten the information you need.
112:
113: Well, this probably doesn't pertain to what your really trying to
114: get at....I know that a couple of times over many years that I,
115: because of my being on the ball so to speak, things have gotten
116: misconstrued or not put down in the paperwork within the doctors
117: office, and I've caught it, and I've had to say, well I know back
118: in such in such a date or year this took place, and it's like
119: they didn't have that in my record or some such thing. Well, I
120: have it in my records because I keep a medical diary. So when I

121: come away from the office for whatever, and there's been times
122: when I have had to come in occasionally for something, and I've
123: gone home and indicated it and written it down. Or if there's a
124: particular medication that's been prescribed that I have to take,
125: I have that logged in my medical diary under medications. So
126: I've triggered a couple of times of them having to look something
127: up. I think when the confusion has come is when they, and this
128: happens as I understand in a lot of offices, when doctors change
129: buildings, or when they change from one system to another. When
130: the computer world came in, when computers weren't compatible and
131: therefore things didn't get put in in the right fashion, or they
132: weren't done the way they used to or something. So anyway, these
133: are kind of like excuses maybe, of why you're not finding the
134: knowledge or finding something, because they're in the middle of
135: this transformation.
136:
137: * So this error in record-keeping, a couple of instances that you
138: have experienced, was that with this clinic or a different
139: provider?
140:
141: No, it was, do you mean this building right here?
142:
143: * This building is a brand new building, but I mean this
144: practice.
145:
146: Well, it actually occurred, I want to say it's been about seven
147: years ago now maybe when the whole big switch came in, the
148: doctors being forced to get out of their private practice and
149: become part of this group up here. I don't know if I am right in
150: that year, but I mean its kind of like and from what I
151: understand, its you come in with the hospital and all of their
152: doctors and all of their buildings and all that they have to
153: offer, or you don't practice here...((? a few lost words)). So
154: in that era, whenever that took place, I think that there were a
155: lot of changes.
156:
157: * Mmh-hmm. Now I want to move to what your medical provider
158: learns and the quality of their learning, how you see that. A
159: medical provider might learn about symptoms, about your ability
160: to cope, about lifestyle conditions, in order to arrive at a well
161: informed diagnosis. The provider might need to know about how
162: much or little you exercise, the kinds of exercise you do, about
163: eating and drinking habits, about how you're feeling when you're
164: dealing with a medical condition. Does your medical provider
165: adequately learn these things from you?
166:
167: I think generally I would say yes, because I happen to be one
168: that will come well prepared for my physical. I gather all the
169: information that I feel it is necessary for him to know about me,
170: even though, well you know, it's been a year, I haven't seen him
171: in a year's time, what changes have taken place from the previous
172: year. So if he hasn't, or she, hasn't asked me the questions
173: about my body or health or whatever, I am surely going to be on
174: the other end asking them.
175:
176: * Do you recall an instance where learning was less than optimal
177: for your medical provider?
178:
179: I want to say one time, it had to do with me getting a shot. And
180: I ended up with an allergic reaction to it. And I felt that that

181: was something they needed to take care of and see me through
182: that, that reaction. And I believe I was upset because there was
183: a charge involved with coming back for them to take a look at the
184: shot area. And I think, this was several years ago so it is hard
185: for me to remember, but I was a little bit disturbed about that,
186: that that was something that I didn't think I should have that
187: kind of charge for. Maybe I'm right, maybe I'm wrong, I don't
188: know. Otherwise, off the top of my head I can't think of
189: anything.
190:
191: * That's an interesting one.
192:
193: They tell you after getting whatever this was, and I can't
194: remember now if it was tetanus or what the shot was for, because
195: I'm not into shots for anything, but it's like, well, let us know
196: within so many hours if this takes place or there's swelling or
197: redness or whatever the symptoms are that would be not good, and
198: then we'll need to see you, you'll need to come back, you need to
199: call us and whatever. So I linked it as if it was all one thing,
200: and it just happens that I thought it was something that they
201: should just take care of it, and not have a charge to me on it.
202:
203: * Mmh-hmm. In some senses that might be more of a billing problem
204: than a learning problem. Now as I listen to that story, the staff
205: actually did a good deed of learning, you might say, by saying
206: look at this, these are the signs if a problem should happen, and
207: here's what you should do, you should call us back, which you
208: also learned well, and indeed came back to them. In some senses
209: maybe that's more of a billing problem than a learning problem, I
210: wonder.
211:
212: Yeah I...
213:
214: * That's okay. I want to show you a couple of diagrams. I've been
215: drawing maps of systems. And this first one, I just want to show
216: you how to read this type of diagram. This happens to be a
217: diagram about back pain...
218:
219: You picked the right person.
220:
221: * ...and happens to be one where there are a number of lifestyle
222: conditions, in this case stress translating into a cycle of back
223: pain. In order to read a diagram like this, a double walled box
224: is either a system input or a system output. And you read an
225: arrow forward by saying 'therefore'. Back muscles tense up,
226: therefore back muscles become inflamed, therefore the back hurts
227: when doing normal activities. Or, you can read the loops around
228: backwards by saying 'because'. Back hurts when doing normal
229: activities, because back muscles become inflamed, because back
230: muscles tense up. I'd like you just to spend a minute or two with
231: this diagram and just read through it, just see if this kind of
232: pattern map makes sense to you. And then I'm going to move to a
233: second one that I'm going to have you study, and I'm going to ask
234: you some questions about the second one.
235:
236: ((20 second pause))
237:
238: Okay.
239:
240: * Does that one makes sense?

241:
242: Yeah.
243:
244: * Does that makes sense from your own lived experience?
245:
246: Yes, I have ways of dealing with this.
247:
248: * Of course, yes, this doesn't show all the ways of dealing with
249: it, as a matter of fact it doesn't show the good ways of dealing
250: with it.
251:
252: Right.
253:
254: * And I would also say that this is just one pattern of many
255: patterns of back pain. And so a pattern map doesn't try to show
256: every pattern, it simply tries to depict a, you might say, one
257: typical pattern. Here's one that's a little bit more complex,
258: but you read it in the same way. You can read it forward or
259: backward. And I would like you to spend as long as you need to
260: look at this one, until you feel like, 'Oh, I've got it, I
261: understand it'. And then I'll ask you some questions about it.
262:
263: ((33 second pause))
264:
265: Okay.
266:
267: * All right, do you think you can understand this diagram or not?
268:
269: Mmh-hmm.
270:
271: * Yes. In your own words, what does this diagram show?
272:
273: ((6 second pause))
274:
275: Well it sort of tells me that...there's managed care hanging over
276: the doctors heads out there, telling them that this is the way
277: the program is going to work. And when you have a patient that
278: comes in, to spend this much time with them, get as much across
279: to them and out of them as you can, and then you go on to the
280: next patient because we need to have you see X number of patients
281: throughout the day. And therefore I think that, and I do not
282: agree with this, I think it's taken away a lot from the old-time
283: way that people used to go and see their doctors. And there was
284: more personal contact, more feeling like they cared for you as an
285: individual, not as a number coming through the office, of which I
286: have to have this many numbers in a day. Therefore I think it can
287: cut down on some of the questions that the doctor might need to
288: ask the patient but doesn't really have the time to. I think
289: their knowledge that goes back out to a patient might be put in a
290: capsule form and given to them quickly because of the time
291: element, because of knowing that there's this umbrella hanging
292: over them. They have to come forth with the rules of the program
293: that they're under. I don't know if that makes any sense.
294:
295: * Yes, it does. When you look at this diagram does it show you
296: anything that you didn't see before, or make anything clearer for
297: you, or show you anything useful or interesting?
298:
299: Well, this looks like it would be related to an HMO, a managed
300: care. Am I correct?

301:
302: * No, not necessarily, this could be related to any provision of
303: health care in a, let's say in a large organization that actually
304: has management as distinct from providers.
305:
306: Now repeat that question again.
307:
308: * I'm curious if this diagram shows you anything that you might
309: not have seen before, anything particularly useful or
310: interesting.
311:
312: I feel I have a more of a negative response to this diagram
313: rather than a positive one, and I relate it again to what I know
314: has happened over many years, doctors being forced to practice
315: differently.
316:
317: * Now when you say a negative response, do you mean that this
318: diagram is perhaps either wrong or inaccurate? Or that it shows a
319: pattern that we wish to avoid?
320:
321: I think the last. More of a pattern that could be altered in a
322: way to be more pleasing to the patient, and have a better
323: satisfaction of your visit to the care provider.
324:
325: * Yeah, I agree that, uh, this is a pattern of insufficient
326: learning, but it, curiously enough, everybody is doing their job
327: just right, you might say. The management is trying to be as
328: efficient and productive as they can because that's what they're
329: paid to do. The provider is trying to hone in on a medical
330: diagnosis under limited time, that's what they're paid to do. And
331: the patient is trying to find some satisfaction for their
332: problem, because that's also their goal. Everybody is doing the
333: right stuff, but we're getting outcomes that we don't intend and
334: don't value. And so it ends up being somewhat inefficient when
335: we are ineffective.
336:
337: And it goes to the square right here. ((referring to patients
338: dropping out of system))
339:
340: * And it can go to this square ((affirming her selection)), but
341: for many patients, it just loops right back in to repeated
342: visits, where some fundamental issues are not getting addressed,
343: it just doesn't fit the flow of time, and the focus of office
344: visits. This is the pattern that we want to avoid. So you might
345: say my question is, how do we recognize this pattern when it
346: happens, how do we get out of it, and how do we prevent it?
347:
348: Well, I don't know if this is the right place for me to say, but
349: personally for my family, which is my husband and myself, we're
350: very strong believers in trying to avoid any managed care, HMO
351: services, at all if we have the choice. And we personally have
352: been involved, I haven't, but my husband's health has been such
353: to where we've been very very grateful we've been able to pick
354: and choose, not only a doctor but a hospital, for very critical
355: surgeries. And in the course of our remaining life we hope to be
356: able to still have that available to us through our insurance
357: policy that we're under, or whatever, that we can still select
358: who we want to have for our health care people to watch over us.
359: So therefore, I know it's like a double edged sword, because I
360: know as I sit here our doctors that are in this clinic right now,

361: or my doctor, he's probably on the list for the HMO or the
362: managed care. However we have opted to choose him outside of
363: that. And yet I know that the doctors that are on the hill in
364: (name of this city) are all underneath the umbrella of the big
365: managed care for the doctors. So from a patient's standpoint it
366: looks as though they all are in together. So the referrals, this
367: is something else that we, we have to sort out I guess as a
368: patient. If you need to get a referral from your primary care
369: doctor, that referral more than likely is going to be right here
370: to somebody else that's right here in these buildings on the hill
371: in (name of this city). Because they are all in under the same
372: umbrella. And so it's like maybe they all, you know, you scratch
373: my back, I'll scratch yours. It's a kind of, a set up. They
374: forget there could be, that there's somebody else in another
375: town, in another area, that is as qualified or better, or
376: whatever. So it's kind of a Catch-22 I guess. You just have to be
377: knowledgeable enough to know, or unless you just sit back and
378: decide, I'm just going to go along with whatever my doctor says.
379: I think there's a lot of things that can be handled differently
380: from the way they are with the system the way it is right now.
381: But again I think it's too bad that they are as forced, and I say
382: that because we know personally some that had their private
383: practices that were wonderful in them, and in order to continue
384: in a separate building elsewhere, and not in a big clinic area,
385: they would probably have folded, because the pressure was put on
386: so hard to become part of the group.
387:
388: * So a lot of economic forces sometimes overshadow quality.
389:
390: Right.
391:
392: * Do you think this shows a pattern that actually occurs?
393:
394: Yes.
395:
396: * Do think that it's a common pattern or a rare pattern?
397:
398: I think it's more common now because of the group situation that
399: I just finished talking about, that the doctors are, I don't
400: think they, they have as much say anymore on their own. I mean,
401: they have to follow whatever the upper echelon is saying, this is
402: what we expect of you. And so we're looking at this pattern
403: where these things are expected of them to do, so it's something
404: they have to move through the system.
405:
406: * Would you say that the language of the statements is fair to
407: patients and to providers and to administrators?
408:
409: The language within these boxes?
410:
411: * Yes. I'm trying to state them in a way that really doesn't
412: blame anybody.
413:
414: Well, again I have to be fair and say in some of these cases I
415: think it depends on who the patient is they're dealing with. I
416: know there are some people, I have personal friends that are like
417: this, they go in and are very closed mouth with their doctor.
418: They're going in to be checked for something or other, and they
419: let the doctor do the looking and the checking and the asking,
420: and they take verbatim whatever is told to them. And they might

421: not have question one, or offer the right kind of information.
422: And I'm a firm believer that you've got to lay everything out in
423: order to receive back enough to satisfy you. But now in that
424: case those people might be very satisfied. But they're not, so
425: that would cut down on what some of these say depending on who
426: the patient is you're dealing with.
427:
428: * Mmh-hmm. Has your experience ever put you in the diagram and if
429: so would you tell me a story about that?
430:
431: Well, on the people consulting providers who are very busy, I
432: don't know how you could sort that out because of our current
433: population and everything else, it just seems like doctors
434: everywhere are overloaded and have far too many patients to get
435: through the day with, so there's waiting periods, there's just
436: going to be a busyness everywhere, you can't just hand pick,
437: well, I'm going to go to this one, because they are as busy as
438: this one. You know, the age old complaint seems to be from a lot
439: of people, we all kind of laugh about it now, but it seems to be
440: the thing, you have an appointment set for say 10:00 in the
441: morning, and you as a patient definitely do everything in your
442: power to be there on time, and if you're trying at all you'll try
443: to walk in that door before your appointment so that you are on
444: time. And then it's just notorious that the waiting is a half an
445: hour or better the majority of the time. And that puts the
446: patient off. I know if it's more of an emergency thing they might
447: try a little harder, but it sure seems like it's very rare
448: anymore that you get called, and I know, I call it like a
449: gimmick, the assistant to the doctor, or the nurse, will try very
450: hard to look at a clock somewhere, that kind of time maybe within
451: five or ten minutes, and puts you in waiting room inside, I mean
452: not the big waiting room but in a private room. Then you sit
453: there another 20 minutes.
454:
455: ((End of tape. The above was in response to the final question,
456: and a few additional sentences were lost beyond this point.))

1: * September 12, 2001 11:00 AM
2: * YYY Conference room
3: * patient4: 'Rodeo'
4:
5: * I want to start out and just ask a couple of demographic
6: questions.   Age?
7:
8: Fifty-six.
9:
10: * Fifty-six.   Race is Caucasian, gender male, education?
11:
12: Two years of college.
13:
14: * Okay. And occupation?
15:
16: Insurance agent.
17:
18: * Okay. Overall, your health status: good, fair, or poor?
19:
20: Fair.
21:
22: * Fair, okay.   About how many visits to a health care provider
23: have you made in the last 12 months?
24:
25: Uhh, probably one.
26:
27: * And about how long did that visit last, do you remember?
28:
29: Probably about 45 minutes.   I do an annual.
30:
31: * Okay, now I want to ask about your perceptions about learning
32: as a patient. A patient might learn how to take better care of
33: themselves, how to take a medicine, how to cope with some
34: difficulty, things like that. In your own experience, has
35: learning in a medical visit usually been optimal for you or not?
36:
37: Yes it has.
38:
39: * All right. Can you recall an instance where learning was less
40: than optimal for you as a patient, and could you tell me about
41: that?
42:
43: Probably, maybe a misunderstanding, I've learned I've got
44: diabetes, a misunderstanding, not taking care of myself properly
45: because I maybe didn't listen close enough to how serious it
46: could be.
47:
48: * Do you want to tell me a little story about that?
49:
50: Well, yeah, I basically, when I was told, and I have it in my
51: family history, when I was told I was on the borderline of it, I
52: kind of went into denial and said I don't think I have a problem,
53: and my wife said yes you do, it can be serious, especially
54: because I don't have my weight off like I should. So I've been
55: trying to lose weight, and I have terrible bad knees, so it's
56: kind of tough, because I used to be very athletic. I can't do it
57: anymore, but I still like my food, you know, so, ((laughter)) and
58: I'm having a heck of a time adjusting to that, but I'm getting
59: there.
60:

61: * That's interesting. What you're telling me, if I understand
62: correctly, you can correct me on this, is that from your wife,
63: and perhaps also from your health care provider, you got told you
64: had borderline diabetes that could be a serious thing, that you
65: needed to make some lifestyle changes perhaps. And that while
66: you heard that, it wasn't that easy to really accept it, and to
67: make the changes that you needed to.
68:
69: Exactly right.
70:
71: * So the teaching may have gone out, but the learning is a
72: different thing altogether.
73:
74: Right, and it was probably a deal that, it wasn't really, I think
75: my wife, which we love each other very much, but she was more
76: concerned than I was. It kind of hit home, this is a, we have a
77: granddaughter, I know you want to live a little longer and spend
78: some time with her.
79:
80: * Now I want to turn this question in a slightly different way,
81: and ask about provider learning, about your health care
82: practitioner's learning. The provider needs to know about your
83: symptoms, your ability to cope, lifestyle conditions, how much or
84: little you eat or drink, your exercise, how you're feeling when
85: you deal with a medical condition. Does your medical provider
86: adequately learn these things from you?
87:
88: I feel he does, but I think where we lack is maybe, and I know
89: that everybody's busy, may be a little more follow up...that says
90: okay I've kind of convinced you of this, now are you doing what
91: we... Dr. ((name)) is a great guy, he's a good listener, you
92: know, so.
93:
94: * Do you recall an instance where learning was less than optimal
95: for your medical provider?
96:
97: I guess I don't understand the question right.
98:
99: * Well, where a medical provider didn't learn the kinds of things
100: they needed to learn in order to be of most help to you.
101:
102: No, I don't think I've ever had that happen.
103:
104: * Good, okay. I want to show you some diagrams, these are
105: systems diagrams, they're really maps of patterns. This first one
106: I just want to show you, to show you how to read them. This
107: one's about back pain, and it's really about lifestyle components
108: of back pain and how they relate to each other. When you see a
109: double walled box, it's either an input to a system, or an output
110: from a system. You just read it by, you can follow an arrow
111: forward and you say 'therefore'. Like: back muscles tense up
112: therefore back muscles become inflamed. Or you could read
113: everything following the arrows backward by saying 'because'.
114: Back muscles become inflamed because back muscles tense up,
115: because pain induces stress.
116:
117: I do have that situation, I've had a back problem for quite some
118: time now. It seems like if we want to try all these different
119: things to see if we can fix the problem, and I asked why don't we
120: cut to the chase, let's get an MRI and see what is going on. And

121: that seems to be they don't want to hear that to happen. They
122: want to do all these other medication and therapy and all this
123: stuff before we really get in to see what's happening. And I'm
124: going to suggest today that I want an MRI, because I have, and
125: I'm following this ((referring to the diagram)). You've got a
126: very good diagram of what...
127:
128: * What I'm trying to point out here, this is just one pattern of
129: back pain. When one draws a pattern map you just try and show one
130: pattern, there are actually many different patterns of back pain.
131: And this is particularly a lifestyle related pattern that would
132: say both cause and cure go deeper into a way of life than into
133: medicine.
134:
135: And I've learned that in my 30's and 40's, no pain no gain, and I
136: believed in that. Now that I'm 50 I have a whole different
137: philosophy that says the pain don't go away like it did
138: ((laughter)) so no pain is no gain, but it gains to me in my
139: middle 50's, it makes it worse. You just can't do what you did in
140: those times. I was at 40 years old, setting in my office and
141: getting out of my chair, and not proper exercising, and going out
142: and sliding into home plate. Now I'm paying in my 50s.
143: ((laughter))
144:
145: * Now you're paying in your 50s. I want to show you another map.
146: This first one is really just to give you an idea of how to read
147: these types of maps, these pattern maps. This is a somewhat more
148: complicated map. I want you to spend a minute or two, just study
149: it, and I want to ask you some questions about it.
150:
151: ((40 second pause))
152:
153: I kind of have a tendency to think, I alluded to that a while
154: ago, about, I know what's going on, I feel I know what's in back
155: of the pain, it is just a bit like, I have a family history of
156: some kind of a big long disease, both your parents had to have
157: it, in fact that's why I'm here today, both your parents had to
158: have it maybe to get this, and it is a life-threatening disease,
159: it can affect your liver. But I couldn't, and so I called and
160: said I just want to go in to the clinic and have this test done,
161: blood test. I had to go see, I had to see the health provider
162: first, that says 'looks like we better have you tested for this'.
163: I think that's kind of somewhere in here ((referring to diagram))
164: you know, that office visits are designed to use provider's...
165: oh, not that one, but one of these I read here, that really, I'm
166: going through stuff, at an expense to my insurance company that
167: wasn't probably necessary.
168:
169: * So you know the test that needs to be run, who you have to go
170: to, to get the test from, but you have to go through that
171: gatekeeper first, and that just adds an expense. So that's some
172: way that the system is ineffective and inefficient.
173:
174: Yeah. And I couldn't get in too, because my whole family is kind
175: of nervous about it, and I've been, because of vacations and
176: everything, which I don't deny anybody vacation, but it's been
177: almost a month to get me scheduled.
178:
179: * Oh, so it's time, that everybody's so busy.
180:

181: Umm-hmm.
182:
183: * In your own words what does this diagram show?
184:
185: ((17 second pause))
186:
187: Uh, I don't really, probably, ((spoken tentatively)) there's a
188: lot of expenses here, like here's one, total health care system
189: costs increase from ineffectiveness...and management responds to
190: market...it's just, there's a lot of things that I think, like,
191: there's a lot of things that's wasted. A lot of wasted efforts
192: that says we're going to do all this stuff, now all this stuff,
193: when the pain's there and I says this is where it is, you know as
194: an example. You still gotta go through all these other steps,
195: and come back and come back and come back. And like I said I felt
196: it, MRI should have been done six or eight months ago. And it's
197: tough to get referred. I mean just as an example, I'll give you
198: another example, I had a skin condition and I came to the doctor
199: and they couldn't get it stopped. So I said I think all I need is
200: a dermatologist, so I finally raised enough Cain that they
201: referred me to dermatologist. He gave me one medication
202: prescription, I've never had a problem with that rash again.
203:
204: * So finding the right person, getting the right referral, and
205: getting it just so. Was that at this clinic or different clinic?
206:
207: This was with Dr. (name), but in a different clinic. And I
208: don't blame anybody for trying to heal you, but I think that
209: sometimes our main care giver maybe too, I hate to use the word
210: but I'll use the word, pride or something that says I really
211: don't want to refer you to that person that spent his education
212: to specialize. And I see that in, and nothing against
213: Dr. (name), just, just, I see that a lot.
214:
215: * By the way, I will not transcribe his name into the tape,
216: neither your name nor his name. I'm looking for some general
217: feedback, so you can say those things and not worry about it.
218: ((laughter))
219:
220: So I guess the feeling I get sometimes, is just we got to do
221: things to keep you coming back, you know. And in the back of
222: their mind, I don't think that's their intention.
223:
224: * What I'm trying to show in this diagram is a pattern of
225: insufficient learning where everybody is doing in one sense just
226: the right thing. The administrators are trying to make a system
227: run more productively, more efficiently. The providers under
228: those pressures are trying to get a medical diagnosis. And the
229: patient is trying to get their own needs met. They're all doing
230: the right thing, it's nobody's fault, we're getting outcomes we
231: really don't desire, and really don't value. And so I guess my
232: big question is how do we recognize this loop, how do we get out
233: of it if we find that we're in it, how do we prevent it. I'd
234: love to have your thoughts about that. I don't know the answer
235: myself, but thought I'd ask.
236:
237: Well you know, I think there's so much emphasis put on, maybe you
238: know, you look at our neighbor Canada that basically has a, I
239: won't say it's, and they don't get the good doctors, and they'll
240: say that, because they're on a...that says I'll accept

241: assignment, this is what you think this doctor is worth. And I
242: think that you know, maybe that there's too much emphasis on, its
243: too political. And I'm talking about two of the strongest people
244: in the United States are the American Medical Association and the
245: pharmaceutical. You know, what I would say probably if we could
246: get the politics out of it, we could probably take a lot of these
247: loops, and fix them.
248:
249: * Thank you, that is a very very good observation, that's
250: wonderful. This diagram, do you think it represents a pattern
251: that actually occurs?
252:
253: Yes I do.
254:
255: * Do you think it's a common pattern or a rare pattern?
256:
257: I'd say it's common.
258:
259: * Do you think it's a fairly accurate representation of that
260: pattern? Or are any of the statements, do you see that and say
261: 'Ooh, that's wrong'?
262:
263: Well.... You've done a good job of it really.
264:
265: * Thank you. Is the language of the statements fair to patients
266: and to providers and to administrators?
267:
268: Yes. I'm just looking at this loop, because I'm in this loop.
269: This comes around like this... ((reference to base of diagram))
270:
271: * Lived experiences, needs not met adequately, healing is not
272: optimal, leading back to coming back into the system, a busy
273: system.
274:
275: That's what I'm saying about not being referred.
276:
277: * So in some senses you would say that your experience, you can
278: see your own experience in this diagram.
279:
280: Yeah. You know, and sometimes you just, you just come to the
281: point that says, well I guess that I'm deemed to live with it,
282: you know, and maybe you shouldn't have to.
283:
284: * Yeah, to live with a medical condition that, and well that is
285: hard with a chronic condition, because some things certainly
286: can't be cured, but sometimes some of the symptoms can be dealt
287: with, and sometimes there's a lot we can do in terms of
288: maintenance and prevention. Those are all the questions I've got
289: for you. Just again I want to thank you so much.
290:
291: ((end of interview))

```
 1: * September 13, 2001  9:00 AM
 2: * YYY conference room
 3: * patient5: 'Pete'
 4:
 5: * Let's start out with a pseudonym, you get to give yourself a
 6: name by which you will be called in this, not your real name.
 7:
 8: How about Pete?
 9:
10: * Pete it is! Okay, now I want to start with some demographic
11: questions.  How old are you, Pete?
12:
13: Seventy-six, I'll be seventy-seven in a week, two weeks.
14:
15: * Okay, race is Caucasian, gender male, education, how much
16: education have you gone through?
17:
18: Up to a couple of years of college.
19:
20: * Two years, okay.  And occupation?
21:
22: Colonel, United States Air Force, retired fighter pilot.
23:
24: * Wow.  So that brings all of these events home doesn't it.
25: ((Reference to 9/11/01 terrorist attack)) How would you report
26: your overall health status: good, fair, or poor?
27:
28: Good.
29:
30: * All right.  And about how many visits to medical providers have
31: you had in the last 12 months?
32:
33: About five times in the last 12 months.  Part of them were
34: routinely scheduled by them as a follow-up.
35:
36: * Okay. In terms of... Oh, let me ask one thing, just about,
37: about how long does an office visit last, in terms of how long do
38: you actually spend with the provider?
39:
40: Oh, it depends on what I've come for.  Some of the follow-ups
41: with urology have been close to an hour, 40 minutes.  Infrequent
42: visits to my local doctor here, 20, 25 minutes.
43:
44: * Okay. I'm interested in the kinds of learning that happen in
45: the medical visit. Patients learn from their providers, providers
46: also learn from their patients.  You might learn how to take
47: better care of a problem, how to cope with difficulty, to learn
48: maybe the correct way to take medicine. In your experience has
49: learning in a medical visit usually been optimal for you or not?
50:
51: Oh, I think so.
52:
53: * Fine. Do you recall an instance where learning was less than
54: optimal for you as a patient, and could you tell me about that?
55:
56:
57: Well, when you're talking about medical, now are you, do you
58: include all branches including eye, opthamologist, including
59: those people?
60:
```

61: * That's a good question, let's say sure, let's throw them in.
62:
63: Okay. Currently I look for a doctor that I can relate with and
64: talk to, okay, so that there's a two-way conversation. But I have
65: gone to some people outside of the pure physical, the eye doctor,
66: that look at your eyes and do all kinds of things, and don't tell
67: you anything. I mean we don't relate, we're talking about
68: machinery, and stuck in there.
69:
70: * So you might go through a whole series of tests and not get any
71: feedback about what the readings are, what they're about, what
72: the tests are showing.
73:
74: Right. I have no idea what the readings are ever. It seems like
75: that's generally with the optometrist, opthamologist.
76:
77: * And what about doctors who take care of the rest of the body,
78: in your own experience, where learning was less than optimal for
79: you?
80:
81: In my personal opinion, we've got the finest medical facilities
82: and people right here I've ever encountered. Not all of them,
83: but by the majority.
84:
85: * When you say right here, and do you mean in (name of this
86: city)?
87:
88: Yes.
89:
90: * And this clinic in specific?
91:
92: Well, or the clinic, or the hospital.
93:
94: * Mmh-hmm. Okay. In terms of perceptions of what medical
95: practitioners learn: a medical provider might learn about your
96: symptoms, about your ability to cope, about lifestyle conditions,
97: in order to arrive at a well informed diagnosis. They might need
98: to know how much or little you exercise, about your eating and
99: drinking habits, about how you're feeling when you deal with a
100: medical problem. Does your medical provider adequately learn
101: these things from you?
102:
103: Oh, I think so. Because as I say, I don't know whether it's
104: through an access or what, but I've had nothing but doctors that
105: I could relate with, we could talk informally, one to one.
106:
107: * That might be real key right there, that informality allows
108: better communication.
109:
110: Well, being a military fighter pilot, we were always close to our
111: flight surgeons. And our flight surgeons, a lot of them were
112: flyers, and we talked to each other all the time. So I grew up
113: from the age of 20 talking to medical people on the one to one
114: basis, because we were, our lives depended on it, everything.
115:
116: * Do you recall an instance where learning was less than optimal
117: for your medical provider, where they didn't learn the kinds of
118: information they needed? I'd like hear a story about that.
119:
120: Oh, I don't know. I really, sometimes when you just come in for

121: a routine, a special visit, for some particular thing, you get 20
122: minute treatment and you're gone. There isn't much longer it goes
123: on, you know you come for a specific reason, and you get a
124: specific thing done. And I don't think, you know you get a
125: prescription, you go away, that's it. But I experienced,
126: ((laughter)) I spent 25 of my 31 years in socialized maintenance,
127: that's what we called it in the Air Force. Everybody calls it
128: socialized maintenance. So I understand time study, and you fix
129: what you have to fix, where and so forth. I understand what the
130: modern medical practitioner is putting up with.
131:
132: * We're going to get to more of that in a little bit. What I want
133: to show you are some diagrams, matter of fact we're probably
134: right there. I've been drawing maps of systems, and these are
135: really just diagrams of patterns. This first one is just to show
136: you how to read this kind of pattern map. Where you see a double
137: walled box, it's either a system input, right there, or a system
138: output. So those are conditions coming in and out. This one
139: happens to be about a lifestyle pattern relating to back pain.
140: Now, there's a lot of other patterns, this is not the only
141: pattern of back pain. So when you're drawing a pattern map,
142: you're just trying to draw one pattern that occurs, and not all
143: of them. There's a certain simplification that happens. And when
144: you read forward, follow an arrow forward, you would say
145: 'therefore', or you could read around these circles backwards,
146: and say 'because'. I want to give you a minute just to read
147: through that and become familiar with how to read this type of
148: pattern map. And let's see if it makes sense to you, just how to
149: navigate around this map.
150:
151: ((12 second pause))
152:
153: I was thinking computer-wise, either - or.
154:
155: * Yes, and this is actually quite different than a binary model.
156: This is about thinking in loops.
157:
158: Right. I was thinking binary and trying to understand it.
159:
160: * That's right, this goes around, you are right on target,
161: because this is thinking in circles rather than in branching
162: lines, where basically a cause ends up becoming an effect, and
163: then becoming its own cause. And so you end up with these,
164: really, loops that reinforce themselves.
165:
166: They're understandable.
167:
168: * Does it makes sense as you read through that, how all those
169: link together and hang together to, you might say in this case,
170: form a self-sustaining cycle?
171:
172: Yes, yes, I'm thinking of a specific case that I can relate to
173: that.
174:
175: * Good, good. I'm fascinated that you right off hit on the
176: difference between computer thinking, binary thinking, and
177: systems thinking, a circular method, because that is quite a
178: fundamental difference. I want to show you a little bit more
179: complex one, and I'm going to ask you some questions about this
180: one, and so I want you to just take whatever time you need. Its

181: read in the same way that this other one is read, and let's see
182: if this one makes sense or not.
183:
184: ((8 second pause))
185:
186: My problem is find a start and end. ((laughter))
187:
188: * Well now, you can start at the double walled box.
189:
190: That's where I finally found the double walled box.
191:
192: * Technically, you can start anywhere, but that's a handy place
193: that sort of makes sense.
194:
195: ((23 second pause))
196:
197: Okay.
198:
199: * Would you say you can understand this diagram or not?
200:
201: Yeah.
202:
203: * And in your own words what would you say this diagram shows?
204:
205: ((laughter)) Socialized medicine! ((laughter)) Efficiency vs.
206: inefficiency, I guess.
207:
208: * Mmh-hmm. Does this diagrams show anything that seems either
209: particularly useful or interesting or insightful to you, anything
210: you didn't see before?
211:
212: No, actually this is putting down a lot of common sense, things
213: the way I relate to the system, or the way I see the system. The
214: way I see the total ((?)) health care system.
215:
216: * This diagram presents a pattern of insufficient learning in
217: medical visits. It's one pattern of many patterns...
218:
219: Right.
220:
221: * ... sometimes there are really very good patterns that occur.
222: This is the one we don't want to have happen.
223:
224: That's right.
225:
226: * Do you think that it accurately represents a pattern that
227: actually occurs?
228:
229: I would say yes, this represents things that actually occur.
230: However I don't feel that it's occurred to me.
231:
232: * This is good. Do you think it shows in the health care system
233: at large, a common pattern or a rare pattern?
234:
235: One I'm sure this, I feel this is a common pattern entirely.
236:
237: * Is the language of the statements fair to patients and to
238: providers and to administrators?
239:
240: Are the statements on this...?

241:
242: * Yes, is the language of these statements fair. Let me back up a
243: little and give you why I am asking this. I'm trying to sketch
244: out a situation where everybody is doing their job just right and
245: under a lot of different pressures, and they are all competent
246: people doing the right things, but we're getting outcomes that we
247: don't want and we don't desire. And so I'm trying to say that
248: this is a systemic error rather than an individual error, and I
249: don't want to, in the language, blame anybody. I don't want to
250: point a finger at any single party and say, 'Ooh, this is your
251: fault'. And so that is why I'm asking, is the language of the
252: statements fair to patients, providers, and administrators.
253:
254: Yeah, I think that this is pretty fair...the statements, how the
255: circle goes.
256:
257: * Has your experience ever put you in the diagram, and if so
258: where? I'd like to hear a story about that.
259:
260: ((18 second pause))
261:
262: Well, yes. I'm having a similar type problem with an eye
263: experience now. The people that I've been talking to act
264: mechanically and don't talk to me, and I can't relate to them,
265: whether they really understand the way I feel about my eye
266: problem. I have, I get with my permanent doctor that I have just
267: seen today, I get more understanding of my problem than I did
268: with a specialist. Okay, I'm a great believer in GP's. General
269: practitioners that look at the whole person as opposed to the
270: specialist.
271:
272: * That's what makes family medicine special. They've taken up
273: that tradition.
274:
275: Yes. That relates back to my experience in the Air Force with our
276: flight surgeons. Because our flight surgeons were part of the
277: family.
278:
279: * Exactly.
280:
281: That's where we lived, yeah. And I don't want to change,
282: ((laughter)) I like living that way.
283:
284: * It's a good way, a very good way. Let me ask you perhaps the
285: biggest and hardest question I've got. If this is a pattern we
286: don't want to happen, how do we recognize this when it's
287: happening, how do we get out of it if it's happening, and how we
288: prevent? Now I'm asking you that, and I don't know the answer to
289: that, but I would sure appreciate your thoughts on it. So the
290: big question is a tough question.
291:
292: ((laughter)) Well, I have two comments. First of all, being a
293: man, and I think I represent other men, men will go off by
294: themselves and as this statement says, drop out of the health
295: care system rather than fool around with it. I think probably a
296: lot of elderly women will too, but most of them will talk about
297: it all the time, and I don't know whether they'd do anything. But
298: I've got the feeling that men will drop out of the system rather
299: than pursue it any further. I think, well I don't know, just
300: from my experience of seeing other elderly women, they'll stay in

301: the circle ((referring to the diagram)) and keep going around and
302: around and around. But that's strictly my opinion.
303:
304: * That's what I'm here to learn about though.
305:
306: But I think men are more individually, individualistic, and tend
307: to drop out of the system.
308:
309: * So that's one way of breaking this pattern for a patient, is
310: simply to step out of the system altogether, maybe finding some
311: other source of health care, or simply not attending to the
312: problem.
313:
314: Right.
315:
316: * So we can recognize it as patients. All right. Well those are
317: my questions, and I'm so thankful for your participation.
318:
319: Well, if I've added anything, so be it.
320:
321: ((end of interview))

```
 1: * September 17, 2001   9:00 AM
 2: * Location: Interviewee's home, in a residential trailer park.
 3: * patient6: 'Rose'
 4:
 5: * Well, let's start off with just a few demographics questions.
 6: Age?
 7:
 8: Eighty-one.
 9:
10: * Wow, you're doing good!  ((laughter)) Okay, race is Caucasian,
11: gender female, education, what did you do in terms of education
12: in your life?
13:
14: I was a schoolteacher, a retired teacher, and I have a Bachelor's
15: plus about 60 hours, a Bachelors of education. I didn't have a
16: Master's, I had enough hours that I could have had a Master's,
17: but I didn't pursue it.
18:
19: * And you say your occupation was a teacher?
20:
21: Yes.
22:
23: * What grades did you teach?
24:
25: Mostly second grade, primary education.
26:
27: * Oh, that's a fun age.
28:
29: I did teach a little high school typing back in the years when it
30: was just typing, not computers, a couple years, but mostly I
31: preferred primary, so that's what I taught most of the time.
32:
33: * And how long have you been retired?
34:
35: Eighteen years.
36:
37: * Uh-huh. Okay. In terms of your health status, would you say
38: your health is good, fair, or poor, overall?
39:
40: Well, considering what I've been through, it's good.
41:
42: * Okay. ((laughter))
43:
44: I had an aorta dissection in 1993 and the aneurysm ruptured, I
45: was in a coma for four days they told me, and since then Dr.
46: (name) has kept me in good condition.
47:
48: * So you had some very serious health problems, but you've come
49: through it quite well.
50:
51: Yes, I'm great.  Can't complain.
52:
53: * Wow! I'm interested in the kinds of learning that happens in
54: medical visits.  Patients learn from their providers and
55: providers also learn from their patients.  A patient might learn
56: how to take better care of themselves, how to take a medicine,
57: how to cope with a problem. In your experience has learning in a
58: medical visit usually been optimal for you or not?
59:
60: Yes.
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61:
62: * It has. Okay, do you recall an instance when learning was less
63: than optimal for you, and if so could you tell me about that?
64:
65: I can't remember a time when it might have been.
66:
67: * Okay.  Oh, one thing we have to do, we have to pick a pseudonym
68: for you.  What name are we going to call you for this study?
69:
70: Rose.
71:
72: * Rose it is!  Excellent.  Okay. A medical provider needs to
73: learn about symptoms, needs to learn about lifestyle things like
74: exercise and diet. They might need to know how you feel about a
75: problem. Does your medical provider adequately learn this type of
76: information from you?
77:
78: Yes.
79:
80: * Yes.  How does your medical provider learn this type of
81: information from you?
82:
83: Asking questions and listening.
84:
85: * Do you recall an instance when learning was less than optimal
86: for your provider, and could you tell me a story about that?
87:
88: I can't think of anything.
89:
90: * Okay, okay.
91:
92: I've had excellent care.
93:
94: * So your experience as a patient, and you've had some
95: experience, has been that usually you've learned the things you
96: needed to know. And usually the provider has learned what they
97: needed to know.
98:
99: Yes, yes.
100:
101: * Excellent. I want to show you some diagrams.
102:
103: I could give you some names of doctors if you wanted them.
104:
105: * Oh, no no no...if you gave me names of doctors, I would change
106: their names to be pseudonyms as well. ((referring now to the
107: diagram on a clipboard)) Actually you don't even need the pen for
108: this one.  This is a map of a pattern, and you'll notice there is
109: a double walled box here. That is an input to the system. A
110: double walled box can also be an output.  If you read forward,
111: and follow the arrows forward, you would say 'therefore'. Or you
112: can read around backwards by saying 'because'. And they follow
113: around in circles. This is a pattern map of back pain, of its
114: association with a number of lifestyle conditions. It's just one
115: pattern of many possible patterns. In mapping you can't show all
116: of the patterns all at once, because it gets very messy. So you
117: just try and show one pattern. I'm going to let you read through
118: that for a minute and just see if it makes sense to you.  Because
119: what I'm going to do next is to show you another diagram and then
120: ask you some questions about it. So this one I'm using just so
```

121: you can understand how to read this one. Does it make sense?
122:
123: Yes.
124:
125: * Yes, okay. That's the easy one, I'm going to take it back for a
126: second, I'm going to show you this next one. I'm going to give
127: you some time to read through that one, it reads the same way
128: this one reads, where you follow an arrow forward and say
129: 'therefore', or you can follow them around backwards and say
130: 'because'. And then I'm going to ask you some questions about
131: this one when you're ready. You let me know when you're ready on
132: that one.
133:
134: ((Pause 105 seconds))
135:
136: Well, I think so.
137:
138: * Okay. Would you say you can understand this diagram or not?
139:
140: I think so.
141:
142: * In your own words what does this diagram show?
143:
144: It wants to know how well the management, such as the HMO, meets
145: the patients' needs. We don't belong to an HMO.
146:
147: * Okay, that's okay. Does the diagram show anything that is
148: particularly interesting or useful to you, does it let you see
149: anything that you might not have seen?
150:
151: No, I don't think so.
152:
153: * Okay. This diagram shows a pattern of insufficient learning in
154: medical visits. Do you think that pattern actually occurs?
155:
156: Not for me it doesn't.
157:
158: * Correct.
159:
160: Okay.
161:
162: * Do think in general in the practice of medicine in this country
163: it occurs?
164:
165: Well, from comments I've heard from other people, yes.
166:
167: * Do you think it's a common pattern in general or a rare
168: pattern?
169:
170: I think it's common, in some clinics more than others. These are
171: the stories that I hear from friends and relatives.
172:
173: * Has your experience ever put you in that diagram?
174:
175: No.
176:
177: * Okay. That's good! How is it that you've managed to prevent
178: this type of cycle from happening in your life?
179:
180: Because we don't have an HMO. I'm on a different health plan,

181: and one doctor said to me one time, 'I'm very glad you're not on
182: an HMO plan so I can send you to any specialist I want to'.
183:
184: * So there's some control over quality of provider that you and
185: your physician have been able to maintain?
186:
187: Yes, that's right.
188:
189: * And if I understand correctly, and you can correct me on this,
190: that your sense is that in an HMO the pressure from management
191: decreases quality of learning.
192:
193: Yes, that is exactly right.
194:
195: * Okay, okay, that's a really important insight for me to get
196: from you, I'm very thankful for that.
197:
198: Because I had the impression definitely that there was a
199: specialist he wanted, he wouldn't have been able to do it had I
200: been with an HMO, he'd have had to send me to someone else or end
201: up with no one.
202:
203: * So both quality of care, and linked up right with that, perhaps
204: quality of learning, were involved?
205:
206: Uh-huh.
207:
208: * Yes, okay. Just looking again at this diagram, would you say
209: that the language I've used in the statements in there is fair to
210: patients, to providers, and administrators?
211:
212: I think so.
213:
214: * What I see happening is that everybody is doing their job here,
215: just right in this diagram, but they're getting outcomes that
216: they don't want, that nobody wants.
217:
218:
219: Uh-huh, I think that might be true.
220:
221: * So I've tried to draw this up in a way that doesn't blame any
222: individual for it. It's a system problem.
223:
224: I think it's the system. Yes.
225:
226: * And so the big question that I have, is how do we prevent this
227: pattern from happening?
228:
229: I don't know.
230:
231: * I don't know either. ((laughter)) I'm hoping that it helps,
232: that if people can see the pattern in the diagram, then they can
233: recognize it and say 'Oh! We see it, we recognize it, we just
234: don't mean for it to happen'. Well that's excellent, those are
235: all the questions I have. You've been very helpful and very
236: insightful. I really appreciate your taking the time, talking
237: with me.
238:
239: ((end of interview))

```
 1: * September 19, 2001   9:00 AM
 2: * Location: at subject's ranch-style home
 3: * patient7: 'Arnold'
 4:
 5: * You know, I want to start out with just a few demographic
 6: questions.
 7:
 8: All right.
 9:
10: * Age?
11:
12: Seventy...let's see, seventy-four, going on seventy-five.
13:
14: * All right, seventy-four plus ((laughter)).  Race is Caucasian,
15: gender male, education?
16:
17: Doctorate level - Bachelors, Masters, Doctor.
18:
19: * All right. What did you do your doctorate in?
20:
21: Well the... actually, did two of them, the one that is, I was a
22: National Science Foundation Fellow at (university name) in
23: biology, that was following Sputnik, ((??)), and then I did one
24: at the University of (state name), instructional systems design
25: and counseling.
26:
27: * Wow, that's interesting.
28:
29: This was really part of my own research.
30:
31: * I wonder if you met Lynn Margulis? ((reference to an NSF
32: biologist))
33:
34: I know the name, let's see, I finished there in '69.
35:
36: * She was probably just a little bit after you.
37:
38: I've heard the name somewhere.
39:
40: * She's a biologist, the symbiosis theory of cell organelles was
41: her major work. Yeah, okay.  Occupation?
42:
43: Retired.
44:
45: * Okay, and before that?
46:
47: Private research.
48:
49: * Okay, how would you report your overall health status in terms
50: of good, fair, poor?
51:
52: Well, it's been great until I got the arthritis in old sports
53: injuries.
54:
55: * Okay, going to pin you down: would use a good, fair, or poor?
56:
57: Good. I mean other than stuff that follows as a result of the
58: arthritis involvement, I'm in very good health, always have been.
59:
60: * All right, and about how many times have you seen a medical
```

61: provider in the last 12 months?
62:
63: Oh, ((laughter)) many. I'd have to, I couldn't, you know because
64: I, I fell getting out of the tub in December of last year, and
65: that seriously aggravated the arthritis problem, so that
66: basically both knees, both hips, are qualified for implant
67: replacement, and now I have to have this one which will be in
68: mid-November. But in addition there are other things, the neck
69: injuries have been here, right ankle, been broken in sports. I
70: have, according to the studies they do where they give you an
71: injection, I have literally arthritis throughout my body. And so
72: that's what I've been living with. And I reject all of the
73: regular drugs given for arthritis, all NSAID's, I can't take any
74: of them. So I do a lot with natural medicine.
75:
76: * Let me come back to this. When you say many visits to medical
77: providers in the last 12 months, can you give me a ballpark?
78:
79: Oh, more than once a month.
80:
81: * Okay, okay.
82:
83: Often it's almost every week for certain times, and it's really
84: working on some problems.
85:
86: * Okay. Now I want to move to your perceptions...
87:
88: I scraped myself somewhere, ((dabbing at a scratch with a
89: napkin)) it's no problem, go ahead.
90:
91: * Okay. Your perceptions about patient learning. I'm interested
92: in the kinds of things that a patient learns in a medical visit.
93: You might learn how to take better care of a problem, how to cope
94: with a difficulty, how to take a medicine. In your experience,
95: has learning in a medical visit usually been optimal for you, or
96: not?
97:
98: Well okay, because of my background, in some areas I know more
99: about the subject than the doctor I'm visiting, and particularly
100: in terms of genetics. And because I've worked with research in
101: mice, and genetics in mice and other things of that nature, plus
102: part of my work at (name) State was in ecology work, and so I draw
103: a lot out of the doctors because of my own background, because I
104: ask questions. And I would say I'm in a very unusual situation,
105: because I'm probably in the third standard deviation above mean
106: as far as what doctors are normally used to dealing with. I had
107: this kind of arrangement with my doctor for 30 years until he
108: retired, more than 30 years to be exact, he was our family
109: doctor. And then, I've been feeling very fortunate with the
110: present situation because I have a young doctor here who was
111: trained in Canada. And they are much, their training, we found
112: this, because my wife and all, there are, have been four doctors
113: in (clinic name) that are Canadian trained. And there is a
114: distinct difference in their acceptance of alternative measures,
115: or willing to listening to that, to what we hear from other
116: people with other doctors that are not Canadian trained.
117:
118: * So the Canadian training, in part, you said gives them some
119: openness.
120:

121: They get a great deal of information about what is going on in
122: Europe, and what is going on outside of the United States, and it
123: distinctly shows up in terms when you are talking to them about
124: what you are going to do. They're much more willing to listen to
125: you. Because what we hear from other people in the area who are
126: going to doctors, different doctors who aren't Canadian trained.
127:
128: * That's a very very fascinating difference that comes through in
129: the training.
130:
131: And as I say, I'm pretty certain of this because of my own
132: research background. And my wife, because we worked together, and
133: she ran the editorial and business side of our research when we
134: had two research organizations we ran, until I lost my hearing.
135:
136: * That is fascinating.
137:
138: As she has the same, the same perception. She's not here but
139: she'd, if we...
140:
141: * I'm going to come back to this question one more time, to say
142: has learning a medical visit usually been optimal for you or not?
143:
144: Because I made it optimal.
145:
146: * Ah, okay. So if I understand correctly, yes it has been
147: optimal, but you've had to go the extra mile.
148:
149: Or I just do it.
150:
151: * You just do it.
152:
153: Yes, I just do it, and the same way because my wife is very much
154: into asking her doctor questions and stuff that she has read or
155: stuff that she picks up on the Internet because everything, you
156: see she has some serious problems that came up recently, and she
157: looks into those.
158:
159: * Well let me turn that question around, and say do you recall an
160: instance where learning was less than optimal for you as a
161: patient?
162:
163: Within the time frame, no, because, well actually going all the
164: way, even our previous doctor we had for 30 years, I was
165: constantly reading research articles, everything he gave me, and
166: essentially he treated me as a co-medical practitioner. Anytime
167: I was given anything or told to take this, I constantly got the
168: references, you can read in the library, or he would give me some
169: of his own library stuff, say, here, read it, and we'll talk
170: about it when you get back. So this has been a pattern, oh lordy,
171: since 1965.
172:
173: * That makes all the sense in the world. Let me move then to
174: perceptions of provider learning. A provider might need to know
175: about your symptoms, about lifestyle, about exercise and food and
176: drink, about how you're feeling when dealing with a medical
177: condition. Does your medical provider adequately learn these
178: things from you?
179:
180: Are you saying then, does he gets all the information I think he

181: should have, I'm not quite following you.
182:
183: * That, I think that would be just about right. Do you think your
184: medical provider is getting the types of information and the
185: amount of information he needs?
186:
187: To optimize his treatment?
188:
189: * Yes.
190:
191: Okay, I would say in the present doctors we have here, yes. Now
192: but again, I say this is biased information in that we have been
193: since we came ((?)) into medical groups here, when our former
194: doctor retired, but I am a biased sample.
195:
196: * Of course.
197:
198: In that, my particular doctors, I have been very satisfied that
199: they are looking into lots of things, but again I am optimizing
200: it, because it is just my nature and my research background, and
201: when a doctor tells me about something, it's like the stuff with
202: my hips, which I saw a ((?)) specialist here. I had a couple of
203: instances where I read about research that they were not yet
204: familiar with here, people that are here working with hips and
205: other joints, where I checked them out years ago when this first
206: started, they are some of the top ones in the country. They said
207: you don't need to go anywhere other than (this city) because
208: that group of doctors there that are doing joint surgery, they go
209: international. And so you don't really, ((laughter)) and so I
210: haven't really been looking elsewhere. I knew the quality of what
211: I was getting.
212:
213: * Well let me try that same thing of turning the question around,
214: to say do you recall an instance where learning was less than
215: optimal for your provider?
216:
217: No, I don't think I do.
218:
219: * Okay, okay. I want to show you a couple of diagrams. I like to
220: draw diagrams. This first one is really just to show you how to
221: read this type of diagram. It's a pattern map really. This
222: happens to be a pattern of back pain that is related to a number
223: of lifestyle factors. A double walled box is a system input or a
224: system output. And when you follow an arrow forward you say
225: 'therefore': back muscles tense up therefore back muscles become
226: inflamed. Or you could read them all backwards by saying
227: 'because'. Back hurts when doing normal activities because back
228: muscles become inflamed because back muscles tense up. I want to
229: give you a minute just to read through that and see if that kind
230: of diagram makes sense to you.
231:
232: ((26 second pause))
233:
234: Okay.
235:
236: * Does that make sense?
237:
238: Mmh-hmm.
239:
240: * It's not a typical cause and effect map because if you notice,

241: it has a circular nature to it. So effects become their own
242: causes...an interesting problem. And again I would emphasize,
243: it's just one pattern that you try to depict in a map. There are
244: many other patterns of back pain. This is just one pattern. This
245: is a slightly more complex diagram, and I would like you to read
246: through this one, I want to ask you some questions about this
247: one, whenever you're ready.
248:
249: ((30 second pause))
250:
251: Okay, what's...?
252:
253: * Okay. Would you say you can understand this diagram or not?
254:
255: Mmh-hmm, I can.
256:
257: * In your own words what does this diagram show?
258:
259: Well, it basically looks at people interacting with doctors, and
260: the kind of, based upon ((laughter)) the kind of doctor as I see
261: it, and their background, they respond in certain ways, they
262: interact in certain ways, and as a result of the interaction and
263: the way that people analyze them personally, certain things
264: happen. I mean like over here, patients dropping out of the
265: health care system, as far as myself, the fact that the way in
266: which arthritis is approached commonly by treating it with
267: chemicals, part of my concern, I just don't talk to them about
268: that because I have experienced the consequences of NSAID's
269: causing my gut to bleed. And so I essentially ask those kinds of
270: questions of everything I do with any medical doctor, not just
271: necessarily the ones, uh, I have a hearing problem, I had a total
272: loss of, the hair cells in the right side died. And at that time,
273: this was in '82 it happened, cochlear implants were just
274: starting. And I have connections at the med school, and family
275: involved up there too, and so I go in and ask questions and there
276: was nothing they could do at that time. The doctor my wife was
277: with here in (this city) at the present time, I was talking to
278: him because he is an ear, ear nose and throat specialist. It
279: turns out a close friend of his is in charge of all the cochlear
280: implant systems up at the med school, and he said, if you want
281: to, go up and talk to him. So I went up and talked to him and
282: they want me back in December because they say, well we couldn't
283: do anything for you in '82, we've now progressed and we think we
284: could perhaps put in a cochlear implant on this side which would
285: allow us, after work to check out the fact that you have a
286: hereditary problem in the bones in the middle ear. And given
287: that the hair cell system works, I mean the cochlear implant
288: system works, for six months to a year, we'll consider whether we
289: can go in and take care of the bones, and essentially you could
290: be, your left ear would be back to literally perfect, except if
291: you get an infection, that's the only thing, literally, at the
292: med school, with the implants today, is if you get an infection
293: you're in trouble. That's true of every surgery these days.
294:
295: * Tell me, has your experience ever put you in this diagram?
296:
297: Well, yeah, definitely in terms of ((laughter)) dropping out of
298: the health care system. Because other than getting the kind of
299: treatment I want based upon my reading of the literature, which I
300: read medical literature all of the time, and every new thing that

301: comes out I am liable to know about it, because that's what I am,
302: and so therefore I fit that dropping out. And in terms of, we've
303: been very lucky with the people we have here, because the office
304: visits are designed not to provide the provider time efficiency,
305: with the group of doctors we have, are very open, we go in, or
306: get told come in, we'll find space for you, and that is not true
307: of other doctors, because people, in the community, that we know,
308: simply can't believe that we get treated this way because they
309: are commonly told, you know, we'll talk to you in six weeks. And
310: again, that's why I talk about the training of these people,
311: these particular doctors, the four that we've been interacting
312: with over time. But this training, this is the way they are.
313: ((laughter)) I wish all doctors were, because it would make
314: things a lot better.
315:
316: * Do you think that this diagram represents a pattern that
317: actually occurs?
318:
319: Oh, yeah.
320:
321: * And would you say that it occurs as a common pattern, or a rare
322: pattern?
323:
324: I would say that much of this is common throughout our medical
325: community.
326:
327: * Would you say that it is an accurate representation of a
328: pattern? Have I caught it, have I captured it?
329:
330: Well it is...okay, it's common to many situations, not all, but
331: there are many that would fit.
332:
333: * Okay. Would you say that the language of the statements is fair
334: to patients, providers, and administrators? Because what I'm
335: suggesting in this diagram is that we have a pattern where
336: everybody is doing their job as they see they are supposed to do
337: it. The administrators are doing, trying to create more
338: productivity, greater efficiency. Providers are working within
339: that and within their training of biomedical diagnoses. Patients
340: are trying to get what they want. And so even while everybody is
341: doing, you might say, what they should do, they're getting
342: outcomes, we are all getting outcomes that we do not desire.
343:
344: Well, we are not looking. Okay, I don't think this is fair or
345: unfair, but the forces, for instance, does this say management
346: responds to market forces, but what they are measuring in terms
347: of productivity in my view has little to do with the, with what
348: happens with the patient. Because I don't think the
349: administrators are looking at it. In fact I'm not sure frankly if
350: they want to look at it.
351:
352: * So they might have the wrong proxies for productivity?
353:
354: That's it, because they're...productivity can be far different
355: for them than what is for the patient, and as I said, this is
356: part of my own research background and what I look for because
357: the kind of research I've done and the training I've done of both
358: in adults and in schools. One of the major research was called
359: career education and we were looking at training kids to be able
360: to make better decisions about what career they might go into.

361: That's what my wife and I were doing until when I had this loss
362: of hearing. And so you look for different things. And for some
363: school administrators, there are certain things that are a payoff
364: for them, for a medical person, if somebody, I mean you have to
365: look at different outcomes for different people. And our system
366: today is not well set up to do it, our country really isn't
367: interested in that kind of stuff, in many fields, virtually all
368: fields.
369:
370: * Does this diagram show anything that seems particularly useful
371: or interesting to you.
372:
373: You mean to me?
374:
375: * Yes.
376:
377: Okay. Well, what's interesting to me is that somebody is looking
378: at this way. ((laughter)) I don't know who you work with, or
379: who's on your doctorate, or their background, but it's
380: interesting that they're giving you the opportunity to look at
381: this way, in my judgment. And that's coming from, as I said, all
382: these other various things I've done and what my own interests
383: are. Because even though I am not practicing research I am
384: following it carefully.
385:
386: * You might say, I want to give you the biggest question here, my
387: concern is obviously how to prevent this kind of loop from
388: happening, it's not a virtuous cycle. And so I guess my question
389: is how do we recognize this loop when it's happening, how do we
390: get out of it, and most importantly, how do we prevent it? I'd
391: love to have your insight on that.
392:
393: Well, I haven't tried to analyze this system, and in terms of
394: what's going on out in the world. And so therefore I really
395: don't.... This is an accurate, an accurate description of what
396: exists. It doesn't mean that I really know how I would intervene.
397:
398: * I don't know either. But I'm asking.
399:
400: It's good to ask. ((21 second pause)) I really, in all honesty, I
401: don't know what to tell you.
402:
403: * That's quite okay.
404:
405: Because I know the system exists, I know that I take care of
406: myself and my family in this regard, I constantly question what's
407: happening to us and what's happening to other people in terms of
408: the way the system handles them. As I said, people in this
409: community, friends of ours, are amazed that, are constantly
410: expressing - 'you mean you got in immediately?' Or 'they told
411: you come right in?' I mean, this whole thing, what...I have a
412: bias, and that's what's running everything today is money. If
413: there is, if there is a chance you're going to make a one percent
414: increase in profit, you aren't going to look very closely at
415: whether or not people result, die as a result of the decision you
416: made. Now, nowhere do I see this more than in the pharmaceutical
417: chemical system, and, or as I said, in places with other surgical
418: procedures and ((?)). There are people out there that in my
419: judgment are just in it to make money, and that's it. And that's
420: not what the medical, that's not the medical practitioners we

421: have been with for years, that's from my childhood on, that's
422: been three-quarters of a century. We just, the family's always
423: had doctors that were interested in us first, and not the how
424: many dollars do I make.
425:
426: * So the business of medicine has...
427:
428: That's right, has changed drastically. The same way the business
429: of education, that I've been in, research and this kind of thing.
430: This stuff we had, without new science programs after Sputnik. A
431: lot of schools wouldn't adopt them because what we were saying is
432: 'you've got to give the kids the opportunity to learn with real
433: materials', and, or as in my particular research, I did a lot
434: with my students with research strains of mice. And I didn't
435: involve them in dissecting a pickled...((laughter)) Those went
436: out the door. And so I am a biased provider of information and as
437: I said, I don't necessarily see the improvement of this
438: ((reference to situation in diagram)) except maybe less emphasis
439: on how much profit is being made. And I am biased when I say
440: that.
441:
442: * You know, every individual is biased in their own ways, and a
443: bias is also the richness that you bring.
444:
445: Well you've got to recognize it, a lot of people don't want to
446: look.
447:
448: * So, many people might not want to see this? ((reference
449: to diagram))
450:
451: Oh, yes, there's no question to that, and at all levels. I know
452: there's going to be a lot of management does not want to have
453: these questions raised, the providers are being faced up to say
454: well, am I doing what I am supposed to do as a medical doctor,
455: there's all kinds of things throughout all of this.
456:
457: * So, ultimately this diagram raises the question of purpose.
458: What's the purpose of our whole health care system, what are the
459: ends we are truly trying to meet?
460:
461: Yes. That's right. And the thing is, it will even raise questions
462: with patients. Am I interacting appropriately with the medical
463: system to take care of all of this as patients. Because you see
464: we have, we have a need to be responsible, we just saw it within
465: the last week. ((reference to 9/11/01 terrorist attack)) I am a
466: ((?)) in World War II, I ended up in intelligence in McArthur's
467: headquarters, we moved into occupation, and taking responsibility
468: for what goes on, or saying I'm going to do this even though it
469: may mean our plane goes down, I'll go down where I prefer it goes
470: down. And those kinds of decisions are not different than this.
471:
472: * Thank you. Those are all my questions, and I'm just so thankful
473: for your insight.
474:
475: ((end of interview))

1: * September 21, 2001, 12:00 PM
2: * Location: subject's work site - public school band room office
3: * patient8: 'Joe'
4:
5: * I want to start off with just a couple of demographic
6: questions. Age?
7:
8: Thirty-eight.
9:
10: * Race is Caucasian, gender male, education?
11:
12: Master's plus.
13:
14: * Okay. What did you do your Master's in?
15:
16: Education.
17:
18: * All right. Occupation?
19:
20: Teaching.
21:
22: * Teaching, you bet! ((laughter)) How would you report your
23: overall health in terms of good, fair, or poor?
24:
25: Well, this week, probably fair.
26:
27: * Okay, okay. How many visits to a medical provider in the last
28: 12 months?
29:
30: Probably sixteen.
31:
32: * Okay. I want to ask a little bit about your perceptions of your
33: learning at medical visits. You might learn how to take better
34: care of a problem, how to take a medication, how to cope with a
35: problem, the very nature of the medical problem. In your
36: experience, has your learning in a medical visit usually been
37: optimal for you or not?
38:
39: I think so, yeah, I do. I've learned. My doctor is very good at
40: explaining what he's thinking, why he's prescribing, what the
41: expected outcome is, what the expected downfalls are. I feel very
42: educated, so I know what to expect.
43:
44: * Do you recall an instance where learning was less than optimal
45: for you as a patient, and could you tell me about that? It might
46: not be at this clinic, it might be at any clinic.
47:
48: Well, after my right shoulder went, nobody told me anything, you
49: know, my doctor basically said, 'ah it's a sprain, strain thing,
50: and don't worry about', go out and got right back into it.
51: Created a bigger injury which is now a lifetime injury which has
52: taken five surgeries to correct. The old phrase, if I knew then
53: what I know now, I would have probably - second opinion. You go
54: to your doctor, your family doctor says you're fine, we didn't do
55: the orthopedist, they just assumed. That's a life altering, it
56: ended up for me being a good thing, when I coach anything I now
57: am hyper-sensitive to certain areas. But that was definitely a
58: poor choice, a very bad learning curve for Mom and everybody. You
59: didn't question doctors, doctors knew it all.
60:

61: * How old were you then?
62:
63: High school, sophomore-ish, sixteen.
64:
65: * So you didn't learn the cause, or differential diagnoses,
66: different things it might be.
67:
68: Mmh-hmm, starry-eyed.
69:
70: * But perhaps the provider also didn't learn what they needed.
71:
72: Yeah. Or didn't say 'I don't know, let's go find out'. Doctor,
73: on two different occasions, I had a broken foot, and then the
74: shoulder, did not send me to a, call it an expert, a specialist.
75: And I still have a foot that slightly limps and a shoulder that
76: required five shoulder surgeries.
77:
78: * Could the shoulder surgeries have been prevented with adequate
79: diagnostic work?
80:
81: Yes, I believe because of the injuries it became destabilized,
82: whereas if it had been caught earlier things would have been
83: healthier. I went out and played to the best of my ability,
84: wreaking havoc. ((laughter)) Because I'm not the smartest person
85: when it comes to that, you know doctor says I can play, I'm in
86: the game.
87:
88: * That's generally true of athletes, where you want to perform,
89: and perhaps that would go as well for music. It's a type of
90: athletics, it tends to be fine motor.
91:
92: I was really concerned I might be having a heart attack not too
93: long ago. I was on my cell phone talking to my physician and I
94: said 'look, here's all the symptoms now, if it was somebody else,
95: I'd tell them to go to the hospital'. He said 'you need to get to
96: the hospital'. I said, 'well, I promise I'll get there, right
97: after this rehearsal, you know ((laughter)) I've got marching
98: band rehearsal, I've got this and I've got this. I'll be done by
99: 10:00, 10:30'. 'But you might not be around by then.' 'Oh well,
100: I have my cell phone.' ((laughter)) No sense of humor!
101: ((laughter)) I survived. But I did have a learning curve
102: experience in the office, the immediate visit thereafter, as to
103: the importance of getting things checked out right away.
104: ((laughter))
105:
106: * You stayed for all the rehearsals?
107:
108: Oh yeah. It hurt.
109:
110: * That's interesting. That's a very interesting story.
111:
112: ((laughter)) Some people call that stupid! ((laughter))
113:
114: * I wouldn't, I wouldn't.
115:
116: I call that dedicated.
117:
118: * It's partly, I think, our denial mechanisms, right? I've got
119: them.
120:

121: Oh, I know. You probably get up there, you're sweating, you're
122: feeling awful, you've got the chest pain, you've got the neck
123: thing, you've got the arm thing. I knew it wasn't my heart
124: though, I just, I just knew it. They gave me the test, and they
125: did the cardiogram, and they said 'Hey, you're right, it's not
126: your heart.' But there is something else wrong, so I get booked
127: for a few more tests. ((laughter)) So, anyway...
128:
129: * Let me turn the question around to the question of provider
130: learning, and you already touched on some rich things about your
131: sense of what providers learn and don't learn. The provider
132: needs to know about symptoms, they need to know sometimes about
133: lifestyle and exercise, and food and drink, about how you feel
134: when you're dealing with a medical problem. Does your medical
135: provider adequately learn these things from you?
136:
137: Yeah, I think, my doctor knows me probably better than I do.
138:
139: * Wow, that's a high compliment.
140:
141: Well it is, I think he's a genius, I really do. He's the most
142: compassionate man, and luckily the last two physicians I've had
143: know me well. And I've got some, I get to visit the doctor
144: because of medications I'm on, more than other people, so we have
145: a chance to sit down and, you know, how are the kids, back and
146: forth. So besides how's it going, what's my blood pressure,
147: what's the blood work say, there's some connection beyond that.
148: So he knows well, that's why when I told him, 'No, I really need
149: to stay here.' 'Well, if you can tolerate it, I don't agree with
150: it, but I know what your tolerance for pain is.' I told him I was
151: bad and had my bacon double cheeseburgers that night. He's
152: telling me how to eat and how to change, and how to make the
153: changes, which I think is a real valuable piece in all of that,
154: and how this dietary change will affect your medication, because
155: this medication already effects you this way, when you add the
156: extra greens to it, you're going to have some, your guts are
157: going to explode from gas, so you need to know that. But it
158: takes about two, two and a half weeks, and it will pass through,
159: and almost like clock work he was right. So, yeah, he knows his
160: stuff. At least for me. Maybe we're just a lot alike, and I
161: don't know it yet.
162:
163: * How does your medical provider learn the types of information
164: he needs?
165:
166: He asks me a lot of questions, you know. He takes time, he must
167: take less patients an hour than most people, I swear, because
168: he's - how can I say that politely - he's not really far behind.
169: Because he sits in a room with me sometimes, a half an hour. And
170: I'm talking with other patients, or how does he keep this close
171: to time, the worst I've ever been was 45 minutes late, behind in
172: his office. So he takes the time and he asks questions. So it's
173: nice, you feel like the guy cares.
174:
175: * All right, well I want to move on to a couple of diagrams.
176:
177: Uh-oh!
178:
179: * This is fun stuff.
180:

181: Oh, good! A butterfly! ((as if it were a name-that-object test))
182: ((laughter))
183:
184: * This first diagram is just to teach you about how to read this
185: kind of diagram. It's a pattern map, and it's in loops. Where
186: there's a double walled box, it's either a system input or a
187: system output. When you read these going from each box to the
188: next one, when you follow the arrows forward you say 'therefore',
189: or you can read it all backward and say 'because'. So: back hurts
190: when doing normal activities because back muscles become inflamed
191: because back muscles tense up. That's reading its backwards. Or
192: you can read it forwards. This is a pattern map of back pain
193: that's associated with lifestyle conditions. There are many other
194: pattern maps of back pain. So a pattern map doesn't try to show
195: all the patterns that exist. You try and lay out one typical
196: pattern. I want you to spend just a minute looking through that,
197: and see if it makes sense to you.
198:
199: ((30 second pause))
200:
201: * Does that make sense to you, in terms of how to read it? Does
202: it make sense in terms of lived experience as well?
203:
204: Yeah.
205:
206: * Okay, now I want to show you a little bit more complex map, its
207: read in the same way, and I'd like you to spend whatever time you
208: need to read through this one, and then I want to ask you a
209: couple questions about it.
210:
211: ((47 second pause))
212:
213: Alright.
214:
215: * Would you say you can understand this diagram or not?
216:
217: Oh yeah, I can understand it.
218:
219:
220: * And in your own words what does this diagram show?
221:
222: ((laughter)) This is the health system that I escaped from.
223: ((laughter)) And the one I avoid, you know, when I was searching
224: for a doctor.
225:
226: * Precisely. This is a pattern map, you might say this is a
227: vicious cycle, this is the pattern we don't want to get into.
228:
229: ((Interruption from a student entering room))
230:
231: * Do you think this diagram is an accurate representation...
232: ((school bell sounds)) Do you think this diagram is a
233: representation of a pattern that actually occurs?
234:
235: Yes.
236:
237: * Do you think it's an accurate representation of that pattern?
238:
239: Yes, I would say accurate is a good word.
240:

241: * Would you say it shows a common pattern or a rare pattern?
242:
243: I'd say it is a diminishing pattern, if I can hedge a question.
244:
245: * I think that's certainly fair. By diminishing, that this
246: perhaps used to happen more, but now happens less?
247:
248: Yes, this was the norm, the old family doctor, we don't do that
249: any more. So when we went to doctors, you know, we were medical,
250: which would be this (indicates diagram), where we didn't have the
251: interaction with patients, and now we're going away from that
252: back to the old family doctor. I'd love to see house calls come
253: back you know, but who knows if that will happen. ((laughter))
254:
255: * Does the diagram show anything that seems particularly useful
256: or interesting or insightful to you, does it show you anything
257: that you might not have seen before?
258:
259: No, I just found it interesting, the manager response to market
260: forces, pressing to be more productive, give us more patients, be
261: more efficient, twelve minutes a person, of fifteen minutes
262: schedules, we can now get that down to ten minutes and add
263: another person, decreasing our costs, decreasing our overhead,
264: because we're getting more people through. The old mill
265: production.
266:
267: * In many ways what I'm trying to show here is that we have a
268: pattern were everybody is doing just what they are supposed to be
269: doing, but we're getting outcomes that we don't desire.
270:
271: Right.
272:
273: * And so I would ask, is the language of the statements fair to
274: patients, to providers, and to administrators? I'm not trying to
275: blame anybody for this situation.
276:
277: Yes, I think it's fair, because you've got the pressure up here,
278: you've got the doctor who is just saying, you know, if I've got
279: to come through I don't have time to know the extraneous, and
280: then you've got, of course, the patient over here who is going to
281: drop out, the heck with you, you know. So I don't understand
282: what you're doing over here ((indicating diagram)) and you don't
283: understand what I'm doing over here. Yes, it makes sense.
284:
285: * At cross purposes, which is just what I'm trying to depict. Has
286: your experience ever puts you in the diagram, and if so where?
287:
288: ((laughter)) In past lives as we've talked about, you know
289: providers see problems mostly in a medical context ((referring to
290: language of the diagram here)), but not looking through, or
291: feeling like you're just rushed through and they don't want to
292: talk to you about it, there's lots of doctors like that. I'm
293: someone who wants to feel like I'm associated with in a nice way.
294: I'm paying their money, and when people come and take my
295: services, I'm trying to make sure they get their money's worth
296: too. I'm a dropout-er. ((laughter)) With my philosophy, I'm a
297: definite dropout, right?
298:
299: * Now, in what sense are you a dropout?
300:

301: I clipped going to doctors for a very long time, it wasn't until
302: I got married that I even started going back to doctors.
303:
304: * Why were you a dropout?
305:
306: It was a waste of time, they weren't fixing what I needed to get
307: fixed, didn't listen what I needed fixed, you know, so the heck
308: with it. Nothing wrong anyway, so you know...
309:
310: * Now I have the biggest and hardest question for you, okay? This
311: is the loop that we don't want to see happen. How do we recognize
312: it, how do we get out of it when it's there, how do we prevent
313: it?
314:
315: How do we recognize it? One is we listen to, what you're doing,
316: we listen to all the people involved. A word I hate, but an
317: appropriate word until I find a better one - the stresses on the
318: 'system' - so you ask the people, 'me's' - how are you accessing
319: or not accessing, because if I'm not accessing... ((enters into
320: hypothetical story here)) Well, you know, I haven't been to
321: doctor for twelve years. Why? Well, you know, the last time I
322: went I sat in the office for 40 minutes. Gee, there's a clear
323: picture, is that still happening today? And when you're in
324: there, you sit in the office for 40 minutes and it's consistent,
325: it's not just one day ((school bell rings)) somebody like me
326: walks in and takes 45 minutes of a doctors time because I have
327: some terrible problem and you're having to sit there because you
328: need to get your blood pressure medicine re-done, but in order to
329: do that we got to take your blood and do your blood pressure. So
330: if you're consistently over-booked and under-staffed, that's the
331: number one piece. And then there's the philosophy of the
332: corporation that runs it, because everything is a corporation. Is
333: the money the number one driving thing, or is it people? And I
334: know you're in business to make money, and now our economics is
335: going to take a downturn, and they're going to have to take a
336: hit, they need to have some money to be hit on, but there's got
337: to be some balance in there, that we haven't reached completely
338: yet, but were getting closer to. When we're sitting there
339: worried about giving a person a test because it may cost too
340: much, and they may end up dying because we didn't do the test, or
341: they have five shoulder surgeries because the test wasn't given
342: from ignorance, or just arrogance, or whatever. So that's how I
343: see it.
344:
345: * Those are all good questions and I thank you so much for your
346: insight.
347:
348: ((end of interview))

1: * September 6, 2001 9:00 AM
2: * YYY conference room
3: * Staff1: 'Siobhan'
4:
5: * I want to start off just asking some demographic questions...
6: Oh, actually the best question, the first question, you get to
7: choose a pseudonym for yourself for this study. You get to pick a
8: name.
9:
10: Oh, well. Let's see, I'm trying to think of who I've always
11: wanted to be as far as their names, ((laughter)) it's my one
12: and only chance. How about Siobhan?
13:
14: * Siobhan, now I'm going to have to spell that. That's
15: S-I-O-B-H-A-N.
16:
17: ...B-H-A-N. I always like the way that looks spelled.
18:
19: * You got it. Siobhan. Okay. Age?
20:
21: Twenty-nine.
22:
23: * Okay, race is Caucasian, gender female, education?
24:
25: High school, some community college classes.
26:
27: * Uh-huh, all righty, when did you graduate?
28:
29: 1989.
30:
31: * Professional title?
32:
33: I believe that's receptionist-scheduler.
34:
35: * Okay, and how many years have you been in your present job?
36:
37: Just two in August.
38:
39: * And how would you describe your duties?
40:
41: I guess my responsibilities would be to be the kind of in
42: between, the go between the doctor and his patients. They call
43: in, I schedule their appointments, I take their concerns down on
44: paper, and ((?)) the chart, ((?)) his assistant the chart, and
45: then they address the patient back.
46:
47: * And what kinds of things would you see as facilitators to
48: helping you accomplish your duties, and what kinds of things
49: would you see as barriers? What helps you do your job, and
50: what gets in the way?
51:
52: Umm, what helps me do my job? Do you mean like technology-wise,
53: what helps me do my job, or like having someone who is an open
54: communicator on the phone, or those kinds of things?
55:
56: * All of the above.
57:
58: Well having someone who is able to talk to you on the phone,
59: who's a good communicator, helps. I'm not afraid to ask
60: questions, so that helps me get the information for the doctor or

61: the assistant that I need. As far as my technological things,
62: pen, paper, scratch paper, message pad, computer, chair, a good
63: phone line((laughter)), a good connection.
64:
65: * Yeah, yeah. Description of an ordinary day's work...what is
66: your day like?
67:
68: I'm on the phone pretty much, seven of my eight hours. I wear a
69: headset, and I probably take on a slow day about 80 calls, and on
70: a heavy day probably up to 200 calls, writing down messages. Some
71: days are more hectic, especially when you have a lot of sick
72: patients, if there's a bug going around, everybody wants to be
73: seen right now, they don't want to wait ((laughter)). ((inaudible
74: joking comment, laughter))
75:
76: * That's true that's true. How long are patient visits? You're
77: doing the scheduling, in terms of say, new patient, return
78: patient?
79:
80: It depends upon what it is they need to be seen for. A regular
81: visit with most doctors is between 15 and 20 minutes. If there's
82: more complicated issues, like having medication problems, or
83: depression, anxiety, if they have a chronic condition such as
84: diabetes or a heart condition, sometimes that mixed in with say
85: they have a cold or maybe they're having an upper respiratory
86: infection, sometimes they are 30 minutes. But a standard regular
87: patient visit is 15, seeing a new patient is 30, just so the
88: doctor can go over medical history and such.
89:
90: * You know, it is occurring to me that the work you do on the
91: phone is first contact with patients, and your sense of
92: understanding of the severity of their problem, the length of
93: appointment time they need, who they need to see...what an
94: incredibly crucial job for the smooth operation.
95:
96: And you wouldn't think that it is, but I, this is the second
97: clinic I've worked in. The first clinic, we had 13 practitioners
98: and I scheduled for five. This clinic is a little smaller, and
99: each physician has different expectations of what they want.
100: Some physicians are 15 minutes for everything, some physicians
101: like to take more time. And so not only do you have to interpret
102: what the patient needs, you have to know what the doctor wants,
103: you have to know what the assistant of the doctor wants as far as
104: taking blood pressure, weight, finding out what the problem is.
105: A lot of times, you know I can't tell you how often it will
106: happen, that a patient won't feel comfortable telling me exactly
107: what the problem is. And not to put a gender swing on it, but
108: especially males have a hard time maybe talking about depression
109: or anxiety. And so they'll say maybe, 'well my knee hurts', and
110: then when the doctor or the assistant really goes in, 'you know,
111: I'm having a lot of anxiety or depression', it turns into
112: something completely different.
113:
114: * Problems are often not what they appear to be.
115:
116: Exactly. So you kind of have to, if a patient hesitates on the
117: phone, kind of telling you sometimes, I just add extra time so
118: that, you know you kind of have to be, you kind of have to intuit
119: exactly what they mean when they say they have a knee problem.
120: ((laughter)) Especially if they are hesitating. Yeah, so it is

121: hard, because if you don't schedule enough time you can make the
122: doctor and the assistant's day be really bad.((laughter))   I
123: really try to make that not happen.
124:
125: * That's a very fine description.
126:
127: Okay.
128:
129: * Yeah, that's excellent. Here I want to go into some questions
130: about your perceptions of patient learning, so I want to ask some
131: questions about that.
132:
133: Okay.
134:
135: * What types of things does a patient need to learn about?
136:
137: Well, I guess it depends. If they really want to be clear with
138: me so that I can be a good advocate for them with the doctor and
139: the assistant, then they need to learn to really trust that
140: everything we say is confidential, that they can tell me, I'm
141: sure that no matter what they say, I've heard more bizarre
142: stories ((laughter)), or, you know, I think a lot of people are
143: just afraid to be truthful. So to learn to be truthful and to be
144: very clear in their communication, would be the best thing to
145: learn. The second thing, is a don't thing, as far as an office
146: visit goes, a doctor can't help you, unless you are truthful with
147: them. You know, if you go in and you only hear what you want to
148: hear, and you don't really go in with an open mind, and be open
149: with why you need what you need, or asking for help with
150: something, the doctor is not going to be able to treat something
151: that he does not know about. They can't read your mind. They
152: can only be as intuitive or in tune as they can be on their best
153: day, you know. And so I think that's really important. And then
154: there are some people who just, you know, I don't know if it is
155: their life situation, I don't know if it's environment, the way
156: they were raised, but a lot of people are like chronic patients.
157: I wonder if they are just, sometimes I wonder, I mean we have a
158: few patients who I wonder if, being in crisis all the time or
159: being sick all the time is really how they get through their day.
160: You know that kind of constant victim, there are a few patients
161: we have like that. That is, maybe this is their only
162: communication with real people, and maybe that's how they get
163: that communication or that attention. You know they talk to
164: someone nice on the phone and they come to a facility where
165: people care for them and are concerned. And so we have a few
166: patients like that. And what I would love for them to do, is to
167: learn how to be happy so they wouldn't have to do that.
168:
169: * So you might say illness is their illness.
170:
171: Exactly. Exactly.
172:
173: * But I want to go back to that thing you said about
174: truthfulness, just to restate it and see if this works for you.
175: There are really two sides to truthfulness. One comes from
176: trusting the people, your advocates...
177:
178: Right.
179:
180: * ...and the other is a certain truthfulness to one's self...

181:
182: Exactly, and being...
183:
184: * ... being willing to see what's going on with yourself...
185:
186: Right.
187:
188: * ...and learn about it even though it might be very
189: threatening.
190:
191: Right. Well you know, it's like the patient who will call in, we
192: had a patient yesterday who two days prior had called in for
193: arthritic knees. She wasn't in the room maybe five seconds when
194: she said, 'I've been having chest pains for several days'. You
195: know that's not ((?)), of not wanting to admit she's having chest
196: pains, it could have cost her her life.
197:
198: * Sure, oh sure.
199:
200: And I'm glad that when she got in the room, finally she was able
201: to say 'I'm having chest pains, I'm having problems'. But you
202: know it would have been so much easier if she said when she
203: called me, 'you know I'm scared, I'm having chest pain'. I could
204: have called, I mean Doctor (name), my doctor and my assistant
205: could have triaged that call, we could have had her seen
206: immediately and if there were anything seriously wrong we could
207: have taken care of it before it turned into a problem.
208:
209: * That's right, that's right, that's really good, that's
210: fantastic, okay. How do the clinic's patients learn the kinds of
211: information they need to know?
212:
213: I think that we really try, and the clinic, as a team try to be,
214: I guess kind of, you put on your kid gloves, and if a patient is
215: not being clear, or you don't feel they are telling you the whole
216: story, you really have to try to weasel it out of them
217: ((laughter)) and I don't mean trick them, I just mean that you
218: have to stroke them and pet them, and so I guess they learn to be
219: truthful, they learn what they need from us by the way that we
220: handle them. You know, not only I'm on the phone with a patient
221: trying to figure out exactly what's wrong and how urgent it is
222: that they see someone, but even the doctor, by how gentle they
223: are with the patient, you know like, 'I know this is kind of
224: scary, but we're going to go through it together, and if you have
225: any'... you know what I mean? I think that they learn by us
226: telling them, and if it is something very sensitive, by being
227: gentle and being supportive and caring.
228:
229: * Well put, well put. So if I hear correctly you're saying it
230: really takes walking a patient through a process of whatever
231: information, at the same time being very receptive, are they
232: getting it.
233:
234: Right. And being open to answering their questions, if I mean
235: even as simple as insurance. I can't tell you how many
236: patients have absolutely no idea what their insurance benefits
237: are, and they call here daily wanting to know if I can tell them.
238: Well I can give them my knowledge, what I know, but there are
239: hundreds of insurance companies and they all have different
240: rules, and all the employers who purchase the insurance, purchase

241: different, you know, parts of that. So somebody may have
242: chiropractic and someone may not, and they call wanting to know
243: information. And so they're either going to learn that we are
244: not responsible for their insurance. ((?)) the best thing to do
245: is to call your insurance company, or talk to your human
246: resources development person, and have them walk you through if
247: you have any questions.
248:
249: * What contributes to a medical visit in which patients do not
250: optimally learn what they need to learn?
251:
252: Probably a gob of things. You know, probably everything from
253: exactly, I know I'm sometimes rummy because I haven't had my
254: coffee or my caffeine, I maybe didn't sleep well the night
255: before, and if you couple that with stress of everyday, you know,
256: got to get three kids off to work, or to school, got to get
257: myself off to work, and feeling really cruddy, you know, just how
258: they are feeling, probably has something to do with it. Again if
259: it is something that they are really scared about, if they are
260: scared, you know how you sometimes are irrational, you know
261: you've got a headache and you're sure you have a brain tumor and
262: you are scared because maybe family history, maybe something in
263: your family history dictates something that you're thinking you
264: might have, you know. For instance a woman finds a lump in her
265: breast and it runs in her family, scared to death to be truthful,
266: to come into the doctor and face that fear. You know facing our
267: own mortality is very frightening, everybody, I mean most
268: everybody has questions or some sort of fear about that. So
269: probably everything from every day stressors to facing our own
270: mortality, that we're not made of steel, that we're human and we
271: break, and you know that, and I know for me personally sometimes
272: I'm embarrassed. Not because it's a personal intimate issue but
273: say I'm, you know, say I'm having an arthritic knee problem, and
274: it's because I'm overweight, which I am. You know, you're
275: embarrassed because maybe you caused your own problem, and if you
276: had taken care of yourself better that you wouldn't be in this
277: position in the first place.
278:
279: * Mmh-hmm. Both embarrassment and guilt. How can I complain
280: about this, it's my fault?
281:
282: Exactly! Right. Exactly. I think probably all of that happens.
283:
284: * Getting beyond, moving beyond the blame.
285:
286: Right.
287:
288: * This is good. Okay, what contributes to a medical visit in
289: which patients do optimally learn what they need to learn?
290:
291: Well I think one, a good physician, a good medical practitioner.
292: You know, I think a good physician or a good medical practitioner
293: is I guess receptive to how you're feeling, you know they can
294: read body language, they see that you need to be handled
295: carefully, that they do handle you carefully, if they see you
296: need a good swift kick in the hiney they tell it like it is, and
297: answer all of your questions, offer themselves and their office
298: up as a team, you know, call us, we'll be happy to address your
299: issues, if you need information on a specialist, you know, give
300: us a call we'll see what we can find out. I think really just as

301: a team, having to take care of the whole person.
302:
303: * Tell me about the components of the team. What's your sense of
304: who's on that team?
305:
306: I think all of us, I mean it starts with the first person who
307: answers the phone and says hello. You know, if they don't sound
308: friendly and inviting, you know, if you are already stressed and
309: angry and embarrassed and all of those things, just the slightest
310: thing can say, 'Oh well, no, they're not interested in helping me
311: out, I'll just not call back', or I won't wait on hold for a
312: moment. Hold time is another thing. My ability to facilitate a
313: patient and glean the information I need from them, get it all
314: written down, and able to answer the phone in a reasonable amount
315: of time, being able to talk to the patient and in a friendly
316: manner get what information I need, being able to get that
317: information from them and writing it down so that it is something
318: that makes sense to the assistant and the physician so that they
319: can then respond back to the patient in a timely manner. So it's
320: really a team effort all the way through.
321:
322: * Wow. You have a very very good sense of it. Okay. In your
323: estimation has learning in a medical visit usually been optimal
324: for this clinic's patients, or not?
325:
326: You know I, I like to think that we really try to take care of
327: our patients, and that we really are as receptive and as, I guess
328: as caring as we can be. I work in a really good pod with three
329: physicians and two assistants who are really good with their
330: patients. I mean I would be able to feel comfortable to, if
331: anyone of my friends say, you can see any one of these physicians
332: and know that you're going to be taken care of. I think yes, I
333: think mostly within our facility it's a good experience, and I
334: think I can say that with a clear conscience, because the other
335: facilities ((laughter)) I worked in I would say were considerably
336: less.
337:
338: * Mmh-hmm. Do you recall an instance where learning was less
339: than optimal for a patient, and without disclosing the patient's
340: name, could you tell me that story?
341:
342: Wow. I'm trying to think of a specific instance... and about
343: what.
344:
345: * I'm looking for the ones that don't work, because it's, like
346: there's the things we want to avoid, and fix, oh yeah...
347:
348: Right. Right. You know I have only been working in this clinic
349: since March, and I really haven't had that many bad experiences
350: here, or unfavorable experiences here, and I owe that to the
351: people that I work with, they're very helpful. I can think of
352: many instances in the other clinic that I worked in, I don't know
353: that you're interested in hearing about that since you're
354: specifically referring to this clinic.
355:
356: * Well, tell me a story from another clinic, because I am
357: actually as much as anything, interested in the question of
358: learning and not learning.
359:
360: Specifically, I had a patient whose husband had chronic kidney

361: problems. And although, and many other problems, just very
362: chronic. And he was working for a company in (town nearby) that
363: went on strike, so they had like 48 hours in order to be seen to
364: get his medications refilled, all of his referrals through and,
365: before they lost their insurance. And so my communication with
366: the assistant and with the physician, I don't know if it was the
367: physician was having a bad day, I don't know if it was the
368: assistant was just tired because this was a chronic patient, and
369: they were very demanding and had a lot of special needs. But you
370: know it ended up that the patient didn't get in to be seen, the
371: patient didn't get their referrals, the patient didn't get their
372: medications, and even though I feel like I had no responsibility
373: in that because I, I did take the phone call, I did go to the
374: physician myself, I mean by hand delivered the message, pulled
375: the chart myself, spoke directly, um, the patient didn't get seen
376: and therefore didn't get the things that they needed and ended up
377: leaving the clinic because they felt that their needs were not
378: met. And I don't blame them, but you know again like I said the
379: reason why I feel like I haven't had that many experiences, any
380: experiences that I can recall like that here, is because even if
381: the physicians here that I work with are over-wrought, if, I mean
382: 99.9 percent of the time they are right on it, even if it is
383: begrudgingly ((laughter)), even if it's like I can't see another
384: person.
385:
386: * But they go the extra mile.
387:
388: They do. I'm really really fortunate, I'm really fortunate. It
389: makes everybody's job easier, you know it really does. And it
390: gives everybody a sense of accomplishment, you know that you did
391: your job, the assistant did her, his or her job, and the
392: physician did his or her job, and we are able to care for a
393: person on all different levels.
394:
395: * That's a wonderful sense of the coordination, and the mission
396: of the clinic, that you carry it, that you understand it, that
397: you say 'I am operating on that level and I am committed to
398: that'.
399:
400: Right, right. It's wonderful, we have very committed physicians,
401: and you know honestly, as much as we can do on the phone, and as
402: much as an assistant is able to do, it really takes a committed
403: physician in order to make it all, you know kind of like the
404: synergy of it all, to make the circle complete. And it's nice to
405: know that, I mean I feel a certain sense of pride knowing that we
406: do that, that we are able to make that, accomplish that.
407:
408: * Now I want to, I asked a little bit about patient learning, now
409: I want to ask about provider learning, your sense of what
410: providers learn. What types of things does a provider need to
411: learn from a patient?
412:
413: Oh, wow. I think probably the number one thing, a couple times
414: I've been turned around on my heels, where you'll have someone
415: who's rude, I don't know if it's in their desperation, doesn't
416: realize that you're trying to help them, they think you're trying
417: to hinder them because you're asking so many questions, you know
418: trying to get all the information you can so that you can help
419: them. If you don't know the right questions to ask you can't,
420: you know you can't get that information from them. Just that

421: sense of understanding that person's energy and where they're
422: coming from, you know they're scared. And sometimes you know if
423: I am not at my best and am not really concentrating and really
424: listening, instead of stopping and saying you know, just so you
425: know I'm asking all of these questions so that I can be your
426: advocate, so that I can be your go between, between the doctor
427: and the assistant, that I can get you help so that we can get you
428: what you need. And instead of saying that to the patient and
429: making that happen, you know taking it personally, 'well what do
430: you think I'm trying to do'? ((laughter)) I'm not doing this
431: because I'm rude, I'm not doing this because I'm nosy, I'm doing
432: this because I need to know the answers to these questions in
433: order to be your advocate. And so I think what we need to learn
434: as people who work in a medical facility, is stop, think a moment
435: where this person is coming from, you know, have you been scared
436: when something like this has happened, take a deep breath, don't
437: take it personally when they're rude, don't take it personally
438: when they snap, don't take it personally when you feel
439: unappreciated and lowly. And just put yourself in their shoes,
440: and even say to them, I mean often I say my only job is to get
441: the information to give it to the physician so that we can help
442: you and get you what you need.
443:
444: * So the providers, the physicians really need a fair amount of
445: information about symptoms, presenting problems, some history,
446: basic history information...
447:
448: Exactly. If a patient says I'm having chest pains, the first
449: thing I ask is do you have a heart condition. You know, if it is
450: a younger patient, and they are having upper respiratory problems
451: it could be asthma. So I mean both are urgent, but one is
452: hospital urgent, 911 urgent, the other is we need to see you
453: right away. You know if it's like a bronchitis thing or an
454: asthma thing or a pneumonia thing, it's completely different than
455: in a chest pain, shooting pain up your arm, are you having
456: nausea, are you dizzy, you know, those kinds of issues.
457:
458: * The information that a provider's going to need and that you
459: need also, in terms of some basic triage, what's the scope of the
460: problem.
461:
462: Right. And a lot of that is not even writing it down on a
463: message because even, even if it was just upper respiratory, I
464: would then put the patient on hold while I talked to the
465: assistant so that I could put the phone call through to her.
466: Because I'm not medically trained. because I'm not an assistant,
467: because I'm not a physician, you know I can't take responsibility
468: to know whether it is heart issues or not. And I think the
469: longer, the other thing is I think the longer you're here, you
470: know your patient base, I know that Mr. Z has heart conditions
471: and when he says he's feeling short of breath, it's urgent that I
472: put him through to the physician or the assistant. And so I
473: think you get to know your patients well. I'm not quite, I
474: haven't quite been here long enough that I know my patients as
475: well as I did at the other clinic, but I'm getting there.
476:
477: * So how providers learn the types of information they need to
478: learn is sort of my next question, and you have really led right
479: into that. You said, well, some of the ways, if I understand
480: correctly, and you can correct me on this, some of the ways the

481: providers learn the information is from your memo that you've
482: taken over the phone, and that may have been passed on to a
483: medical assistant, or conferred with a medical assistant.
484:
485: Right.
486:
487: * Some of it is going to come from their own memory of this
488: patient, 'I know this patient, I know their history'.
489:
490: And how much time they spend a visit.
491:
492: * All of that. And so there is this continuity aspect.
493:
494: And even, even patient history so far back as how honest was the
495: patient in their patient history form that they filled out, when
496: the doctor went over it with them.
497:
498: * The third factor that I picked up is that there is this
499: gestalt, this intuitive sense that a provider brings to the
500: exam room...
501:
502: Right.
503:
504: * ... that's got to be there if you really want to understand in
505: a human way as well as in a medical way.
506:
507: Right, right, absolutely. And I know for myself, I do not go to
508: this clinic, for reasons, it would be too hard to work with the
509: same people that, you know, look at me naked. ((laughter)) So I
510: go to another clinic and you know, and there are two physicians
511: that I see there, and one physician, I can't be fragile when I
512: see him, I love him to pieces, he always takes care of me, he
513: listens to me, but he doesn't baby you. So you need to walk in,
514: you need to say 'that antibiotic doesn't work for me, I have a
515: horrible headache, my eyes are goopy, my throat is sore, I need
516: this antibiotic'. He writes you the prescription, he goes through
517: it. Now I have another physician, the other physician I see, who
518: when I feel like I need to be babied, I need to cry, I, I see
519: her, because there, and she, I guess she's much more, I don't
520: know what the term is other than warm and fuzzy. He's warm and
521: fuzzy too, but in a different way, he's kind of no nonsense,
522: she's like, 'Oh, how can I help you', and we can talk more
523: intimately.
524:
525: * It sounds like one of them has a kind of paternal authority,
526: and the other is much more of a motherly person.
527:
528: Exactly. Right. And so depending upon what I need, that's who I
529: see. So I imagine that, you know, part of that responsibility,
530: if you're feeling that you don't click with a physician, that
531: responsibility falls back on a patient, because if they feel, I
532: mean there are some people you feel that you just can't talk to,
533: you feel like you can't be honest, you can't tell them the whole
534: story, (a) because they'll judge you, maybe (b) because they just
535: don't pick up on the nuances of the conversation that you need
536: them to fill in. I think part of that responsibility goes to the
537: patient knowing how honest they can be with someone. I mean we
538: all have friends, I have a friend, I have several friends, I am
539: very fortunate, to who I can tell anything to, anything. I can
540: say anything to. And there are some friends that, you know, we

541: do shopping, we don't do that real intimate conversation with.
542: And so that, I think is a patient's responsibility to find
543: someone that they can click with so that they can get the best
544: care possible, so that they can say, 'ucch, you don't want to know
545: about this itch I've got, you know it's horrible, take care of
546: it', you know, maybe they wouldn't be able to say that to another
547: physician. Does that makes sense?
548:
549: * It makes a ton of sense.
550:
551: And so part of the responsibility I think is the patient, their
552: learning, and the physician's learning, is part of the patient's
553: responsibility, as far as being able to have that conversation.
554:
555: * Mmh-hmm. And I hear you saying something about trust.
556:
557: Right, right.
558:
559: * And that you've learned that there are some providers that you
560: can trust more with your emotional self, there's another type of
561: human intimacy that you can share with them, and another type of
562: human need that's met at that level, as versus a strictly
563: biomedical encounter. And both are important.
564:
565: Right. Exactly. Absolutely. Absolutely.
566:
567: * I think you've covered a lot of this pretty well. I want to hit
568: a couple of these questions. I'll flip the tape. ((pause to flip
569: tape)) What contributes to a medical visit in which providers
570: optimally learn what they need to learn?
571:
572: Wow, again, it is such a vast question. You know, I think
573: number one, you have to like what you are doing. I think
574: providers need to like that they are caring for people, like
575: to help people, like to be receptive. I mean if you're doing
576: something you hate, you're not going to be very good at it.
577: ((laughter))
578:
579: * So provider satisfaction might be a real...
580:
581: I think so. I believe so. Probably, gosh, probably, you know,
582: kind of the same qualities as far as the patient, being open with
583: a patient, being able to be diplomatic, you know, again with that
584: knowing whether your patient needs to be handled kids gloves, and
585: can have this question squeezed out of them, or you know, they
586: can ask something point blank and get an answer. Probably their
587: education, you know, did they, did they embrace all their
588: learning with wholeheartedness or, you know, if it is a
589: specialty. I know that one of the physicians that I work with
590: really loves working with children. And so a lot of his patients
591: are children, and so he I think he, you know, that is his
592: responsibility as far as he knows that's what he really likes and
593: so he's really good with kids. And so he's able because it is
594: something he loves to do, because he's got a knack for it, kind
595: of being soft-spoken with children and being able to kind of, you
596: know, you have to kind of sometimes manipulate people, I don't
597: mean manipulate in trick them, manipulate like as in be able to
598: push all the right buttons and herd them along. He's able to do
599: that, and he's really good, he's not scary, you know. And so
600: he's, because he's really good with children and because

601: probably 50 percent of his practice is children, he loves what he
602: does, and he's good.
603:
604: * Let me turn that question around. What contributes to a
605: medical visit in which providers do not optimally learn what
606: they need to learn from patients?
607:
608: Again probably a lot of the same thing. You know if, if you don't
609: have a willing participant on the other side, they're not going
610: to be able to learn what they need to learn in order to treat the
611: problem. You know.
612:
613: * So mutual participation.
614:
615: Right. And I guess then that responsibility would, like, with
616: the specific providers that I'm thinking, you know, if the
617: parents weren't forthcoming with the information that they
618: needed, they were disinterested, I could see this physician
619: being, you know, not being able to, well if he's a good enough
620: physician he can probably figure it out, but I mean it would
621: probably dishearten him to see a parent not as involved as they
622: should be, or what have you. And so that can probably
623: contribute.
624:
625: * In your estimation, has learning in a medical visit usually
626: been optimal for providers at this clinic, or not?
627:
628: With the experience that I've had with my physicians I would say
629: yes. I think that they are where they want to be, they're happy
630: doing what they want to do, and so they are fairly happy. I mean
631: there's a few patients that they grumble about, but those are the
632: patients that are, are not forthcoming, are not compliant, that
633: are constantly calling at 3 AM saying something when they missed
634: their appointment at 3 PM and could have had the problem treated,
635: you know. ((laughter))
636:
637: * All right. I want to move on to diagrams.
638:
639: Okay.
640:
641: * I draw pictures of complex situations, and hopefully that makes
642: life simpler, we'll find out though ((laughter)) because this
643: gives me feedback on drawing diagrams. This is really a pattern
644: map that I've drawn, and I wanted to show you this one so I can
645: show you how to read a pattern map.
646:
647: Okay. It looks like my life. ((laughter))
648:
649: * This is a pattern map about back pain, and it's really a
650: pattern map about lifestyle components of back pain. It's not
651: the only pattern that there is for back pain, it's just one, and
652: so the intent in a pattern map is to show, you might say one
653: typical complex pattern with a whole bunch of linkages. And the
654: way you read this is, a double walled box is either a system
655: input or a system output. And the arrows, when you read it
656: forward you say 'therefore', like you can say: back muscles tense
657: up therefore back muscles become inflamed, therefore the back
658: hurts when doing normal activities,...then come down to this
659: loop... therefore motion and activity are limited to decrease
660: pain. Or you could read it backwards, going up the arrows saying

661: 'because'. Motion and activity are limited to decrease pain and
662: protect back, because back hurts when doing normal activities,
663: because back muscles...
664:
665: Okay.
666:
667: * That's how you read a pattern map, this type of a pattern map.
668: It's again just one pattern of many, in this case involving back
669: pain. Does that makes sense to you?
670:
671: Absolutely, and you know, the different, the different...
672:
673: * Loops.
674:
675: ...loops can be done many different ways.
676:
677: * That's right.
678:
679: Absolutely.
680:
681: * All right, now I want to show you another one that's a little
682: bit more complex, and I want to give you just a minute to look at
683: this one. Let's see if this one makes sense as well. And I'll
684: give you a minute or two to read through that one, and then I'll
685: ask you some questions about it.
686:
687: ((24 second pause))
688:
689: Okay.
690:
691: * My first question is: would you say you can understand this
692: diagram, or not?
693:
694: Yes. It's not as easy as the other one, but I got it.
695:
696: * It's a little more complex. In your own words, what does
697: this diagram show?
698:
699: ((Laughter)) It's showing exactly what we are trying not to be.
700: ((laughter)) Sorry!
701:
702: * That's just the case.
703:
704: It shows that, it's like I said, it's exactly what we don't
705: want to be. We don't want to rush people, we don't want to be
706: all about numbers, we want to bring that humanness and take the
707: time with our patients, all of those things that this shows that
708: we are not.
709:
710: * Okay, that is good. Is there anything, this is again just one
711: pattern of many patterns, and it's a pattern of dysfunction that
712: we really want to avoid.
713:
714: Right.
715:
716: * But as a pattern, is there anything that you see that might be
717: wrong about it, in terms of 'No, no, that's not the way the
718: pattern works', or 'That doesn't make any sense'?
719:
720: Well, I'm sure, I mean I think it looks fine. I mean there,

721: I'm sure you can add more boxes, but I think it looks fine.
722:
723: * Okay. It represents a pattern of insufficient learning....
724:
725: Insufficient care.
726:
727: * Do you think it's an accurate representation of a pattern that
728: actually occurs?
729:
730: Oh, yes. Absolutely. This is the clinic I used to work for.
731: ((laughter))
732:
733: * There you go. Now do you think it shows a common pattern or a
734: rare pattern?
735:
736: To be honest I don't think I have enough experience in the
737: medical system yet to know whether or not this is more common or
738: not. I do know that this pattern, this pattern of inadequate
739: care, really was exactly where I was in my other clinic. It
740: didn't just affect the patients, it affected the people who
741: worked there, a gob.
742:
743: * That's right.
744:
745: I mean, I would probably say honestly that 70 percent of the
746: people I worked with were unhappy, and I think part of that comes
747: from job satisfaction. If you're someplace eight hours a day and
748: you don't feel that you're doing good, you know that you're doing
749: something for the better good of humanity and that, you know, you
750: don't have physicians who are willing to take the time, that you
751: don't have physicians and management who, instead of caring about
752: numbers and how much you can get accomplished, rather than being
753: able to take care of the people, which is what we're supposed to
754: do, it's a service industry, that's exactly what we're supposed
755: to be doing. You know, nobody's going to be happy. And it
756: reflects, and the sad thing is the people that I worked with
757: before were absolutely incredible people, lovely people, but
758: when the management part of that doesn't flow, when not
759: everybody's mission is the same, when not everybody has the
760: single like-mindedness of team work, of caring for the
761: community, which is kind of what we are supposed to be doing,
762: everybody suffers. I mean not only the community but the office,
763: we had horrible turnover, I mean it really was multi-dimensional
764: and multi-faceted. It wasn't just that we were providing some
765: inadequate, I mean quite a bit of inadequate care, my guess is,
766: to our patients, but we weren't doing ourselves any favor either
767: as an office.
768:
769: * Isn't that fascinating.
770:
771: Absolutely.
772:
773: * I want to sort of amplify that a little bit because it is so
774: interesting. You said the people are all incredible people, and
775: yet they were involved in a pattern that had them.
776:
777: Absolutely.
778:
779: * And didn't know quite how to break out of it. And that's
780: exactly why I have drawn this diagram, to say, well, we have

781: management trying to be efficient and productive, to make that
782: happen...
783:
784: Right.
785:
786: * ... we have providers who are, have their time that they can
787: spend with patients very compressed, so they have to be devoted
788: to medical diagnosis and efficacy, and therefore they miss
789: effectiveness from whatever the patient's perspective is.
790:
791: It's that whole receptive thing that I think kind of...
792:
793: * And so everybody is doing the right thing and they are good
794: people...
795:
796: They are.
797:
798: * ...but they are trapped in a pattern.
799:
800: Right.
801:
802: * And so my next question would be if somebody, if an
803: organization is trapped in a pattern like this, how can it get
804: out? That's a tough question. ((laughter)) I can't answer it
805: either.
806:
807: Good question! And the reason why I sigh is because, that was
808: the most difficult reason I had leaving the other clinic. There
809: were so many people that, like I said, I felt were exceptional
810: and incredible and good and, as long as we weren't seeing
811: patients we were a great group. ((laughter)) Outside of work we
812: had a lot of fun, you know during clinic get-togethers, and we
813: all had a lot of things to share, and so it was really hard to
814: leave that as an employee and as a co-worker, it was really hard,
815: I mean I cried and sobbed and really really thought you know, am
816: I leaving because I feel like I've given up all hope, am I
817: leaving because I've given up thinking that I can do any good in
818: this clinic, you know, and it was too complicated a question for
819: myself to answer, and I figured if it was that complicated the
820: best thing to do would be to separate myself and try to find some
821: place that was a little bit more functional. I don't know how
822: you get out of it. I know that probably the reason these
823: exceptional incredible people stay is because of the incredible
824: exceptional people they are working with. It's really hard to
825: get out of, it's really hard to get out of a pattern once you get
826: into it. I mean we all know that even in our own personal lives,
827: bad habits are hard to break out of. And I don't know. I do
828: know that all the things that I didn't think were possible in a
829: clinic when I came here, are possible. I think that whole
830: receptive, intuitive, caring for your patient really pays off.
831: You know, maybe, maybe you don't get your whole patient load in,
832: maybe instead of seeing 20 patients in a day you only see 12, and
833: maybe the doctor makes less money, I'm sure it has something to
834: do with production. But when you have those 12 patients who
835: come in and are repeat customers and then they tell 12 friends,
836: and those patients are satisfied and continue to stay here, I
837: think you have a much healthier base. You know, it's not
838: quantity, it's quality.
839:
840: * Slow is fast.

841:
842: Exactly. Exactly.
843:
844: * I like that. I have a quick and easy question perhaps. Is the
845: language in these statements fair to patients and providers and
846: administrators? Have I managed to avoid maligning anybody? Or
847: blaming anybody?
848:
849: Yeah. I think so. It's fairly honest, yeah I think you're
850: pretty fair.
851:
852: * Okay, okay.
853:
854: Yeah, I think you're pretty fair. I mean of course depending
855: upon your slant, you could read into it that it's not fair, you
856: could say it's not fair that you say we don't learn enough about
857: a patient because we don't have enough time. That's really not
858: their problem, it's that they didn't take enough time. So
859: sometimes you have to take responsibility and break, it sounds
860: horrible, but sometimes you have to be responsible enough to
861: break the rules for the better good.
862:
863: * That's exactly right, that's exactly right. Wow. Does this
864: diagram show anything to you that is either particularly useful
865: or interesting or an 'a-ha'?
866:
867: Umm. You know, it might if I didn't come from a clinic where I
868: didn't see all of this happening, because I truly believe in
869: everything that we do, it's a circle. And when we don't complete
870: that circle is where we feel unsatisfied, or not whole, or what
871: have you. And so... or it doesn't makes sense. And this
872: ((referring to diagram)) pretty much shows how this affects
873: everybody, not only management. The only thing maybe I would add
874: is that like I said, it doesn't only affect the doctors and the
875: patients but it affects the clinic as well, the workers, the
876: co-workers. If they're not feeling that like I said, that
877: they're not all working on the same level, and we don't see
878: patient satisfaction, and we don't feel like we're part of the
879: bigger loop, you feel kind of worthless. You feel like you're
880: not accomplishing anything, you feel like, God if we could just
881: make this all kind of synergized together and make everybody have
882: the common vision that this is what we're supposed to be doing,
883: then you would feel satisfied, you'd feel like you'd done
884: something worthwhile.
885:
886: * So you might say there's another loop that one could put in
887: here about when patients are frustrated with the system,
888: everybody is frustrated with the system.
889:
890: Absolutely.
891:
892: * And it has to do with the spirit of the clinic and the
893: satisfaction of everybody involved, and that's another one of the
894: costs that occurs when you step into a dysfunctional pattern and
895: are trapped by it.
896:
897: Oh, absolutely. If management has to constantly, it costs money
898: to hire people, if management constantly has to hire people with
899: no training and you have to re-train someone, and just about the
900: time they're getting just in training they quit, you're looking

901: at, I mean I can't tell you how much turnover we had at the other
902: clinic. And so yes, that's part of the ineffectiveness, you
903: know, where it says total health care costs increase from
904: ineffectiveness, it's because of turnover.
905:
906: * Those are all the questions... and what a pleasure to talk to
907: you. You are a tremendous asset to this clinic.
908:
909: Well, thank you.
910:
911: ((end of interview))

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 1: * September 10, 2001 1:00 PM
 2: * YYY conference room
 3: * staff2: 'Jill'
 4:
 5:
 6: * You get to pick a pseudonym now! ((Laughter))  How would you
 7: like to be known in the course of this study?
 8:
 9: How about Jill?
10:
11: * Done deal. ((laughter))  We get our altar egos with this, no
12: problem, this can be done. Okay Jill, thank you for being here.
13: First, I just have some very simple demographic questions and,
14: just questions about what you do.
15:
16: Okay.
17:
18: * Age?
19:
20: Forty.
21:
22: * Forty.  Race is Caucasian, gender female, education? Meaning,
23: well, how much education have you done?
24:
25: I went all the way through 12th grade, and then I had two years
26: of college.
27:
28: * Okay, two years of college.  Professional title?
29:
30: Certified medical assistant.
31:
32: * All right, that's actually an important job.
33:
34: Mmh-hmm, but not well paid. ((Laughter))
35:
36: * But not well paid, that's right.  How many years have you been
37: in your present job?
38:
39: Only one.
40:
41: * Okay. And how many years have you been a CMA?
42:
43: One.
44:
45: * Also one.  Okay, so you trained and did this.  How would you
46: describe your duties?
47:
48: What ever I do, or...?
49:
50: * Yep.
51:
52: Well, I do a lot of phone triage-ing, charting, taking patients
53: back to the room, collecting information from them, doing vital
54: signs, finding out why they're here, filling the doctor in on
55: what they're here, setting up procedures, keeping the doctor on
56: track ((laughter)), taking care of patients.
57:
58: * What are the things that make your job easier, and what are the
59: things that are, that you see as real barriers for you
60: accomplishing your tasks?
```

61:
62: Well, I think it is easier when the patient is real clear about
63: what they're here for. I think some of them, and they're kind of
64: hissy and don't want to be here. And they make it easier if the
65: doctor makes sure that him or her fills you in on everything,
66: like say the doctor sent the patient down to get a x-ray or lab,
67: and I was away from my desk, I didn't know it, it helps if they,
68: like, tell me or leave a note on my desk when they come back,
69: and when the patient comes back and I don't even know that they
70: went anywhere or anything, well it's kind of hard because then
71: you have to kind of back track, you have to find out where they
72: went and why they went.
73:
74: * So you need some good communications between you and other
75: staff members to keep track of the patients, as well as good
76: communication between you and the patients.
77:
78: Right.
79:
80: * And when that is well, when all of that is going good, those
81: are real facilitators.
82:
83: Right.
84:
85: * That really helps. And the flip side is, when that is not
86: good, those are the things that are barriers.
87:
88: ((Laughter)) Right.
89:
90: * How would you describe an ordinary work day?
91:
92: Busy. ((laughter))   Well, it's busy but rewarding.
93:
94: * Well, I want to start off with the busy one then. How busy is
95: busy, in the sense that, how many patients do you need to
96: interact with in the course of a day?
97:
98: Well, it depends if you are on call, if you are on call then you
99: can see up to 25, 30 people a day. On a regular day, 15, 20
100: maybe.
101:
102: * Now as a CMA, are your services, are you linked to one
103: provider?
104:
105: Mmh-hmm.
106:
107: * Consistently?
108:
109: Right, here. Also, if another doctor asks for help if you're not
110: ((?)), 99 percent of the time you're with your doctor.
111:
112: * I assume that that consistency can also help you in terms of
113: building the kind of communication patterns you need.
114:
115: Mmh-hmm, right. Yep, I mean after, if you're with the same doctor
116: all of the time you kind of know what they do and how they like
117: things and ((?)).
118:
119: * You said busy and rewarding. How is it rewarding?
120:

121: ((Laughter)) Knowing that when people, when patients come here
122: that you've helped them.
123:
124: * You said that you do some telephone triage. Can patients reach
125: you anytime?
126:
127: Mmh-hmm.
128:
129: * And are you the person they talk to after they talk to someone
130: at the main switchboard, the front desk?
131:
132: Usually they'll call, and some of them know my extension so they
133: just call it, but otherwise they'll get the front desk, and then
134: they'll just ask to talk to myself or they'll say Doc (name),
135: yeah. So I talk to them first, and if I can't help them or there
136: is something I don't know, then I'll ask Dr. (name) to call them
137: back.
138:
139: * Is there any set time for patients to call in, or can they
140: call anytime?
141:
142: They call all the time. ((laughter))
143:
144: * They call all the time. Okay, okay. I want to ask a few
145: questions just about your perceptions of patients, of what, how
146: patients learn and how well they learn. First a real broad
147: question: what types of things does a patient need to learn?
148:
149: Well, they need to learn, if they are on a medication, they need
150: to learn about the medication, how to take it, when to take it,
151: ((?)). And you know, if they're here to have a wound taken care
152: of, they need to learn wound care, and different things like
153: that. Blood pressures, if they are high, they need to learn
154: different ways to lower the blood pressure, and just the same as
155: cholesterol. So, there is a lot of teaching, we have a lot of
156: paper handouts to give to patients on certain things.
157:
158: * You just answered my next question.
159:
160: Okay!
161:
162: * That's wonderful, that's why it makes sense I guess: how do
163: patients learn these types of information?
164:
165: From the doctor and then handouts.
166:
167: * But you do some of that too.
168:
169: Mmh-hmm, right.
170:
171: * Okay. What kind of questions do you get to answer for patients?
172:
173: A lot of, I have this, what should I do, you know sort of
174: questions, like when they call. That's, usually that's why they
175: like the assistants to do the triage, because a lot of times it
176: might be that they just needed to take an aspirin or put some hot
177: pad on or something, instead of coming in here, and being told
178: that and get charged for it. ((laughter))
179:
180: * But telephone triage, you know, that has its own set of

181: demands.
182:
183: Mmh-hmm. I have a triage book that I made in school, that when I
184: started with Dr. (name), she went through it. The doctor has to
185: okay the things you're telling people. So she went through it
186: and okayed it, and that gives me the power, not the power but the
187: right to tell these people ((?)), because we can't, you know,
188: diagnose and treat, but as long as the doctor signed that off,
189: then it helps a lot because you're helping them and answering
190: their questions and giving them some relief instead of coming in
191: here, and being ((?)) and getting charged. ((laughter))
192:
193: * There you go. What contributes to a medical visit in which
194: patients do not optimally learn what they need to learn?
195:
196: You mean if they come here and they don't get...?
197:
198: * What happens if they come in and they're not learning the
199: things they need, what makes that happen? What contributes to
200: that?
201:
202: Well, they might get mad, or they don't necessarily agree with
203: what they're being told, they might leave, they leave before they
204: are given the things they need, that's mainly what I would say.
205: Being irritated or they don't like the answers.
206:
207: * Yeah, that's a good observation. I hadn't thought about that
208: one much. I think that's a real important one. This one might
209: not simply agree with the advice at some level.
210:
211: Right, mmh-hmm. ((laughter))
212:
213: * What contributes to a medical visit in which patients do
214: optimally learn what they need to learn?
215:
216: Well, it would just be the opposite of that one, they're here and
217: they are willing to accept what's wrong and what thing to do to
218: fix it. Then they're more interested in learning, in finding
219: out. I guess ultimately they have to accept that they, whatever
220: is wrong with them, and they have to want to fix it in order for
221: you to help them.
222:
223: * So the patient has to be invested at some level, that they
224: might have to do something for their own care.
225:
226: Right, they can't just have the doctor to fix it all, they have
227: to help too.
228:
229: * But you know what just occurred to me, sometimes just as, just
230: because a person is ill, they're going to have strong emotions
231: about what's happening. And so they might not come in mad, but
232: they might come in scared. And that might be as much of a
233: barrier. And in either case whether someone comes in with anger
234: about a situation or not liking what they're told, or they're
235: coming in worried, I wonder how, how you turn them around to make
236: them more able to learn, to get through that to where they can
237: learn.
238:
239: Well the answer is, put yourself in their shoes, I guess. You
240: kind of try and work through it with them, let them know that

241: it's going to be hard but if they have any questions or concerns
242: they can always call you.
243:
244: * Do you find yourself sort of engaged in that process sometimes?
245:
246: Sometimes, mmh-hmm. I see patients that are like that, but
247: that's fine, that's what we're here for.
248:
249: * I'd love it if you could tell me a story about that. Don't
250: tell me a patient name, but tell me a story about someone who
251: might have come in with a real strong emotional loading, and how
252: you were able to help turn that around.
253:
254: Well, actually there's a lady that lives on the coast, she's in
255: her 70's, she came here because she wanted to quit smoking, and
256: so she was having trouble breathing too, I believe, and so Dr.
257: (name) let her know that she, do that quit smoking thing, sent
258: her for an x-ray, come to find out that she had lung cancer. And
259: so of course she was scared and she came back, and Dr. (name) and
260: myself, whenever she called, you know, we tried to encourage her,
261: because she was pretty down there for a while, because she had
262: quit smoking and found out she had cancer, and Dr. (name)....
263: they became pretty well attached. Dr. (name)'s went over there
264: for a picnic and stuff with her. When she calls, when the
265: patient calls here, we don't, I mean, favor her, but I'm just
266: using her as an example. There's a couple others like her, you
267: know you try to, if she calls, if she's having a bad day, and if
268: she's going to be over here, we'll have her come in. She comes in
269: and just talks to us, she always feels better when she leaves.
270: It's kind of, she has put her trust in Dr. (name), that she knows
271: what she's doing. She, actually, she's better... they're not
272: going to do any surgery or anything because she doesn't want it.
273: But she's on oxygen and that's helped her a lot, we had to
274: encourage her to do that. And so it's just, I don't know, a lot
275: of it is just being there to listen when they're having trouble.
276:
277: * Mmh-hmm. That's wonderful, yeah, I mean what I'm hearing is
278: that you extended empathy to the patient, a sense of real human
279: warmth....
280:
281: Right, right.
282:
283: * ... in that kind of situation. And that helps.
284:
285: And they like that.
286:
287: * Yes, of course, of course. Okay. In your estimation has
288: learning in a medical visit usually been optimal for clinic
289: patients, or not?
290:
291: I think it has.
292:
293: * This is good. Do you recall an instance where learning was
294: less than optimal, where learning was not good for a patient, and
295: without disclosing the patient's name, could you tell me a story
296: about that?
297:
298: You mean like, if you're trying to teach them something, and
299: they just don't...
300:

301: * Yeah, well, if they're just not learning what they really need
302: to learn at a visit.
303:
304: Well actually, I had a patient that came in today that decided
305: that she didn't want to come here anymore. She had came to, she
306: had been seen at a, well she'd seen several doctors, she has
307: chronic fatigue, she has a few other things I can't remember
308: that, but I know one was chronic fatigue and chronic pain, and
309: saw another doctor prior to this one here, put her on a whole
310: bunch of narcotics. And my, the doctor I work for, doesn't
311: believe in all these narcotics she's on. So when she came here,
312: the doctor I work for explained to her she didn't believe in all
313: that, she could keep her on what she'd already been on because
314: she's been on it for so long that she was used to it. Well then
315: she started, the patient started getting where she wanted more
316: and more, and the doctor was refusing it, and so she would come
317: in upset and crying, and I'd try to explain to her that the
318: doctor wasn't doing it to be mean, it's just that she was at her
319: limit of drugs. I mean she was getting more than what she had
320: believed, and that, and she didn't want to listen and she got in
321: an argument with the doctor. So that's kind of, she put, she
322: wouldn't listen to anything, to try to accept, you know, and so
323: she just got mad, and now she's at a different doctor's.
324:
325: * So she basically, that's a good example, a good example, she
326: did not want to learn about other avenues of dealing with her
327: problem, and was anxious certainly about changing. Mmh-hmm.
328:
329: And she's done this several times, she's been ((?)) with four
330: different doctors, she will go to them, you know at first, until
331: you actually see her pattern, then you kind of you know, he feels
332: sorry for her and you understand, and once you get in to where
333: you're doing what she wants you to do, if you don't do more, then
334: she gets angry and goes to a different doctor.
335:
336: * But this, you know, I've seen this pattern particularly around
337: the issue of narcotics, where there's a tension where a physician
338: might feel taken advantage of by a patient, or burned by a
339: patient. And so that there's a real sensitivity to prescribing
340: narcotics, where from the patient's perspective, you know it's
341: comfortable, the narcotics really help me, I really want them,
342: whatever set of reasons, physical addictions, psychological
343: addictions, may be involved.
344:
345: Mmh-hmm. Right. And she had a drug contract with the doctor that
346: specified this is what I will do, this is what I won't do, from
347: the very beginning, to the first visit, she signed it and so,
348: that's why that doctor goes to that drug contract. They sign,
349: they're all in agreement and then they come back later and say I
350: want this, and then you'll go, 'well you signed this'. That was
351: another thing, why she got mad.
352:
353: * Mmh-hmm. Sure, sure.
354:
355: And she wasn't willing to try to do anything, to even see if it
356: worked, she just, 'no it won't work, I'd just need this, the
357: drug'. You know, she wasn't willing to try anything else that
358: might help her.
359:
360: * How common is that, a disagreement, if you will, over

361: prescribing narcotics comes up?
362:
363: Oh, it doesn't come up a lot, mainly we have another patient
364: that tries to do that, but you just have to be firm with them and
365: let them know you're not, you're not in this business just to
366: prescribe narcotics for them, and there are other things that
367: need to be done first, and that you just have to let them know,
368: this is what you're going to do, you can't take narcotics
369: forever. Well you can, but not, you know...
370:
371: * So there's not that many, it's not that high a percentage of
372: patients for whom narcotics, negotiations over narcotics is a big
373: deal.
374:
375: No, no.
376:
377: * But somehow they leave a strong memory, let's put it that way.
378:
379: They're usually problem patients.
380:
381: * They have a larger impact on the whole way medicine is
382: practiced than the numbers might suggest.
383:
384: Mmh-hmm, right.
385:
386: * Does it seem to be that way?
387:
388: Mmh-hmm.
389:
390: * Okay, I want to ask a little about providers and what they
391: learn. What types of things does a primary care practitioner
392: need to learn from a patient? Big question.
393:
394: Hmm. Mmh-hmm. I don't know, that's kind of hard. Because I'm
395: only deal, I'm only working for this one doctor, so from that...
396:
397: * Just from your experience though.
398:
399: I don't know, the doctor that I work for, she's real, all her
400: patients seem to like her, except the one she won't give
401: narcotics but ((laughter)), she's real easy going, easy to talk
402: to, I don't really think that, I guess maybe sometimes, like this
403: patient I was just telling you about that got mad and left, I
404: guess maybe she is... the doctor just needs to learn maybe, more,
405: I don't know it seems like from the beginning she didn't really
406: believe that she was in all the pain, that, I don't know what,
407: she said, it's kind of a fine line, she said, you want to believe
408: that they are, but you have reason to doubt and you're kind of in
409: the middle there, how can you really tell if they're in that much
410: pain and they need all the narcotics? So...
411:
412: * That's a wonderful answer, because what you're suggesting is
413: that for a provider to learn the information they need to learn,
414: they've got to have trust in the patient.
415:
416: Right. And a lot of times that's hard, because you can and then
417: you get burned, then you're kind of leery about trusting people
418: that have all that, those narcotics, they come to you from
419: different doctors, you know. I don't know. And I've heard
420: several doctors here say the same thing, because the doctors here

421: in this practice, one doctor's not here, the on-call doctor gets
422: all that, you know, those patients. I've heard them say before,
423: 'how can you know?' And you do have to trust the patient, but if
424: they abuse it that makes you wonder.
425:
426: * Okay. In your estimation has learning in a medical visit
427: usually been optimal for providers in the clinic, or not?
428:
429: Um, yeah... you mean what they learn from patients? Yeah.
430:
431: * Yeah. Okay. I want to move into some diagrams that I've done.
432: I want to teach you how to read this type of diagram.
433:
434: Okay.
435:
436: * And this first one is just sort of, just to show you how to
437: read them. And then we are going to go to a second diagram, and
438: I'm going to show that to you and ask you some questions about
439: it. I need your feedback on it.
440:
441: All right. ((laughter))
442:
443: * Its that's simple, I have to learn from you. This is a systems
444: diagram, it's a set of loops really, that interlink. When you
445: see a double walled box, that's either an input into the system
446: or an output from the system.
447:
448: Okay.
449:
450: * And when you follow an arrow forward from a box, you say
451: 'therefore'. For instance, back muscles tense up, therefore back
452: muscles become inflamed, therefore back hurts when doing normal
453: activities. Or you can read them backwards by saying 'because'.
454: Back hurts when doing normal activities because back muscles
455: become inflamed. I'd like you to spend just a minute reading
456: through those loops. It's a description of a pattern, so you
457: might say it's a pattern map, and this is one pattern of many
458: patterns. This is not the only pattern of back pain, this
459: happens to be an emotional and lifestyle pattern.
460:
461: Okay.
462:
463: ((15 second pause))
464:
465: This one could go over here.
466:
467: * Yeah, I think some of these could go either way; which ones in
468: particular?
469:
470: Well, there's one.
471:
472: * Lifestyle becomes more physically inactive therefore weight
473: gain occurs. ((reference to a back pain loop diagram statement))
474: Which other way could it go? Weight gain occurs therefore
475: lifestyle becomes more physically inactive. ((reference to a back
476: pain loop diagram statement)) Actually it does get there, this
477: way. ((tracing loop around in other direction))
478:
479: Well, then it goes up this way too.
480:

481: * Uh-huh, yeah, yeah, and it's a way of showing, you might say,
482: some complex interactions in a fairly simple visual way. That's
483: what we're up to. Does that make sense, how to read those?
484:
485: Mmh-hmm.
486:
487: * Okay, I've got another one here, this is the one that I need
488: your feedback on. You might say this is the pattern that we don't
489: want to happen.
490:
491: Okay. ((laughter))
492:
493: * And again, as with the back pain pattern, there are many other
494: patterns, so this is just one pattern of many. I'd like you to
495: take a minute and read through that, then I'm going to ask you
496: some questions about it.
497:
498: ((38 second pause))
499:
500: Okay.
501:
502: * Would you say you can understand this diagram?
503:
504: Yeah.
505:
506: * In your own words, what does this diagram show?
507:
508: Well, it shows providers are kind of forced, not forced,
509: pressured into seeing more patients, it could be that they're
510: not, because they are so pressured into seeing so many patients,
511: that they are not learning all they need to learn from the
512: patient, getting the whole story, they're kind of pressured and
513: they are just seeing as many patients as they can, and kind of
514: getting to the point of why they are here, and which in turn
515: makes the patients not feel like they're getting what they need,
516: and they go somewhere else.
517:
518: * Good, that's just about what it's talking about. Is there
519: anything about this diagram that you would say 'Oh no, that's
520: wrong'? Perhaps any statement that doesn't make sense in there,
521: or...
522:
523: I don't think so.
524:
525: * Okay. Do you think it is an accurate representation of a
526: pattern that occurs?
527:
528: Yes.
529:
530: * And do you think it is a pattern that actually occurs...
531: maybe I should make that a separate question.
532:
533: Here in this office?
534:
535: * Well, no, let's just say in general in medicine.
536:
537: Well, yeah, I think so, because I hear patients say all the time,
538: that's why they switched from a different doctor and came here,
539: because they felt like they were another number.
540:

541: * Yeah. All right. Do you think it shows a pattern that is
542: common or rare... again generally in the practice of medicine.
543:
544: I would say common, but I don't know.
545:
546: * Is the language in these statements fair to patients and
547: providers and administrators?
548:
549: Well, I guess it kind of depends about where. Like if you were
550: talking about this office, I would say it wasn't because most of
551: them here will stay in with the patient longer than they are
552: allotted, just to get the problem taken care of. Like I said,
553: we've had lots of people come in, that that's why they came here
554: is because they felt like they were numbers. But I guess maybe
555: it's fair in general.
556:
557: * Has your own experience ever put you in the diagram, and if so
558: where? I'd like to hear a story about that.
559:
560: No. I haven't really had too much of anything wrong with me so I
561: haven't really been to the doctor a lot. When I have gone, I've
562: felt that I've gotten what I needed from the doctor.
563:
564: * And does this diagram show anything to you that is either
565: useful or interesting?
566:
567: Well it, I mean I already knew this, but I guess if you don't
568: work in a medical field, I guess like to a patient it would be,
569: like, really useful because then they can kind of, they do go to
570: the doctor and it's kind of hurry hurry hurried, and that kind of
571: gets the reason why, it's because they're so pressured into
572: seeing so many patients a day, you know.
573:
574: * Mmh-hmm. I've tried to draw a map of a system that doesn't
575: blame anybody. Administrators are doing what they are supposed
576: to do, to try and keep productivity high and keep the system
577: efficient. Providers are doing what they are supposed to do in
578: terms of identifying biomedical problems. And patients are doing
579: their best to get their own set of needs solved. So everybody is
580: doing just the right thing, but sometimes when that happens we
581: get outcomes that we don't like, don't intend, and we don't
582: value. And so I guess the question I'm chewing on, is how do we
583: recognize this pattern when we're caught in it, when it's
584: happening, how do we get out of it if we find we're in it, and
585: perhaps most important, how do we prevent it. Do you have any
586: thoughts on any of those?
587:
588: Well, I don't know about the administrators. But the doctors,
589: and I see it here all the time, most of them aren't worried about
590: how many patients they see, they're worried about taking care of
591: the patient that's there. And sometimes that puts them an hour
592: behind.
593:
594: * So if I understand correctly then, having a strong sense of
595: patient orientation, a strong sense of mission, helps the
596: providers resist these pressures.
597:
598: Right. There are a few that worry about how many patients they
599: see, but on the whole the most of them are, they don't come to
600: work, well how many patients do I have today, they go in and they

601: deal with what they need to deal with, and make sure the
602: patient's taken care of, if that means a 15 minute appointment is
603: a 30 minute appointment then that is what they do. So, I mean I
604: don't know what they're being told from the administrators, I'm
605: just going by what I see here. This being pressured, I don't see
606: any of our doctors here being pressured to make sure they see
607: such and such amount of patients ((?)).
608:
609: * No, I don't think they're told that. I think that that's one
610: of the reasons this is a very special clinic.
611:
612: Mmh-hmm. Yeah.
613:
614: * A very healthy clinic.
615:
616: Right.
617:
618: * All right, well those are my questions, and I thank you so much
619: for participating.
620:
621: You're welcome.
622:
623: ((end of interview))