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FROM THE ACC

President's Page: Restoring the Patient–Physician Relationship

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The American College of Cardiology (ACC) believes that patients have the right to be supported and encouraged to participate in their health care decisions, be educated with accurate and understandable information, and have their goals and concerns honored.

The notion of patient-centered care (PCC) has been gaining currency in the quality improvement discourse. Is it just the latest buzzword, destined for obsolescence in a few years, or is there something larger that is worth grabbing hold of? In this month's President's Page, we argue that we should take the concept seriously, although perhaps not at face value.

The idea of PCC is not exactly new: The Picker/Commonwealth Program for Patient-Centered Care (now The Picker Institute) used the term back in 1993 to call attention to the need to shift the focus away from diseases and back to the patient and family (1). A few years later the Institute of Medicine (IOM) followed suit by naming PCC one of the 6 core principles for the improvement of health care in its report "Crossing the Quality Chasm: A New Health System for the 21st Century" (2).

The IOM defines PCC as "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (2). This does not seem terribly controversial, but it marks a shift from the clinician- or disease-centered model of care that came to prominence in the 20th century.

When physicians still made house calls, they were part of the fabric of patients' lives but limited in how much they could offer beyond the body's natural healing mechanisms. With technological advances and various economic and cultural changes, they could offer a lot more, but the price was a less humane model of production, for both physician and patient. A clinician at a hospital could see a dozen patients in the time it took to visit one at home, but spent much less time getting to know each, and had far less opportunity to observe and understand the particular contours of each patient's life—what mattered to them, what strengths they could call upon, what weaknesses they kept hidden.

The mid-century flirtation with Fordism made it clear that an emphasis on efficiency cannot achieve good health outcomes, satisfied patients, happy clinicians, or even lower costs. PCC is an effort to restore the patient to their rightful place as the central concern of medicine, and in the process regain some of what we have lost.

PCC: What's In It for Me?

PCC acknowledges and seeks to bridge the vast gulf that separates the clinician's understanding of disease (pathology, treatment, and outcome), and the patient's experience of illness. If we are to truly maintain the patient's best interests, however, we must not confuse PCC with a consumerist model of medicine, something akin to "the customer is always right." We would prefer to think about human-centered care, which acknowledges the fact that both clinician and patient bring a combination of knowledge and individuality to the encounter.

Unsurprisingly, studies have shown that PCC exerts tremendous beneficial effects: it results in greater patient satisfaction, fewer malpractice claims, lower operating costs, and better retention of employees (3). Even more impressively, PCC:

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- improves disease-related outcomes and quality of life;
- makes it much more likely that patients adhere to medications and regimens for controlling chronic diseases;
- reduces racial, ethnic, and socio-economic disparities in both care and outcomes; and
- reduces the overuse of diagnostic testing and certain procedures (4).

There is no technology that can accomplish such a wide range of goals, at so little cost.

The cornerstone of PCC is shared decision-making, the process by which a health care provider communicates information to the patient about the options, outcomes, probabilities, and scientific uncertainties of available treatment options—all tailored to the patient's specific circumstances—and the patient communicates his or her values and the relative importance he or she places on various benefits and harms (5).

Shared decision-making has been widely advocated as an effective means for reaching agreement on the best strategy for treatment (6), and it has been demonstrated to decrease variations in care, increase patient satisfaction, and, in some cases, decrease utilization. Notice that shared decision-making acknowledges the crucial fact that clinicians have expertise that patients lack; the difference is that the model avoids the paternalism of 20th century medicine and calls on patients to take an active role in learning about their health.

The ACC and PCC: PC3 and Shared Decision-Making

The American College of Cardiology (ACC) believes that patients have the right to be supported and encouraged to participate in their health care decisions, be educated with accurate and understandable information, and have their goals and concerns honored. In March 2009, under then-President Alfred Bove, MD, MACC, the College launched the "Year of the Patient" with the goal of developing a framework and a strategic plan to promote PCC throughout cardiology.

Dr. Bove initially appointed a PCC Work Group, which was subsequently made into a formal committee by the Board of Trustees in August 2009. The PCC Committee, dubbed "PC3," includes a broad representation from the ACC divisions on education, advocacy, and quality, and has member leadership from the Boards of Governors and Trustees and from member sections (cardiac care associates, fellows in training, and practice administrators). Applying the philosophy it promotes, PC3 has invited patients to be involved in several of its initiatives.

The mission of PC3 is to: 1) transform the delivery of cardiovascular care to empower patients across the care continuum; 2) enhance the patient–cardiovascular specialist relationship through the recognized voice of the ACC; and 3) develop clear recommendations for content to the ACC patient-centered portfolio of tools, campaigns, resources, and projects. The PCC committee, with the help of many members and ACC staff, has already made progress on several fronts:

- JoAnne M. Foody, MD, FACC, Medical Director, Brigham and Women's Hospital Wellness Service, serves as the Editor of CardioSmart™, our web portal for patient education and engagement in care. She is overseeing the revamping of the website to increase its usefulness for both the care team and the patient. Several stellar new features on the site are already operational and are available for cardiovascular professionals and patients at www.Cardiosmart.org.
- Many strategic business partnerships have been established with consumer companies interested in health and wellness.
- A working group is analyzing the role of cardiovascular specialists in the Patient-Centered Medical Home.
- We are fostering community engagement at the local and national level by organizing health fairs and other health-related events.
- ACC committees and councils are incorporating elements of PCC into their work, where appropriate; the response has been invigorating.
- Last but not least, this issue of the *Journal of the American College of Cardiology* includes the ACC's new health policy statement on PCC (7).

Under the guidance of the PC3 Steering Committee, the ACC has also formed a working group with a sole focus on how to foster a shared decision-making process. The shared decision-making work group has been actively exploring partnerships with organizations with expertise on this topic, evaluating tools for patient use and facilitating the use of these tools by ACC members and their patients. Many are being tested via CardioSmart™ and through applications available for device download.

The health care professional remains the most trusted source of information for patients, and the ACC is doing its best to support time-pressed health care providers with a library of resources to effectively engage patients. Evidence from the ACC/American Heart Association guidelines will lay the foundation for the information that is translated into patient-ready tools. The broad use of shared decision-making will set the stage for partnerships with

payers to explore different payment models for clinicians who provide such decision support to their patients.

What Does PCC Look Like in the Near Future?

Implementing the principles of PCC throughout the practices of ACC members should benefit both the cardiac care team and patients. ACC members can expect to:

- receive and make use of regular feedback based on patient experiences;
- participate in shared-decision making methods to better understand their patients' preferences;
- refer patients to CardioSmart™ to extend care beyond the office setting;
- participate in direct clinician–patient outreach activities, e.g., hospital- and practice-based patient seminars; and
- be recognized for incorporation of patient-centered care into their practice.

In turn, patients can turn to CardioSmart™ for information and assistance outside of interactions with their clinicians. They will be enabled to engage in dialogue with their clinicians so that they can develop informed preferences regarding their treatment and care. They will be equipped to take greater responsibility for managing their cardiovascular health and working collaboratively with their clinicians to achieve common goals.

Ultimately, medicine is about a healing connection between human beings. We need to re-establish the ideal of medicine as an art as well as a science, and restore the patient–physician relationship. PCC is the right thing to do, both in principle and in practice.

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