

# Ability of Patients to Identify Their Attending Physician: An Academic Medical Center Study

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**Introduction:** It is of utmost importance that patients are able to identify their attending physicians. There is a paucity of data in this area, particularly in teaching hospitals that have protocols for physician and staff communication with patients and their families. In order to optimize the patient experience, more research is needed on physician performance and patient satisfaction. Little is known about hospitalized patients' ability to identify their attending physician. This paper evaluates the rates of patient identification of their attending physician in surgical and non-surgical specialties. **Methods:** A total of 15,828 surveys, spanning September 2010 to June 2013, were assessed. This included patient representation from 9 departments within UCLA Health. Of these, 6,473 interviews were conducted among patients admitted to surgical specialty service lines while 9,355 interviews were conducted among patients admitted to non-surgical specialty service lines. Statistical comparisons were made using the student's t-test and evaluated for variance using the ANOVA test. **Results:** It was determined that significantly ( $p < 0.001$ ) more patients in surgical specialty service lines were able to positively identify their attending physician than patients admitted to non-surgical specialty service lines; 65.7% and 35.7%, respectively. **Conclusions:** It is plausible that a greater percentage of surgical specialty patients can identify their attending physician because the attending is often the physician performing the operation. These results suggest that measures should be undertaken in order to improve patient identification of their attending physicians, which may also improve the quality of care and clinical outcomes. *Journal of Nature and Science, 1(4):e62, 2015*

Patient Experience | Attending Recognition | Physician Recognition | Patient-Centered Care

Delivering high-value, patient-centered care is at the core of ensuring patient engagement and active participation that will lead to positive outcomes. Physician-patient interaction has become an area of increasing focus in an effort to optimize the patient experience. Positive patient-provider communication has been shown to increase satisfaction,[1-4] decrease the likelihood of medical malpractice lawsuits,[5-8] and improve clinical outcomes.[9-13] The multi-faceted effects of improved communication are impactful to both the patient and the physician, therefore it is essential that we understand how to optimize this interaction.

Patient-centered care is a critical objective for many high-quality healthcare systems.[14] This move towards patient-centered care is coming in wake of a time when public opinion is turning against physicians, as reflected in a survey by the American Medical Association (AMA), conducted in 2000, that suggests that 69% of Americans are losing faith in physicians.[15] Healthcare is becoming interdisciplinary and there are an increasing number of specialties that are involved in the condition and care of hospitalized patients.

Patients in academic medical centers may be confused regarding who is in charge of coordinating their care. Currently there is a paucity of data and research in the field evaluating the ability of hospitalized patients to identify their attending physicians from surgical and non-surgical service lines at teaching hospitals.[16] Ensuring the patients know the names of those attending them is a task given low priority.[16-18] Such knowledge is a crucial element in establishing the high-priority patient-provider relationship, and certainly one within hospitals' control.[18]

## ARC Medical Program

In 2006, the Office of Patient Experience at UCLA Health, in conjunction with the David Geffen School of Medicine at UCLA, launched the Assessing Residents' CICARE (ARC) Medical Program. CICARE is a protocol that emphasizes for medical staff and providers to Connect with their patients, Introduce themselves, Communicate their purpose, Ask or anticipate patients' needs, Respond to questions with immediacy and to Exit courteously. CICARE represents the standards for staff and providers in any encounter with patients or their families. Its goals are to monitor house staff performance and patient satisfaction while improving trainee education through timely and patient-centered feedback. The ARC Medical Program's survey has served as an important tool to assess and improve physician "Professionalism" and "Interpersonal Skills and Communication" – two of the ACGME core competencies.[9]

The ARC Medical Program has an established infrastructure to conduct evaluations on a system-wide scale, including nine departments within UCLA Health. ARC volunteers interview patients using a CICARE Questionnaire (ARC Survey) to assess their physician's communication patterns.

As part of UCLA Health's mission to ensure the highest level of patient-centered care, the CICARE standards were introduced in 2006. Given the lack of previous research and conflicting results on the rates of identification of attending physicians, this paper uses ARC data to assess whether or not there was a significant difference in identification rates for patients from surgical and non-surgical service lines.

## Methods

This study analyzed data gathered from an audit tool assessing physician-patient interaction at UCLA Health from 2010-2013. The Materials and Methods of this study are largely based on the Materials and Methods of a previous study, also published by the ARC Medical Program.[19, 20]

## CICARE Questionnaire – ARC Survey

The CICARE Questionnaire is a standardized audit tool (Figure 1) consisting of a total of 20 questions used by the facilitators that work with ARC. There are a total of twenty items on the ARC survey, including 18 multiple-choice, polar and Likert scale questions, and two free-response questions that assess the patients' overall perception of their resident physician and their hospital experience. Questions 1 and 2 pertain to the recognition of attending physicians and resident physicians, respectively. For this study, Question 1 of the ARC Survey was a particular focus. The CICARE Questionnaire was chosen instead of a standard survey such as HCAHPS because it examines the physician-patient interaction in more detail.

## Interview Procedure

The ARC Medical Program survey was conducted by fifty-four premedical UCLA students. New surveyors were trained by the senior surveyors for a minimum of 12 hours before being allowed to conduct a survey independently. All surveyors were evaluated

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bi-yearly by their peers and the program director for quality assurance and to ensure uniform procedure. The average volunteer surveying experience during this retrospective study was as follows: ( $\mu=10$  months, [2-37 months],  $\sigma=10$  months).

Prior to the interview, the surveyor introduces himself or herself, informs the patient of the purpose and length of the interview, and informs the patient that participation is optional and confidential. Upon receiving verbal consent from the patient to conduct the survey, the surveyor asks the patient for the name of his or her attending physician. The surveyor then presents a picture card to the patient and asks him or her to identify a resident who was on rotation during his or her treatment. If the patient is able to identify a resident correctly, the surveyor asks each question and records each response verbatim. The surveyors are trained not to probe for responses, and to ensure that the patients answer in accordance with the possible responses. Although it has not been formally studied, the inter-rater reliability of the survey is likely to be very high due to the verbatim requirements.

### Population Interviewed

During retrospective analysis, 15,828 surveys were evaluated from patients in the departments of internal medicine, family medicine, pediatrics, general surgery, head and neck surgery, orthopedic surgery, neurosurgery, neurology, and obstetrics and gynecology. We excluded all patients who were unable to confidently interact with the surveyor.

### Data Analysis

The researchers reviewed and evaluated all data using standard protocols. Statistical comparisons were made using the student's t-test and evaluated for variance using the ANOVA test. All quantitative analyses were performed in Excel 2010 (Microsoft Corp., Redmond, WA) and SPSS version 21 (IBM Corp., Armonk, New York). Data was analyzed to determine whether or not there was a significant difference in the number of hospitalized patients who can identify their attending physician from surgical and non-surgical service lines.

### Results

A total of 15,828 interviews were conducted from September 2010 through June 2013. Of these, 6,473 interviews were conducted among patients admitted to surgical specialty service lines while 9,355 interviews were conducted among patients admitted to non-surgical specialty service lines. The survey breakdown is summarized in Table 1.

	<b>Department Name</b>	<b>N</b>
8	Orthopaedic Surgery	1210
3	Head and Neck Surgery	569
2	General Surgery	2086
6	Neurosurgery	833
7	OB/GYN	1775
1	Family Medicine	769
9	Pediatrics	3079
4	Internal Medicine	4609
5	Neurology	898
	Surgical	6473
	Non-Surgical	9355

Student's t-test analysis of survey responses revealed that attending physicians in surgical lines were identified significantly more frequently ( $p<0.001$ ) than attending physicians in non-surgical specialties; the breakdown was 65.7% and 35.7%, respectively ( $p<0.001$ ) (Table 2).

In total, 48.02% of patients were able to identify their inpatient attending physician in charge of coordinating their care. Moreover, patients in every surgical specialty identified their attending physician at a significantly higher rate than every non-surgical specialty, excluding family medicine ( $p<.001$ ).

Attending physicians from Orthopedic Surgery were identified by 92.3% of patients, significantly higher than any other service line ( $p<.001$ ). 99.4% of patients who reported receiving a business card from their attending physician were positively able to identify their attending physician. Patients admitted to the Neurology service line were least able to positively identify their attending physician (27.2%). Figures 2 and 3 elucidate these results.

### Discussion

A significantly smaller fraction of patients interviewed in non-surgical departments, excluding family medicine, recognized their attending physician compared to those in surgical departments. One reason for the high attending recognition rate observed in primary care is due to the continuity of care, which leads to a more sustained and developed relationship with the physician.[21] A defining characteristic of family medicine is the sustained doctor-patient relationship. Studies have demonstrated that as the length of the doctor-patient relationship increased, scores on communication, accumulated knowledge of the patient by the physician and trust all increased.[22] Thus, the development of a relationship may be a primary reason that family medicine had a higher attending recognition rate as compared to other non-surgical specialties.

The highest recognition rate was observed in patients admitted to the orthopaedic surgery specialty service line, while the lowest recognition rate was observed in patients admitted to the Neurology service line. These findings demonstrate the disparity of patient recognition of their attending physician between surgical and non-surgical specialties and demand attention to recognition rate as a possible factor in enhancing patient-provider communication and optimizing the patient experience. In addition to the significantly higher attending recognition rates in orthopaedic surgery, additional studies suggest that orthopaedic surgeons have fewer malpractice payments than other high-risk specialties.[23]

Another possible reason for this disparity is that at teaching hospitals with teams of residents and medical students, a surgical attending physician stands out more than a non-surgical attending physician.[24-25] Specifically, a surgical attending physician performs pre-operative and post-operative visits and so the role may be more obvious.

One more possibility is that patients have a greater motivation to know their surgeons due to their fear of surgery.[26] Patients gain confidence to undergo a surgical procedure by learning about their surgeon's expertise and also asking the surgeon questions about the possibility of complications. The invasive and often life threatening procedures that a surgeon performs in contrast to non-surgical specialties may be what shapes that fundamental difference in the development of the surgeon-patient relationship as compared to the physician-patient relationship.[15] Though a patient has a say in and must consent to a surgical procedure, once by the operating table, a surgeon has total control of the patient. The development of trust and a relationship with the surgeon seems necessary. In contrast, in non-surgical specialties, the patient's role is more pronounced. Patients further a relationship with their surgeon by listening to his or her opinion of what the "best" treatment option is in the context of that individual patient. In addition, the surgeon educates the patient of the risks and benefits of the procedures. Through this process of discussion and education, the patient feels that he or she has developed enough of a relationship with their surgeon that they are willing to trust them during an operation.[15]

Taken together, the differences in attending recognition rates this study illuminates may be rooted in the nature of the relationships that are developed in a surgical specialty compared to a non-surgical specialty. Cumulatively, these factors could contribute to patients being able to recognize their surgeon more often than their physicians from non-surgical service lines.

Steps to improve patient physician communication should be identified and implemented because gaps in understanding and communication could result in decreased quality of care.[27-29] A focus on patient-centered care and increased patient engagement leveraging the electronic health record will allow for healthcare

**Table 2: Analysis of Responses**

Legend	Department Name	Mean	Mean*100	Std. Error	Std. Error	N	3	2	6	7	1	9	4	5	Non-Surgical	*** p<.001
8	Orthopaedic Surgery	0.922	92.2	0.0077	0.77	1210	**	***	***	***	***	***	***	***		** p<.01
3	Head and Neck Surgery	0.83	83	0.0158	1.58	569		***	***	***	***	***	***	***		* p<.05
2	General Surgery	0.632	63.2	0.0106	1.06	2086			***	***	*	***	***	***		
6	Neurosurgery	0.537	53.7	0.0118	1.18	833				**		***	***	***		
7	OB/GYN	0.466	46.6	0.0118	1.18	1775						***	***	***		
1	Family Medicine	0.563	56.3	0.0179	1.79	769		*		***		***	***	***		
9	Pediatrics	0.372	37.2	0.0087	0.87	3079							***	***		
4	Internal Medicine	0.311	31.1	0.0068	0.68	4609										
5	Neurology	0.272	27.2	0.0149	1.49	898										
	Surgical	0.646	64.6	0.0059	0.59	6473									***	
	Non-Surgical	0.348	34.8	0.0049	0.49	9355										

systems to achieve Meaningful Use Stage 2 criteria.[20, 30] It is imperative that physicians ground a bond with their patient based on trust and ethical and moral obligation.[15] Patient identification and knowledge of who is in charge of their condition and care is at the core of this relationship.

Our data suggests that over 99% of patients who reported receiving a business card from their attending physician were positively able to identify them. These results suggest an interesting method for attending physicians to improve the abilities of their patients to positively identify who is in charge of their condition and care; ultimately enhancing the patient experience and doctor-patient relationship. The business cards ensure that patients always have access to their physician and also serve as tools to assist the patient in remembering their physicians.

An effective practice implemented by the family medicine and orthopedic surgery departments is the use of white boards in patient rooms to display the name of the attending physician. Patients often do not remember the names of their attending physicians when they are told the name verbally for a variety of reasons including difficulty in pronunciation and not being alert, among other reasons. The white board practice offers the name of the attending physician to the patient in plain sight, which encourages the patient to remember the name of his/her attending physician. The use of the white boards in patient rooms is one possible explanation for the increased attending recognition rates seen in the family medicine and orthopedic surgery departments. Other departments can adopt this practice to potentially increase their recognition rates.

#### Study Limitations

Limitations to this study should be considered. Patient demographic or clinical data were not accessed for this study. However, a significant change in the patient population that would alter the survey responses was not anticipated. Patients were required to recognize their attending physician by name as opposed to on a photo card presented to them by the surveyor, which likely favored patients with strong feelings towards their attending physician. Due to this, the population sampled may not be indicative of the entire patient population. All findings simply indicate a correlative rather than a causal relationship.

Additionally, data was collected at a teaching hospital as opposed to teaching-affiliate hospital. This may impact the number of attending physicians identified correctly. Due to the increased number of physicians, whether resident physician or attending physician, caring for a patient, this may make patients

unsure of which physician is in fact the attending physician in charge of their condition and care. Studies have shown that resident physicians are significantly more likely to introduce themselves as “doctor” and not reveal that they were still a physician trainee.[25]

Lastly, single-center study design and timing of patient interviews, potentially introducing recall bias. Nevertheless, the results illuminate the paucity in patient’s abilities to identify their physician.

#### Future Directions

This study not only elucidates the disparity in patient identification of their attending physicians based on the type of service line he/she is admitted to, but also provides an opportunity to understand why this is so. Top priorities for healthcare quality improvement based on quality metrics such as readmissions may be improved if patients are able to positively identify the individual in charge of their treatment and care coordination. Future studies will focus on patient’s ability to recognize their resident physician in both surgical and non-surgical specialties.

Further, future directions can be to determine if there is a significant difference in the ability for hospitalized patients to identify their attending physician for teaching-affiliate hospitals compared to academic medical centers. Future studies can assess whether the number of attending physician’s giving patients business cards is significantly related to attending recognition.

Following further investigation, these results can be used to make suggestions for best practices to make alterations to the CICARE protocol in order to optimize the patient experience.

#### Contributors

A.A.N., A.H.L., C.D.H. and S.H.S. contributed equally to this manuscript. A.A.N., A.H.L., C.D.H. and S.H.S. collected data, performed statistical analyses, and drafted and revised the manuscript. A.A.N. oversaw the program and provided administrative support.

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