AD REM HEALERS: A STUDY OF MICROPRACTITIONERS AND THEIR MANNER OF PRACTICE

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Mary Elizabeth Grassi

Drew University

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ABSTRACT

Ad Rem Healers: A Study of Micropractitioners

and Their Manner of Practice

DMH Dissertation by

Mary Elizabeth Grassi

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This dissertation begins an academic conversation about physicians who practice medicine as micropractitioners. By exploring this physician subset and their style of practice, a scholarly discourse is established regarding physicians who provide care in a way that does not underplay the physician-healer role. Unlike mammoth and cumbersome health care delivery systems that tend to obscure a physician from routine care, the day-to-day practice of medicine for a micropractitioner situates the physician at every point of the encounter in an *ad rem*, direct manner. This construct is built around the invaluable benefit of generous physician time with patients and the forging of meaningful therapeutic alliances that continue across timelines. This author takes into account the make and mold of the physician-patient relationship, how technology impacts the clinical accord, and the capacities of physicianship.

The attributes of this physician population along with practice features were investigated by means of quantitative and qualitative analysis. Through the instrumentalities of time, access, and technology, micropractitioners manifest physician excellences. They are in tune and in touch with their patients. This author concludes that

this physician cohort provides quality care comprised of humanistic facets. Furthermore, findings reveal that physicians in micropractices recognize the importance of self-reflection and being well-grounded, thus indicating they have an awareness of the implication of humility in their roles as physician-healers.

DEDICATION

This dissertation is dedicated to my late husband:

Joseph J. Grassi, M.D.

An extraordinary physician

Ti penso sempre

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To Jennifer Marie Holly-Wells, Ph.D. who made the Joy of Scholarly Writing truly joyous. To Mr. Richard A. Anderson, President and CEO, St. Luke's University Health Network, Bethlehem, Pa.—thank you for your kindness and counsel. It has been a long and challenging journey. And most notably, to Om Sharma, M.D., Philip Scibilia, D.M.H., and all the professors in the Drew community who readily supported me along the way.

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INTRODUCTION

The sacrosanct relationship between physician and patient is being attenuated. Patients are experiencing less contact with their physician and having more interaction with various health care extenders. This plight over the ever-diminishing face-time between physician and patient is intensifying as present-day health care delivery seeks to reshape this time-honored interconnection. Throughout history this unique association has always involved the coming together of two distinct categories of individuals: the person who needs help and healing and the person who is believed to possess specific knowledge to help and heal. Time and again this proceeding unfolds whenever an individual seeks the aid and assistance of a doctor. Siegler explains, "the clinical encounter between patient and healer is *the unchanging event in medicine*, the constant."[1] Thus, this frames the practice of medicine as relational, and in this context, the physician-patient dyad proves axiomatic. However, in contemporary medicine, this customary correlation and its capacities are being constrained.

Physician and patient as paired system have dimensions of the most private and intimate of relationships. In the ideal, such a relationship should embody attributes of positive regard, genuineness, and empathic understanding in an easeful atmosphere. Respectively, the profound nature of this special affiliation can be viewed through the influences of time and interface shared between these central actors. As the depth of any relationship can be measured over time, the physician-patient relationship is no

[1] Mark A. Siegler, M.D., "The Professional Values in Modern Clinical Practice," The Hastings Report 30 (2000): (4 Suppl.) S20.

exception. McKinlay and Marceau point out that with regard to actual face-time with a physician, "length of encounter in the Mid 20th century was 15 -20 minutes, Late 20th century 6-8 minutes."[2] Physicians bear the brunt of increased demands on time and although this challenge is not a new phenomenon in medicine, what is new is an emerging breed of physicians who have chosen to start micropractices, whereby the benefit of time spent with patients is safeguarded through lower patient volumes and facile use of technology.

The practice of modern medicine is in the midst of unprecedented social and cultural changes coupled with technological proliferation. In over 35 years of healthcare experience, I have witnessed and experienced extensive developments, both intrinsic and extrinsic, to care and cure. Current market forces and governmental regulations demand cost containment along with overall standardization of services within the sphere of health care delivery. Economics has become an overarching driver in the health care arena and as a result, the one-on-one relationship between physician and patient is being arbitrarily affected. The multi-factorial wave of managed care, accrual of mid-level providers, and advances in technology seek to reengineer the manner in which medicine is practiced and provided.

In the arena of contemporary health care delivery, the consociation of physician and patient stands poised at the center of ongoing service pattern transformations: *the*

[2] John B. McKinlay and Lisa D. Marceau, "The End of the Golden Age of Doctoring," *International Journal of Health Services* 32, no. 2 (April, 2002): 403.

unchanging event in medicine, the constant[3] is in the throes of being weighed and measured. Evolving biomedicine categorizes, and through iterations, division of labor gets systemized. These permutations in health care delivery always introduce new functions, and new functions always create new requirements. As explained by the National Health Policy Forum, "physician work [depends] on Relative Value Units [which] account for time, technical skill and effort, mental effort and judgment, and stress to provide a service."[4] Simply put, these Relative Value Units are metrics used by bureaucratized third-party entities to assign a value to a physician encounter. This model rewards volume and factors in the aspect of time as a unit of measure for physician work output. Thus, time has become designated as a commodity in contemporary health care and as such the allotment of time with individual patients is summarily regulated. High volume patient panels are translated into productivity measures and levels of reimbursement are affixed to swiftly paced physician performances.

In concert with the element of time, continuity of care has long been associated with primary care. Ridd has found that in primary care, "continuity matters."[5] If a physician is in a position to form long and lasting relationships with patients, it adds to the dynamism of the therapeutic alliance. Experiential components related to face-time

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[3] Siegler, S20.

[4] National Health Policy Forum, "The Basics: Relative Value Units," February 12, 2009, http://www.nhpf.org/library/the basics/Basics_RVUs_ 02-12-09.pdf (accessed July 31, 2014).

[5] Matthew J. Ridd, MRCGP, Ph.D., et al., "Patient-Doctor Depth-of-Relationship Scale: Development and Validation, *Annals of Family Medicine* 9, no. 6 (November-December, 2011): 544.

allow a physician to have a more effective mode of interaction with patients. Medicine can be practiced unabridged and in a more humanistic manner.

The concept of a micropractice as an initiative by physicians to provide office-based care for the mutual benefit of both doctor and patient is an understudied model. No preexistent academic investigation explicitly examines this practice design. This small-scale undertaking configured to allow for maximum facility in physician-patient encounters also presides over a physician's professional fulfillment and capableness. It is a practical approach to the practice of medicine.

A hallmark of the micropractice model is that the therapeutic dyad is consolidated to common measure. This theoretical simplification allows for a meaningful understanding of the binary set that consists of physician and patient in the clinical milieu. As an evolving exemplar, micropractice is in a prehistory phase. Moore and Wasson,[6] recognized as spearheading its genesis provide a framework of care that denotes agility of practice style and vitality to the physician-patient relationship. Dr. Moore entered upon this construct as a prescript for rediscovering the joy in primary care medicine. As a salaried physician he experienced the treadmill of bureaucratic health care delivery wherein the parameters of physician excellence are designated by how many patients a clinician can see in a day. Volume-based rubrics encourage physicians to see more and more patients in order to achieve incentive compensations written into

[6] Gordon L. Moore, M.D. and John H. Wasson, M.D., "The Ideal Medical Practice Model: Improving Efficiency, Quality, and the Doctor-Patient Relationship," *Family Practice Management* 14, no. 8 (September 2007): 20-24.; Gordon L. Moore, M.D., "Going Solo: Making the Leap," *Family Practice Management* 9, no. 2 (February 2002): 29-32.

employment contracts. In this manner, forging a strong physician-patient relationship is in direct opposition to the capacity of a physician to keep up with both volume measures and maintaining effective therapeutic alliances. The affinity between doctor and patient is especially important in primary care medicine. Knowing a patient as a person and having a relationship built on provider trust and confidence is crucial to patient compliance and thus outcomes. In a proper environment with manageable patient panels effective treatment is easier to realize by way of dynamic partnerships with patients rather than by having incidental contacts with them. In a practical sense, having prudent office space within which to provide patient care and smart-sizing patient panels allows for a level of connectivity that is difficult to accommodate along pathways in corporate medicine. In addition, the nimble use of technology is regarded as an adjunct for enhancing rapport.

The intimacy of the physician-patient relationship and its "in the moment" dimensions are bracketed by the mode of practice a physician embraces. Thus, the caliber of the compact can be examined from the ways this therapeutic alliance is managed. A mainstay of spending more time with patients and smart utilization of technology describes exemplary elements of the micropractice concept. Guglielmo states, "the benefits of ideal micropractices... better efficiency, more time for patient visits, enhanced physician and patient satisfaction—certainly make it a model worth investigating."[7] Schroll concurs that in the contemporary parameters of medicine, "time with patients [is]

[7] Wayne, J. Guglielmo, "What's a Micropractice?" *Medical Economics* no. 51 (December 2006): 55.

limited"[8] and adds that third party entities create "an outrageous intrusion into the doctor-patient relationship."[9] Gordon Moore, M.D. considered a trailblazer in the micopractice concept concludes, "[m]eaningful interaction is the foundation of excellent care, but in many practices, physicians can't afford to spend the time it takes to create these actions."[10]

The physician-patient dyad represents one of the greatest human connections. Wherein the current climate of health care delivery depreciates this alliance, the niche model of micropractice seeks to enhance it. My dissertation delves into the standards held by micropractitioners that contribute to the fortification of this unique accord along with grounding for physician personal and professional appraisal. Chapter 1, *The Post and Presence of the Physician,* examines facets of primary care medicine and how micropractitioners negotiate the therapeutic alliance.

In Chapter 2, *Practical Doctoring and Technology*, I examine innovation and its impact on the clinical encounters physicians have with their patients. In Chapter 3, *Physicianship and Dimensions of Virtue*, I analyze the praxis and art of humanistic care as they relate to practitioners engaged in the micropractice model. Chapter 4, focuses on the research results from a self-designed study on micropractice physicians. The nature of the inquiry was mixed-method and presents both quantitative and qualitative analysis. The eleven-question self-designed survey instrument was constructed on a five point

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[8] Aldebra Schroll, M.D., "A Vision Sparks New Beginnings," *Medical Economics* (July 25, 2011): 39.

[9] Ibid.

[10] Moore, 32.

Likert scale. An invitation with a link provided to SurveyMonkey was electronically sent to 377 physicians who identified as micropractitioners. The list-serve of Ideal Medical Practices, an affiliate network of micropractitioners, was utilized for this purpose; 150 physicians opened the e-survey invitation and 68 physicians responded. One physician submitted a paper response. Survey questions focused on demographics and inquiry on practice style and attributes. The data collected captured information about micropractitioner perspectives on patient-centered care, time, time-aids, access, and continuity of care in addition to self-inventory accounts.

Wherein the quantitative analysis looked at the frequency distributions, qualitative analysis captured overarching thematic patterns. In addition, a semi-structured joint telephone interview was conducted with two eminent physicians known for their understanding of micropractice. The interview was recorded and transcribed in order to ascertain additional predications of micropractitioners and the finer points of its small-scale environment. Close readings were carried out in order to identify statements that were related to overall themes. Systematic investigation and data collection followed Institutional Review Board and Drew University requirements and protocols. In Chapter 5, I discuss my conclusion and final thoughts, which includes considerations for future study.

CHAPTER 1

THE POST AND PRESENCE OF THE PHYSICIAN

Medicine is as old as the human race, as old as the
necessity for the removal of disease.
— Heinrich Haeser

In nothing do men more nearly approach the gods,
than in giving health to men.
— Marcus Tullius Cicero

A Connection of Past and Present

Physicians serve as the principal advocates for the health and wellbeing of the patients they attend to. Designated as agents of healing, they engage in endeavors that ideally are viewed as noble and necessary. For millennia they have been called upon to help and heal. Cast as having special abilities to restore health, the manner by which they care for patients shapes medicine's sphere and trajectory. The title "physician" infers certain prerogatives; the extent of their undertakings inevitably a reflection of the capacities of their craft. Whether or not their acquirements are gauged by superstition or science, physicians have always been viewed as adversaries against illness: the province of their profession is duly wedded to frames of reference regarding health beliefs.

In the earliest days of doctoring, nothing was treated without the element of mysticism. As far back as Babylonia and Mesopotamia: "medicine might be regarded as sorcery systematized. Parallels to this are offered by Egyptian medicine, which developed at the same time and presents comparable healing practices involving prayers, magic,

spells, and sacrifices together with practical drug treatments and surgery."[11] Causes of illness were tied in varying degrees to belief systems in the supernatural. In the era of physician-priests their aura of knack and know-how was distinctly connected to the spirit world.

> Physicians were trained in temple schools and probably remained priests all their lives… [s]pirits and demons 'cause[d]' diseases, and spells [were] used against them. Special gods gave protection against special diseases and invented new remedies for them, while other gods were the authors of disease. Sometimes the same god would both send the disease and cure it. Each limb of the body was connected to a special god.[12]

The body was not seen as a whole but comprised of component parts susceptible to the discretions of malevolent spirits. Taking into account that the goal of medicine is to alleviate disease, "Disease, like other disasters, [was] construed as a result of a transgression against nature or against the world of the enemy… as the intrusion of a foreign object or of an evil spirit into the victim's body and sometimes as the capturing or the loss of the soul from the body."[13] The practice of medicine relied on a three-fold methodology: [1] to avert disease by ritual sacrifice; [2] to abort disease from the body by rites of propitiation or atonement; [3] to expel disease from the body by rites of lustration.[14] These preventative and treatment exercises in the healing arts were a

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[11] Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*. (W. W. Norton & Company, 1999): 46-47.

[12] Erwin H. Ackernecht, M.D., *A Short History of Medicine*. Rev. ed. (Johns Hopkins University Press, 1982): 20.

[13] Edmund D. Pellegrino, *Humanism and the Physician.* (University of Tennessee Press, 1979): 39.

[14] Fielding H. Garrison, A. B., M.D., *An Introduction to the History of Medicine.* (W. B. Saunders, 1929): 82.

complicated mixture of maneuvers tied to the mystical and interpretations of therapeutic techniques considered practical. Although ancient practitioners could provide little curative measures, what they could consistently offer was "the time devoted to the patient… in the performance of the elaborate rituals necessary for cure."[15] There may have been a lack of clinical acuity but the beneficial ingredients of time and effort dispersed during ceremonial endeavors in attempts to restore health cannot be dismissed.

It was Hippocrates of Cos, who elevated the practice of medicine to a completely rational endeavor. "Appeal to reason, rather than to rules or to supernatural forces, gives Hippocratic medicine its distinctiveness. It was also to win a name for being patient-centered rather than disease-oriented, and for being concerned more with observation and experience than with abstractions."[16] Hippocratic teachings stressed, "the naturalistic approach… the value of observation on the disease process… prognosis and treatment."[17] Also, a Hippocratic physician's "first interest was not in a disease manifested by the patient, but in the patient himself. He was concerned with the body as a whole rather than with the lesion of parts."[18] There was attention fully dispensed by the physician to the patient as a person. "The true doctor was no longer intermediary with the gods but the bedside friend of the sick."[19] It was Hippocrates who "virtually founded that bedside

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[15] Pellegrino, 40.

[16] Porte*r*, 56.

[17] Ackerknecht, 58-61.

[18] Ibid., 61.

[19] Porter, 53.

method which has been the distinctive talent of all true clinicians."[20] Hippocratic physicians, "proclaimed their devotion to the patient as person, and they set out to win their patients' trust."[21] This dedication to patients and a desire to serve provides for the special affinity of the physician-patient relationship. Such is medicine's foundation: the provision of beneficent healing endeavors imparted within the one-to-one correlation of physician and patient. Having a trusted caregiver who renders time well-disposed in the pursuit of healing, along with continuity of care have remained expectations of patients to this very day. Nothing has supplanted its paramount importance in the undertaking of healing for over two thousand years. Hence, the practice of medicine ideally consists of a union of all of these facets aimed at restoration of health. It is the contemporary practice pattern of micropractice that resolutely embraces this prescriptive compound in Hippocratic tradition. Whilst the history of medicine is a record of progress and advancement built from expanding knowledge bases, its inherent principles of caring for the patient are chronologically consistent. Micropractice in its simplicity of design allows physicians who practice within this construct the advantage of being *ad rem* healers. Specifically, this compact pattern of practice concentrates physician and patient to the smallest unit so the physician can engage with the patient in a straightforward manner. Physicians in micropractices are on board as the irreducible half of two central actors. By embracing a measured and practical stance to patient encounters micropractitioners are very much aligned to the Hippocratic approach of a strong one-to-one alliance. True to

[20] Garrison, 94.

[21] M. Gregg Bloche, M.D., *the hippocratic myth* (Palgrave Macmillan, 2011): 6.

this tradition, micropractice always situates this formulary at its most deducible simplification thereby enhancing the capacities of care. Hippocrates enacted the time-honored patient-focused interface; micropractice seeks to uphold this clinical connection.

The Doctor and the Dyad

> Only those who regard healing as the ultimate goal of their efforts can, therefore, be designated as physicians.
> —Rudolf Virchow

The entire commentary of medicine from any historical perspective is simply a long winding narrative about the special accord that is the doctor-patient relationship. Resultantly, the practice of medicine and its vitality is determined by how this alliance is administered. Micropractitioners tend to the rectitude of their profession by way of generous physician attendance. They embrace a style of practice that demonstrably affirms "[m]edicine… is an activity whose essence appears to lie in the clinical event… [and]is a practical application of theory… operat[ing] through a relationship of persons."[22] This assemblage of physician and patient constitutes a unit welded together in a problem solving activity. It has a clear-cut roster of members: the physician and patient and it has a defined program of activity: health and healing. The physician and patient roles create a particular pattern according to the place they occupy, and this alignment exhibits certain properties. The individual member responds to the other member in terms of his or her respective place in this unique pattern and the interaction between physician

[22] Pellegrino, 78-79.

and patient reveals a certain structure, channels behaviors, and produces something. It is an extraordinary arrangement of interdependent parts. Over and above this integration of human needs one must also take into consideration the sublime attribute that is anchored to the dimension of a physician's utility. It is embedded within the therapeutic activity and takes form in the post of the physician: a "special role that makes possible the… almost magical connection, that constitutes the doctor-patient relationship."[23]

Buckman and Sabbagh describe the taxonomy of this relationship as one in which:

> [T]here are two major ingredients in every interaction between a patient and a doctor or healer. One of the ingredients in the transaction is usually easy to see and to measure or analyze. It may be a pill, herb, operation, or any other physical form of intervention... However, almost every interaction between a patient and a healer or doctor has another non-material, almost indefinable and perhaps subconscious element. This second ingredient consists of the interaction between the person of the doctor... and the person of the patient. That element is often shrouded in mystery and sometimes in mysticism... that non-material, invisible, inaccessible (and perhaps unmeasurable) constituent 'magic.'[24]

In seeking alleviation of sickness, the present-day drawing power of the physician's station can still effect an allurement not unlike that of ancient priestly practitioners. The "healing art can never be turned into a technique that works by itself—apart from the one who utilizes it."[25] The physician as an indispensable factor in the equation of this paired system is also a part of the medicine itself. Balint phrased it

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[23] Eric J. Cassel, *Doctoring: The Nature of Primary Care Medicine.* (Oxford University Press, 1997): 108.

[24] Robert Buckman and Karl Sabbagh. *Magic or Medicine? An Investigation of Healing & Healers.* (Prometheus Books, 1995): 6-7.

[25] G. Gayle Stephens, M.D. *The Intellectual Basis of Family Practice*. (Winter Publishing, 1982): 163.

eloquently in the concept of "the doctor is the drug"[26] meaning that the patient responds to the persona of the doctor, the atmosphere the doctor generates. Across timelines and among practitioners of all sorts "[h]ealing can be practiced by the prescientific or the unscientific person... [and although]... it should ideally be practiced by the genuinely scientific person,"[27] the assumed role of the physician as healer is not only conducive to driving the formation of this unique human group but it also relates to the product that results from its gathering. The motivational base of doctors who opt for micropractice derives from a sense of wanting to serve their patients rather than merely service massive and unmanageable patient panels: this reflects certain group properties. By being active participants in the care of their patients they always keep the therapeutic relationship patient-focused. This entails requirements that drive their ideals; holding to norms of patient management that fittingly consist of the attributes of compassionate understanding and engaged interchange. The spartan framework of this practice pattern delineates how these clinicians condense to the essentials, standards for the physician-occupied position. "Primary care requires of its practitioners the clinical skills of maintaining therapeutic relationships with many patients over extended periods of time, not only for the chronically ill but for care of multiple episodes of illness and for health maintenance."[28] This focused attention calls for dexterity in intercommunication processes on the part of the physician. The clinical exchange then becomes a therapeutic means. Translated into

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[26] Michael Balint, "Balint Quotations," The Balint Society, http://balint.co.uk-quotations/ (accessed February 10, 2016).

[27] Stephens, 37.

[28] Stephens, 87.

professional behavior it can be defined as a skill set. As primary care physicians, micropractitioners rely on productive conversations with their patients. Proficiency in communication has long been considered part of personal traits or styles of professional technique but judicious communication is a therapeutic asset in clinical medicine. Travaline, et al., define communication competencies, within the healing aspect of the relationship, as "techniques for listening, explaining, questioning, counseling, and motivating. As such, these techniques are central to delivering a full and tailored health prescription."[29] Effective communication on the part of the physician is considered a high value attribute in the provision of quality medical care: an important component of a physician's clinical repertoire. The Council for Graduate Medical Education prescribes that rapport can be increased by: [1] allowing patients to tell his/her own story; [2] listening attentively; [3] using non-technical language and involving the patient; [4] encouraging questions and checking for understanding; and [5] demonstrating ability to counsel and obtain informed consent.[30] Such tutoring can only be reasonably brought to bear when physicians practice in environments where they can interface with patients without bureaucratic interdictions. Hasty patient encounters create a chokehold on lessons proffered.

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[29] John, M. Travaline, M.D., Robert Ruchinskas, PsyD., Gilbert E. D'Alonzo, Jr., DO, "Patient-Physician Communication: Why and How," *Journal of the American Osteopathic Association* 105, no. 1 (2005): 13.

[30] Accreditation Council for Graduate Medical Education, "Global Residency Competency Rating," http://www.acgme.org./acgmeweb/Portals/ 01/PFAssets/ProgramResources/999/GlobalResidency CompetencyForm.pdf (accessed February 20, 2016).

Focused communication and time shape a relationship and garner feelings of safety, security, and trust. It is the aspect of time that allows the physician to know the patient well so anything out of the ordinary can be ascertained and addressed. As previously noted, McKinlay and Marceau point out that with regard to actual face time with the physician, "length of encounter in the Mid-20th century was 15-20 minutes, Late 20th century 6-8 minutes."[31] This circumscribed interface can obviate the development of trust and speaks to an evolution of care in contemporary medicine where time has been designated a commodity. If a physician feels pressured to compress time, logic dictates that his or her frustration can pervade provision of care and affects the manner in which that care is offered. Physicians grapple with demands on time; it is finite and it cannot be increased or be inflated. Effectively managing this key element is the only viable option available by which the physician can hope to nurture a good relationship. Gathering and processing information within an easeful setting can enhance a treatment plan, but is there an optimal factor of time associated with physician satisfaction, patient satisfaction, and better healthcare outcomes when considering the clinical encounter itself? A "physician's level of satisfaction is connected to their perception of the amount of time that they have to do their work,"[32] and "physician satisfaction contributes to patient satisfaction."[33] Within this context, Dugdale et al. cite optimal patient visits per hour as indicators of both physician and patient satisfaction and suggest that, "rates above 3 to 4

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[31] McKinlay and Marceau, 403.

[32] David C. Dugdale, et al., "Time and the Patient-Physician Relationship," *Journal of General Internal Medicine* 14 (January 1999):(Suppl1) S35.

[33] Dugdale et al., S35.

per hour are associated with suboptimal visit content."[34] In concert with the element of time, continuity of care has long been associated with general or family practice. Primary care physicians are positioned to form long lasting relationships with patients. They provide clinical care over timelines that can span acute and/or chronic phases of illness and therefore develop relationships with patients unlike other specialties in medicine. Micropractice as first contact and continuing care is about a "*managerial* role as part of the clinical task physicians perform in rendering primary care."[35] This role "requires a historical understanding of the individual… [s]uch understanding cannot be gained in 'slice-of-life' encounters, no matter how intensive and detailed."[36]

A physician of forty years experience laments the lack of unblurred encounters:

> Physicans are now insulated from knowing too much about their patients. It's all about… the testing, the imaging… the data—once collected by the doctor, but now so regulated and overwhelming the paramedical professionals have been enlisted to record the so-called minutiae, the often rote information in which may lie important clues. Some of these may remain forever buried, the patient not wanting to share sensitive details with just anyone, especially someone who no longer makes eye contact, whose face remains buried behind a computer screen, who seems uninterested or just unskilled in reading body language—that downward glance, that shift in the chair, that half-swallowed response.[37]

Better communication with patients can certainly contribute to better outcomes, and enhanced skills can serve to improve the ability to decipher emotive inferences. "When physicians are skillful at decoding body movement and postural cues to emotion,

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[34] Dugdale et al., S40.

[35] Stephens, 25.

[36] Ibid., 210.

[37] Jerald Winaker, M.D., "In America, The Art of Doctoring Is Dying," *The Washington Post*, (February 12, 2016).

their patients show higher levels of satisfaction and compliance."[38] Pollack, et al. expand this concept by describing additional quality interchanges that physicians should employ such as, "motivational interviewing,"[39] which is comprised of empathy and reflective listening. It is designed to close the gap between patient and physician as they engage with each other and set treatment goals. It requires a physician to be on point at every juncture and position the patient at the center of attention. Operationalizing empathy allows a physician to address a patient's emotions as part of patient-centered care and to do so within a treatment plan that is sensitive and timely. As stated by Mayeroff, "to care for another person, I must be able to understand him and his world as if I were inside it. I must be able to see, as it were, with his eyes what his world is like to him and how he sees himself."[40] Empathic understanding refers to an individual's capacity to understand another person's emotional experience. The most significant of aspects of this cognitive behavior are cited as follows:

> The first goal is for physicians to *cultivate genuine curiosity* about the complexity of human emotional lives, avoiding too simplistic a view. This curiosity will foster attentive listening and help physicians invite patients to share more complicated feelings. The second goal is *nonverbal attentiveness* with the aim of nonverbal attunement. The path to this goal is through practices that instill self-awareness and mindfulness so that physicians can be calm enough to attune to their patients. The third goal is maintaining *genuine, proportional concern* for one's patients, so that when something serious is occurring one can convey

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[38] Shiraz Mishra, M.D. and Howard Waitzkin, M.D., PhD., "Physician-Patient Communication," *Western Journal of Medicine* 147, no. 3 (September 1987): 328.

[39] Kathryn I. Pollack, et al., "Physician Empathy and Listening: Associations with Patient Satisfaction and Autonomy," *Journal of the American Board of Family Medicine* 24, no. 6 (November-December 2011): 665.

[40] Milton Mayeroff. *On Caring.* (First Harper Perennial Press, 1971): 54.

> genuine worry without becoming overly anxious. This skill will promote trust and therapeutic effectiveness.[41]

The technical skills of the physician must therefore be both scientific and humanistic if he or she is to engender trust and provide compassionate care. The following section considers the physician-patient relationship through correlative constructs.

Models of Interaction

> The good physician treats the disease; the great physician treats the patient who has the disease.
> — Sir William Osler

> Invisible threads are the strongest ties.
> — Friedrich Nietzche

The physician-patient relationship does not exist in a vacuum. Recognizing its dynamism helps crystallize the nature and actions of the actors within this set. Emanuel and Emanuel propose four models of looking into the relationship based on ideals originating from sociologist, Maximilian Weber. These serve as constructs to bridge difficulties in encapsulating the entre depth and breath of phenomenology of the therapeutic alliance. Each encompasses essential aspects important to patient autonomy

[41] Jodi Halpern, "Clinical Empathy in Medical Care," in *Empathy,* ed. Jean Decety (MIT Press, 2012): 240.

and physician obligation. The models proposed are, "The Paternalistic Model, The Informative Model, The Interpretive Model, and The Deliberative Model."[42]

Within the Paternalistic Model, a physician employs a biomedical framework. He or she assesses the patient's medical condition, prescribes appropriate tests and treatments and presents information to the patient. This model presumes the patient will comply with the physician's authority in order to promote and restore health. The physician obligation is to place the patient's interests above his or hers and to act as an authoritative agent, although this model is illustrative of physician dominance and patient passivity. According to Beauchamp and Childress, their definition of [P]aternalism prevails upon neutrality and define the principle as:

> the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the good of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden. Although the definition assumes an act of beneficence, analogous to parental beneficence, it does not prejudge whether the beneficent act is justified, obligatory, misplaced, or wrong.[43]

The model as presented by Emanuel and Emanuel embraces physician oversight and assumes limited patient value or voice even though the patient's wellbeing is paramount to the decision making process. Thus, to a degree, a patient may feel disenfranchised.

The second model is the Informative Model. In this model the physician provides the patient with all pertinent facts, risks/benefits of all interventions, and the patient makes the decision as to what treatment best meets their individual values. The physician

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[42] J. Emanuel Ezekiel, M.D., PhD. and Linda L. Emanuel, M.D. PhD., "Four Models of the Physician-Patient Relationship, *Journal of the American Medical Association* 267 (16 April 1992): 2221.

[43] Beauchamp and Childress, 215-216.

as truthful technician provides a consumer of healthcare with all necessary facts for an informed personal choice. The patient as client has full control of treatment options and interventions. This model can be seen as candid, clinical, and analytic.

In the Interpretive Model, a physician explores the patient's wishes aligned to their particular value set and assists the patient in "interpreting" their values as they apply to their medical situation. It is a biopsychosocial model whereby the physician acts as medical adviser and guide. In this functional role, patient narrative is accented and patient values are explored and appropriately applied to the selected treatment plan. This model does not take into account the time sensitive clinical encounter. Whereas, this model might inaccurately represent a preferred approach, in reality it may impose physician value judgments onto the patient when considering the restriction of time factored into the clinical encounter.

The Deliberative Model helps the patient determine and select the best possible health care option for him or her. Patient autonomy is paramount and patient values pertinent to health and wellbeing are arrived at through dialogue and deliberation with the physician.

In this model it can be assumed the physician and patient have a history together, that the physician knows the patient well and there is personal regard for one another. There is a role for deepened trust in this model.

Table 1 depicts the differential aspects of each model:

Table 1 – Comparing the Four Models

	Informative	**Interpretive**	**Deliberative**	**Paternalistic**
Patient's values	Defined, fixed, and known to the patient	Inchoate and conflicting, requiring elucidation	Open to development and revision through moral discussion	Objective and shared by physician and patient
Physician's obligation	Providing relevant factual information and implementing patient's selected intervention	Elucidating and interpreting relevant patient values as well as informing the patient and implementing the patient's selected intervention	Articulating and persuading the patient of the most admirable values as well as informing the patient and implementing the patient's selected intervention	Promoting the patient's well-being independent of the patient's current preferences
Conception of patient's autonomy	Choice of, and control over, medical care	Self-understanding relevant to medical care	Moral self-development relevant to medical care	Assenting to objective values
Conception of physician's role	Competent technical expert	Counselor or adviser	Friend or teacher	Guardian

Source: Data adapted from Ezekiel J. Emanuel, M.D., PhD., and Linda L. Emanuel, M.D., PhD., "Four Models of the Physician-Patient Relationship" Journal of the American Medical Association 1992; 267: 2222.

Each model provides for a role and a set of performances by each actor. Although Emanuel and Emanuel contend that it is the Deliberative Model they advocate, it can be argued that each of these models may be applicable to a vast range of medical backdrops, and can speak to situations that may call upon the physician to carry out his or her duties by reflecting upon the moment and asking—what kind of doctor do I need to be for this patient today? Micropractice allows a physician the latitude to answer this question without having to bend to pressures of time.

The Dyad, the Disunity

> What happens then is like what happens when we separate a jigsaw into its five hundred pieces. The overall picture disappears. This is the state of modern medicine. It has lost the sense of the unity of man. Such is the price for its scientific progress. It has sacrificed art to science.
> — Paul Tournier, M.D.

How is the convention of doctor and patient rendered in contemporary medicine? Expectations about care evolve from advances in everyday life in addition to medical discoveries that revolutionize concepts of disease: the relationship between doctor and patient continually seeks to synthesize itself within these factors. For the physician, the delivery of care and the prescribing of treatment are indeed predicated on the climate of the times. The characteristics of present day medicine can be traced along the chronological lines of corporate medicine, which according to Starr, "has been in the making...since the passage of Medicare and Medicaid... pressure for efficient, business-like management of healthcare has also contributed to the collapse of the barriers that traditionally prevented corporate control of health services."[44] In Starr's estimation the "medical-industrial complex"[45] of the 1970s that was the intertwining of physician, the hospital, and all ancillaries morphed into a series of mergers and cost containment measures. The business of medicine unfolded and medicine was placed in a position to be managed.

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[44] Paul Starr. *The Social Transformation of American Medicine*, (Basic, 1982): 428.

[45] Starr, 428.

The micropractice concept can be viewed as having evolved from the hollows of current assembly-line medical care. Micropractice pushes forth along the edges of contemporary health care delivery. Dr. Starr did not envision its attraction and germination amidst the metamorphosis of modern medicine. He was wrong when he postulated:

> Physicians' commitment to solo practice has been eroding… The longer period of residency training may cultivate more group-oriented attitudes. Young doctors may be more interested in freedom from the job than freedom in the job, and organizations that provide more regular hours can screen out the invasions of private life that come with independent professional practice.[46]

Micropractitioners embrace a pragmatic approach to this scenario: independent practice by means of a practical approach to office management and its associative need for clinical data collection provides a platform for high quality patient care along with a work-life balance. Such is a formulation Starr did not conceptualize. This might seem somewhat starry-eyed but Moore describes it as, "We've got the Norman Rockwell thing going plus the software."[47] Swaby-Ellis notes, "physicians who perceive themselves as caring are frustrated by a health care system that discourages the development of a close relationship with patients."[48] These physician pathfinders see the micropractice design as a directive for what it means to be a good doctor and for the provision of excellence in medical care. Current day health care delivery looks upon a physician as a technician of

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[46] Starr, 445-446.

[47] Gordon Moore, M.D., comment in "It's about time, say doctors in vanguard; with micropractices, they give patients better access and cut overhead costs," Kathleen Kerr, *Los Angeles Times* (July 10, 2007).

[48] E. D. Swaby-Ellis, "The Caring Physician: Balancing the Three e's: Effectiveness, Efficiency, and Empathy," in *The Crisis of Care: Affirming and Restoring Caring Practices in the Helping Professions.* Susan Phillips and Patricia Brenner, eds. (Georgetown University Press: 1994): 85.

sorts or mere provider of a service and a patient as a consumer of those services. This attempt at restyling the physician-patient relationship can cast an antiseptic overlay onto the dyad. The genesis of how current day medicine is typically practiced finds its roots in the "shake-out and retrenchment"[49] of hospital and physician alignments which were poorly conceptualized in the 1990s. The economic characteristic of the time was that hospitals competed for market share and there was a desire to "convert the 'cottage' industry of physician practices"[50] thus, achieving market superiority. As the delivery of medicine was being reformatted, "medical practice shifted to ambulatory settings and physicians became less connected to the hospital on a daily basis."[51] The main concerns of the day for both hospital and physician were fortifying revenue streams and increasing market strength in light of managed care constraints. Physicians formed mega-groups, and hospital systems sought to recalibrate the traditional notion of how physicians and the hospital interacted. Physicians had always been a variant of serving as volunteers. As cited by The Camden Group, "Hospitals focused on gaining market share in key service lines. This made them willing to negotiate with payers on price... and seek new ways of relating to their medical staff, including integrating primary care physicians into their systems as a response to managed care."[52] Seeking refuge from solo practice or small group practices highlights the steady erosion of a physician's independence. Increased

[49] Mary Witt and Laura Jacobs, "Physician-Hospital Integration in the Era of Health Reform," The Camden Group, White Paper (December 2010): 2.

[50] Ibid., 6.

[51] Ibid., 13.

[52] Witt and Jacobs, 13.

expenses stemming from operating costs and overall administrative burdens can make the very practice of medicine almost unsupportable if one decides to hang out their shingle alone in a conventional configuration. The Medical Group Management Association lists 2010 total operating costs even for cost sharing multi-specialty practices, as percentage of revenue at 64.2 percent.[53] The declining economies of traditional private practices, therefore, make the collaboration between physicians and hospital attractive to the masses. A 2012 survey in Becker's Hospital Review cites, "one in three physicians is seeking transition to hospital employment."[54] Physicians are seeking a level of financial security but professional uncertainties remain. Although physicians and hospitals have always been interconnected through patient care, the dynamic of physician integration poses a practice model that may be challenging for the therapeutic relationship. Physician integration that began in the 1990s has gained greater traction in the current day as collaboration to achieve both quality and reduce cost has intersected with typical start-up costs and operational expenses of private practice. Health care delivery is being reformatted and care pathways are being remolded by a number of overarching issues. Physician integration introduces the demand for productivity and salaries that are tied to a level of performance in the clinical setting. Understanding these forces that prevail upon physicians gives clarity to the effects that this may have on the physician-patient

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[53] Medical Group Management Association, "Industry Data," http://www.mgma.com/ (accessed August 1, 2014).

[54] Molly Gamble, "Number of Independent Physicians Expected to Drop to 36% by Year's End." *Becker's Hospital Review* (November 2012), http://www.beckershopitalreview.com/hospital-physician-relationship-number--of-independent-physicians-expected-to-drop-to-46-by-years-end.html (accessed August 1, 2014)

relationship. Merritt Hawkins explains performance pay in terms of Relative Value Units, as defined by the Centers for Medicare and Medicaid Services, which are used to establish the relative level of time and intensity that is needed to provide a given health service. Work RVUs are applied in establishing physician work productivity and "volume-based metrics are attached to the number of patients physicians see or the amount of revenue they bill or collect."[55] Work output is then determined by a set of goals, according to service volumes. Simple calculations would evidence that the more patients a physician sees, the greater the amount of revenue generated. Physicians may then be incentivized to see more patients, which may contravene the importance of time in the physician-patient relationship. Service volumes, by reason, would increase the utilization of ancillary services for the hospital system, and greater utilization of these services would increase market leverage. Volume based services would ultimately fortify the bottom line for the system. Therein lies controversy for the physician-patient relationship. Although quality of care and quality improvement are commonly linked to guidelines for performance based pay, the American College of Physician has stated that the:

> current incentives that could result in de-selection of patients, 'playing to the measures' rather than focusing on the patient as a whole, misalignment of perceptions between physicians and patients...have the potential to harm access to care, continuity of care, the patient-physician relationship, and care for those patient with complex chronic disease.[56]

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[55] Merritt Hawkins, "RVU Based Physician Compensation and Productivity," http://www.merritthawkins.com/pdf/mhaRVUword.pdf (accessed August 6, 2014).

[56] American College of Physicians, "Pay-for-Performance Principles that Ensure the Promotion of Patient Centered Care—An Ethics Manifesto." Professionalism and Human Rights Committee Position Paper (2007).

The primary aim of any quality measure should always focus on the individual patient, and tying physician reimbursement to measures of performance places the practice environment within a manufacturing mentality. Bean counting can eclipse being “in the moment” with a patient: the authenticity of the relationship replaced by mechanisms of control and efficiency.

Does health care delivery create a devaluation of the physician-patient relationship in the quest to fortify the bottom line? An employed physician has a contract, and every contract has accountability provisions. The objectives of a system hierarchy dictate the binding terms. There are contracts where base salaries are protected and there are contracts in which salaries are eroded if production standards are not met. The quandary physicians can face based on contract stipulations are many, such as, when what may be fundamentally needed for a patient is supported by the bounds of professionalism, yet is in contention with what is financially endorsed by the hospital system. Clinical effectiveness versus cost of a clinical approach may not always be aligned. If a physician is practicing efficient and effective clinical care and the system encourages maximum utilization of specific services, a physician faces serving two masters. Health systems may utilize physician integration models to secure physician loyalty and enlarge patient pools, but what about the vitality of the physician-patient relationship? Howard Brody contends:

> It is relatively easy to measure the percentage of diabetic patients for whom the physician has ordered a glycohemoglobin level test in the last 12 months. It is much more difficult to measure the components of the patient-physician encounter that go toward creating and sustaining a personal relationship. In all such cases, the measurable usually drives out the important. When physicians are

> paid a lot for doing discrete, technical procedures and very little for spending time with and talking to patients, we have the sort of health system we have today, which is long on procedures and short on meaningful relationships.[57]

The critical drivers of a strong relationship can well be considered discretionary when measurement of physician efficiencies and volume-based metrics reshape the practice behavior of employed physicians. "Clinicians think one patient at a time and administrators think aggregate patient calculations."[58] If a physician can step back from the numbers long enough, it may be manageable to see each patient as an individual, although patient responsibilities and institutional policies can create tensions of dual agency. A system hierarchy provides the necessary conduits for a physician to care for patients but the vigor of a health care system is an end unto itself. A physician's treatment of patients within the landscape of the institutional setting depends on factors of time and efficiency to the benefit of institutional gains in the marketplace. The factors of time and efficiency in a micropractice are aligned solely for the benefit of the individual patient and the physician, the two most important stakeholders. The principles of a micropractice include:

> Care driven by the patient's need, goals and values versus the practice priorities. The majority of office time is spent with the physician rather than spent waiting. [Even] though the physician is able to see fewer patients per day, the physician does not have to generate high numbers of visits to cover overhead or to meet [metrics] though micropractices measure themselves on performance data... Because of reduced overhead these practices need to see fewer patients thereby

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[57] Howard Brody, M.D., Ph.D., "New Forces Shaping the Patient-Physician Relationship," *Virtual Mentor* 11, no. 3 (March 2009): 256.

[58] Kathryn Bailey, MBA, Executive Director Physician Services, Florida Hospital New Smyrna, interview by author, (March 31, 2014).

> allowing doctors...to feel more in control and avoid the devastating consequences of 'productivity fatigue.'[59]

In response to a variety of factors that includes physician task performance, some health systems are introducing novel approaches to delivery of care by mimicking a Marcus Welby era. A trending model is a team-based medical home that purports to impart a warm and fuzzy feeling to counteract the cold antiseptic care often felt within institutional parameters. Cassidy lists two principles that are emblematic of a medical home. They include the concept that, "each patient has close ongoing contact with a clinician for continuity of care, and second, that this clinician takes the lead on referring the patient to specialists when needed."[60] A generic staffing model as delineated by Group Health consists of, "physician, physician assistant, nurse practitioner, registered nurse, licensed practical nurse or medical assistant and pharmacist."[61] An American Hospital Association white paper suggests that roles and responsibilities be formulated in new primary care environments, such as depicted in medical homes, which maximize the scope of practice for the team members providing care for patients. The recommendations are as follows:

> The physician role is to diagnose, oversee the plan of care and care for complex patients. The physician assistant diagnoses and oversees the plan of care under physician supervision. The advanced practice nurse diagnoses and provides the

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[59] Moore and Wasson, 22.

[60] A. Cassidy, "Patient Centered Medical Homes: A New Way to Deliver Primary Care May Be More Affordable and Improve Quality. But How Widely Adopted Will the Model Be?" Health Affairs, Robert Wood Johnson Foundation Health, Policy Brief (September 14, 2010).

[61] Michael Erickson, et al., "Medical Home Model: Patient Centered Care," Group Health, http://www.slideshare.net/grouphealth/the-medical-home-patient-centered-care (accessed March 1, 2016).

> plan of care. The registered nurse triages patients, provides education and overall care management. The medical assistant provides direct patient care.[62]

New and emerging care delivery models reframe role and task, which necessitates a new paradigm, especially for physicians. Team-based care may require a round table design of care delivery with lines drawn against traditional physician undertakings. The doctor's role in this configuration might be a retrograde progression from the traditional position of "giving orders." A physician may not necessarily be viewed as the categorical authority, but rather as a valued team member. High performance teams are characterized by trust in one another so consensus building seems to be indicative of how these new care models might be optimally driven—whomever may be designated as team leader. Team-based patterns of care as in the medical home are a trending example for primary care health delivery. This model attempts to restyle the role of physician with patients and as Brody states:

> If the medical home concept develops as now envisioned, patients will find themselves experiencing an ongoing personal relationship with, not one individual, but a facility and team of individuals...Transferring allegiance from a primary physician to a care team and clinic facility could lead to a diminished sense of a personal relationship.[63]

This pattern of care may reconfigure the conventional physician-patient dyad. If the occupying positions that anchor the physician-patient interchange are removed, nurse or other professional in place of physician, the entire character of the grouping may be transformed. Status and role relations become interchangeable, but are they

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[62] American Hospital Association, "Workforce Roles in a Redesigned Primary Care Model" White Paper (September, 2011): 5.

[63] Brody, 254.

commensurate? Experience of continuity of reliable care only happens when at every juncture along the care pathway, patients feel the provider knows them well and that the provider has appropriate knowledge and information to adequately care for them. Care has to be, in essence, flawlessly connected. The design of multiple providers does not equate to identic care or to continuity in and of itself. Consultative management designs where the rendering of care is set by management methodology can designate a physician's position to that of any widget. But in medicine, there is always judgment needed in the face of uncertainty. As Montgomery asserts, "the practice of medicine is an interpretive activity. It is the art of adjusting scientific abstractions to the individual case."[64] Physicians may be viewed as providers of a product, and management of the health care marketplace may consider the exclusive bounds of care by a physician to be incrementally outdated. But it should be noted that in the end care is relational, and there will always be patients who feel they wish to have their care delivered by a physician and there will always be physicians who wish to render that care. A Merritt Hawkins survey conducted in June 2012 reveals physicians are divided on the efficacy of the medical home concept, "Many (37.9 percent) remain uncertain about their structure and purpose, and close to 92 percent of physicians are unsure where the health system will be or how they will fit into it three to five years from now."[65] Is the care being delivered through a cadre of allied health professionals and being so devised that the physician is so many

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[64] Kathryn Montgomery Hunter. *Doctor's Stories.* (Princeton University Press, 1991): xvii.

[65] Merrit Hawkins, "National Survey Points to a 'Silent Exodus' of Physicians," http://www.MerrittHawkins.com/uploadedfiles/ MerrittHawkins/pdf/mhafoundation2012/surrelease.pdf (accessed August 30, 2014).

standard deviations away from mainstream care? Singleton states, "it may be no exaggeration that the [health] industry will see 75 percent of the nation's physicians employed by hospitals in 2014,"[66] which could mean further erosion of physician independence. Physician integration allows a physician to be relieved of the burden of running a business but Becker's Hospital Review does cite some challenges employed physicians face within these circumstances such as "[feeling] disadvantaged by limited influence in decision making, too many rules, being bossed around by management, and burdensome productivity formulas."[67] Conventional roles for physicians as care providers offering routine episodic care are being reformatted. The contemporary practice of medicine portends task shifting and transitioning to team-based care designs that tout interdependence and newly created professional skill mixes. These circumstances hold both positive and negative aspects for primary care physicians. Physicians must decide for themselves what best meets their vision of a doctor's function in caring for patients. A physician's role need not be purely transactional or incidental to the care of a patient. Discontent with leviathan systems can serve as motivation for physicians who view themselves as principled practitioners of medicine's ethos in that they wish to "reclaim an

[66] Travis Singleton, "Hospitals will employ three-quarters of physicians in 2014," in *Fierce Practice Management, Operations and Business Management*. http://www.fiercepracticemanagement.com/story/survey-hospital-employment-eclipse-private-practice/2012-07-08 (accessed August 1, 2014).

[67] Molly Gamble, "The Good & Bad: 20 Things Physicians Like, Dislike about Hospital Employment," *Becker's Hospital Review* (March 14, 2014).

older, leaner style of medical practice...where open access to the physician leads to improved doctor-patient interaction."[68]

The Micro Movement

The practice of medicine will be very much as you make it.
—Sir William Osler

"Physicians who perceive themselves as caring are frustrated by a health care system that discourages development of a close relationship with patients."[69] Regarding the state of delivering health care, Swaby-Ellis asserts, "We should focus on the doctor-patient relationship more. When this is sacrificed for convenience, economics, or efficiency, we sacrifice our capacity to care."[70] The conventions of micropractice allow a physician to attain meaningful physician-patient relationships against the grain of mega-medicine. Micropractice is about process and capabilities; it "defies the conventional wisdom of practice management experts who urge doctors to boost their productivity by delegating non-physician chores."[71]

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[68] Medical Economics, "What is a micropractice?" (2006), http://www.idealmedicalpractices.org/ ststic/medeconIMP.pdf (accessed April 9, 2014).

[69] E. D. Swaby-Ellis, "The Caring Physician: Balancing the Three E's: Effectiveness, Efficiency, and Empathy," in *The Crisis of Care: Affirming and Restoring Caring Practices in the Helping Professions.* Susan Phillips and Patricia Brenner, eds. (Georgetown University Press, 1994): 85.

[70] Ibid., 85.

[71] Robert Lowes, "Small Practice Evolution: The Medical Micropractice," *Modern Medicine*, http://www.modernmedicine.com/modernmedicine/ content/printContentPopup.jsp?id=522081 (accessed November 15, 2015).

Gordon Moore, M.D., credited with the breakthrough move to this medical model, held the notion that medicine's true north is attained by medializing the interface between physician and patient in the primary care setting. His impetus to "go solo and go small" is articulated as follows:

> Not long after I finished residency, I began to realize that medical practice wasn't the bundle of unfettered joy for which I had yearned... I began to be embarrassed by the monotonous frequency with which I started patient encounters with, "Sorry I've kept you waiting." I was chagrined when my open-ended question, "What can I do for you today?" was met with, "I was sick last week but thought I might as well come in today since it's so hard to get an appointment."[72]

In this smallest of serviceable work units:

> A micropractice doctor typically works without employees in a space that's drastically smaller than what the average soloist has. Such austerity reduces the customary overhead by 40 to 50 percent thereby lowering the break-even point and enabling micropractitioners to spend more time with fewer patients.[73]

This creates an atmosphere that allows the interaction between physician and patient to avoid the encirclements of customary practices. When the pace of medicine discourages a doctor from experiencing any appreciable gratification from the practice of medicine, the prescriptive actions of Dr. Moore encapsulate a commonsense restorative:

1) eliminate barriers between the patient and the doctor
2) make time for meaningful interaction
3) invest in technology that puts scientific and patient information at the physician's fingertips[74]

To achieve these goals one must structure the practice on a nano-scale and critically examine revenue and expenses as shown in the overview provided in Table 2.

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[72] Gordon Moore, 29.

[73] Lowes, 1.

[74] Gordon Moore, 31-32.

Table 2 – Average Monthly Revenue and Expenses for 12 One-Doctor Ideal Medical Practices

Revenue per Month	**$17,829**
Patients per day	11
Days per week	4.6
Weeks per month	4.05 (48.6 per year)
Average reimbursement per visit	$87
Expenses per Month	**$7,562**
Employee	$2,160
Malpractice	$797
Rent	$1,547
Loans	$534
Telecommunication	$286
Medical supplies	$358
Dues/fees	$126
Billing	$297
Office supplies	$124
CME	$166
Office software	$148
Business insurance	$130
Accountant/legal services	$103
Marketing	$80
Computer technical support	$172
Computer hardware	$90
Personal/family insurance	$238
Disability/life insurance	$98
Auto insurance	$83
Other insurance	$25
Net Revenue per Month	**$10,267 ($123,204 per year)**

Source: Data adapted from L. Gordon Moore, MD and John H. Wasson, MD, "Improving Efficiency, Quality and the Doctor-Patient Relationship," Family Practice Management 2007, September; 14 (8): 22.

When reviewing the financial data for these 12 micro practices, it is important to acknowledge that although the model is financially sustainable for many, it is challenging in certain environments because of immense variation in payers rates and policies, malpractice rates and cost of living. For example, average local payment for a 99214 visit can range from as little as $62 in one region of the United States to more than $140 in another. Similarly, a doctor in Eugene, Ore., may pay $1000 per year for malpractice insurance while another in Chicago may pay $35,000 (neither including OB or special procedures).[75]

[75] Gordon Moore, 22.

Given these variables, micropractice is not for everyone. A physician requires the conviction "to wear the many hats in order to keep overhead lean... If you don't want anything to do with administrative duties, this isn't the kind of practice for you."[76] Also, if you are a physician who seeks a high net income, this is not the mode of practice for you. Physicians drawn to micropractice seek to avert the congestion surrounding day-to-day clinical care. They aim for a sense of fulfillment in their life's work in preference to profuse profit. For Dr. Donald Stewart, after 25 years in medicine he began a micropractice. He did so in order to break with a common algorithm of practice progression and its accompanying oppressions. As described by Dr. Stewart:

> You start a practice, you work hard, you see a lot of patients, you grow the practice, you hire more doctors, you keep growing the practice... The problem is that in primary care, the economy of scale doesn't work. Pretty soon you hire an office manager and someone to deal with all the government regulations and so on. At his group practice...five doctors needed a support staff of 22, which means you have to see patients more quickly because of the overhead.[77]

In big business environments where expenditures are a significant part of operations, overbooking is typical, and face-time with the physician is minimal. Professional satisfaction erodes when the coercive measures of bureaucratic routines become more important than the patient. For Dr. Stewart, micropractice allowed him to

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[76] Wayne J. Guglielmo, "What's a Micropractice?" *Medical Economics* (December 1, 2006), http://www.idealmedicalpractices.org/static/medeconIMP.pdf (accessed March 15, 2016).

[77] Erik Lacitis, "Doctors Going Solo with Micropractices; Leaving a Group Practice Can Mean Less Paperwork, More Time with Patients," *The Washington Post* (May 4, 2008).

recapture his joy for medicine. “It’s the most fun I’ve had since I started in medicine 25 years ago... I’m having enough time with patients so I can enjoy working with them.”[78] Patients need time to talk and physicians need undivided time so they can listen; this scenario predisposes the attentiveness of the practitioner squarely on the patient without the tumult of distractions found in big business medicine. Table 3 illuminates the differences in micropractices versus mainstream practices.

Attributes of micropractice cast physician and patient squarely in the problem solving activity mode relying on sufficient time, easy access, and quality of care. Quality indicators used to capture meaningful data for micropractices as put forward by Moore and Wasson include:

1) I receive the care I want and need.
2) My care is perfect.
3) My doctor’s office is efficient, well organized, and does not waste my time.
4) My doctor’s office provides excellent education on my condition.
5) My doctor is aware of my emotional needs.[79]

[78] Erik Lacitis, “Doctors Find Going Solo Painless,” *The Seattle Times* (September 6, 2007).

[79] Moore and Wasson, 23.

Table 3 – The Mark of an IMP

Ideal Medical Practices	Typical Practices
Care is driven by the patient's needs, goals and values	Care is driven by the practice's priorities
Access is 24-7	Access is 9-5
The care team uses technology to its fullest (e.g., electronic health records, e-mail, Internet scheduling)	The care team avoids new technology
Patients can see their own physician whenever they choose	Patients must see whoever is available
The majority of the office visit is spent with the physician	The majority of the office visit is spent waiting
Overhead is low	Overhead is high
Patients are seen the same day they call the office	Patients typically wait for an appointment
Physicians are able to see fewer patients per day	Physicians must generate high numbers of visits per day to cover overhead
Practices measure themselves regularly	Practices have little or no performance data
Practices are proactive in their care of patients with chronic illnesses	Practices are reactive in their care of patients with chronic illnesses
Physicians are satisfied and feel in control	Physicians feel harried and overbooked

Source: Data adapted from L. Gordon Moore, MD and John H. Wasson, MD, "Improving Efficiency, Quality and the Doctor-Patient Relationship," Family Practice Management 2007, September; 14 (8): 21.

Moore and Wasson assert these care experiences correlate to better clinical outcomes:

> A key step in taking control in our practices is taking control of the measurement—that is, measuring ourselves to understand how we are doing and to demonstrate our value to others. Ideal medical practices build quality measurement into all patient interaction using a few key measures that focus not only on 'what is the matter' with the patient but also on 'what matters to the patient.'[80]

[80] Moore and Wasson, 22.

Micropractitioners see themselves as agents of healing, providing care that is both noble and necessary in a traditional and historic sense. Its no-frills framework inspires those wishing for an authentic connectivity to patients. Its lean and practical approach to care earmarks a physician as the principle advocate against ill health: working toward an outcome that is beneficial to the patient while at the same time providing professional fulfillment to the practitioner. In Chapter 2 this author explores doctoring and technology.

CHAPTER 2

TECHNOLOGY AND PRACTICAL DOCTORING

One machine can do the work of fifty ordinary men.
No machine can do the work of an
extraordinary man.
— Elbert Hubbard

Any sufficiently advanced technology is
indistinguishable from magic.
— Arthur C. Clark

A Historical Perspective

Medicine's lineage has always included administering remedial treatment to patients through the utilization of contrivances. Implements to ameliorate illness have long been included in the annals of the art of healing. On one hand it might have been modifying a tree branch to reinforce someone's balance or employing a crude apparatus to cut and excise; devices have been duly constructed to solve problems and to help patients achieve health related goals. Although the utilization of iatrical objects has been part of the repertoire of doctoring throughout time, there is a turning point when the rough-hewn transforms into cutting-edge therapeutic know-how. At this interchange, when an implement burgeons into nascent technology, it amends the manner by which medicine is thought about and rendered.

Merriam-Webster defines technology as "knowledge of crafts or tools derived from the Greek word *techne*."[81] Duffin illuminates:

> Technology...refers to the tools in the service of an intellectual enterprise. Tools can be objects, practices, or even ideas; social and conceptual factors both influence their invention. Once established, technologies not only alter practice, they also change perceptions of illness, patients, doctors, and disease.[82]

Although the mark of invention seems to prevail upon a social setting with tremendous velocity, it is important to understand that:

> Usually... they have a long prehistory, during which the inadequacy of old ways – the 'need'- is defined. Conditions that favor scientific discoveries are related to changes in ideas about the body, but they also incorporate factors from society, politics, economics, culture, and philosophy. In this sense, a discovery does not explode on a scene so much as it emerges from a milieu.[83]

The most prominent example that encapsulates the evolution of tools and technological advancement in the realm of medicine is the discovery of auscultation and the subsequent invention of the stethoscope. It is heralded as, "one of the most fascinating and stimulating stories in medicine, and is a striking record of the combination of genius and industry."[84] By the nineteenth century, the outcome of generations of catalogued observation of the human body lead to a level of understanding about the relationship between symptoms and anatomy. With regard to cardiac problems, before this time,

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[81] Merriam-Webster, http://www.merriam-webster.com/dictionary/techne (accessed March 8, 2014).

[82] Jacalyn Duffin. *History of Medicine: A Scandalously Short Introduction*, 2nd ed. (University of Toronto Press, 2010): 221.

[83] Ibid., 222.

[84] R. A. Young, M.D., B.Sc.,F.R.C.P., F.S.A., "The Stethoscope: Past and Present," Presidential Address delivered before the Medical Society of London, October 13, 1930. *Lancet* vol. 216, no. 5590 (1930): 883.

"physicians could only listen to the heart by applying their ear directly to the chest. This 'immediate auscultation' suffered from social and technical limitation, which resulted in its disfavor."[85] Aversion to palpation and touching during this period of history was connected to strict rules of demeanor in European society. Modesty was of paramount importance especially in the treatment of female patients and professional propriety was ruled by constraints of gender and social stratum.

Dr. Rene Laennec made a remarkable revelation at the bedside of a female patient, "the 'discovery' was simply the rediscovery of a phenomenon: sound can be transmitted through a mediator."[86] Rectitude required Laennec to follow the decorum of the times. So as not to directly touch his female patient and keep the requisite distance, he "rolled a notebook into a cylinder, placed one end on her chest, the other to his ear, and was astonished to hear the beating of her heart."[87] Visualizing internal anatomy through his sense of hearing was a "clinicopathological correlation,"[88] and Laennec's newly invented cylinder was named "stethoscope after the "Greek words for 'chest' and 'to explore.'"[89] Although it was "the first diagnostic instrument to achieve rapid international popularity,"[90] embracing change is often difficult. Even with the sweeping advances in medicine brought about by Laennec's insight and innovation, there were those who

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[85] Ibrahim R. Hanna, M.D., and Mark E. Silverman, M.D., "A History of Cardiac Auscultation and Some of Its Contributors," *The American Journal of Cardiology* vol. 90, no. 3, (August 2002): 259.

[86] Duffin, 226.

[87] Ibid.

[88] Ibid.

[89] Ibid.

[90] Ibid., 229.

resisted the transition. As noted by Shorter, "around the turn of the century… [some] physicians of the old school carried a stethoscope, not from any personal conviction of its efficacy as an aid to diagnosis, but in deference to the prejudices of younger colleagues."[91] The physicians who endorsed scientific progress were clearly at an advantage. Archaic ways were transformed into advancement through instrumentation. This acoustic device led to an established standard of practice for listening for breath sounds that is still used today. Even though the stethoscope has been modified and refined over time, the instrument itself has seemingly become such a defined symbol associated with physicians, that the age old adage, "hanging up one's stethoscope"[92] is taken to mean a physician's retirement.

All discoveries have impact and how they fit into the arena of clinical medicine is predicated on the times. Laennec used his ear to help his eyes envision the internal structures of his patient, but actually seeing images not visible to the naked eye, is probably medicine's greatest technological asset. The birth of medical imaging took place over one hundred and twenty years ago. In 1895, Wilhelm Rontgen, who studied electric currents through gas realized, "when a voltage was applied between two metal plates …a weak light appeared on a screen a bit away even though the glass tube was shielded."[93] This discovery of the phenomena of x-rays revolutionized clinical care and won Rontgen

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[91] Edward Shorter, *Bedside Manners: The Troubled History of Doctors and Patients* (Simon and Schuster, 1985): 83.

[92] Donna Littlejohn, "At 90, Gardena Doctor Is Hanging Up His Stethoscope," *The Daily Breeze* (October 29, 2013).

[93] The Nobel Prize Organization, "Wilhelm Conrad Rontgen—Biographical," http://www.nobelprize.org/nobel_prizes/physics/laureates/1901/rontgen-bio.html (accessed March 20, 2014).

a Nobel Prize in Physics in 1901 "in recognition of the extraordinary services he has rendered by the discovery of the remarkable rays subsequently named after him."[94]

Imaging and visualization has decidedly changed the way medicine is practiced or even thought about. From a certain perspective, all subsequent generations of enhanced visualization refined the ability to diagnose. Medicine, through the use of x-ray, was able to do more in response to disease detection than ever before. Invasive surgical procedures could be duly prevented or they could be precisely indicated. Technological applications allowed physicians to see beyond certain barriers. With the advent of the X-ray, "even if there wasn't much the doctor could *do*...he could make the *diagnosis*."[95] Physicians armed with scientific certainty were empowered even when powerless. Medicine was becoming information-based and "diagnostic technologies were invented to 'see' beyond the patient's story into the patient's body to identify material basis for the symptoms."[96] Standard operating procedure was being geared toward the authority of technology.

"By the beginning of the twentieth century, X-rays, and a host of other inventions had added to medicine's capabilities...no longer could a doctor deliver state-of-the-art care …[without] equipment and other gadgetry."[97]

> Diagnostic instruments...began to expand the physicians' sensory powers in clinical examination. The use of the stethoscope, at least momentarily, required a physician to isolate himself in a world of sounds, inaudible to the patient. Diagnostic technologies…such as the X-ray…and machines that generated data

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[94] The Nobel Prize Organization, "The Nobel Prize in Physics 1901," http://www.nobelprize.org/nobel_prizes/physics/laureates/1901/ (accessed March 20, 2014).

[95] Shorter, 89.

[96] Duffin, 234.

[97] Bloche, 8.

> on patients' physiological condition...produced data seemingly independent of the physician's, as well as the patient's subjective judgment. They also made it possible to remove part of the diagnostic process from the presence of the patient into "backstage" areas where several physicians might have access to the evidence.[98]

Technological advances firmly acted upon the rendering of care. If there were degrees of partitioning between physician and patient, it was not so much a disunion as it was a yet to be fully realized appreciation of new junctures in therapeutics. Greater analysis and treatment regimens remodeled conduits of care. Patients were the recipients of medical interventions derived from groups of experts rather than solely from their general practitioner. However, these new headways in applications of healing were only available in leading-edge venues; hospitals were clearly gathering points for all this remarkable equipment. The implements housed within their walls elucidate how doctors and the tools they used propelled the practice of medicine to new meridians. Decidedly, from a certain point of view, hospitals could be categorized as being a physician's most potent prescriptive mechanism. "Undoubtedly the most influential explanation for the structure of American medicine gives primary emphasis to scientific and technological change."[99] This tremendous technological advancement increased reliance on tools, which extended their presence as necessities in physician's offices. Specifically, micropractitioners, as technophiles, use their computer savvy know-how to enrich their relationships with their patients. Micropractice defies the postulation that "[m]en have always sensed that the more tools they forged and the more machines they built, the more

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[98] Starr, 136-137.

[99] Ibid., 16.

they were forced to know, to love, and to serve these devices."[100] "Medicine is unique in being so thoroughly steeped in the practical on the one hand and so dependent upon the humane and scientific on the other"[101] that the individualistic micropractice model comfortably straddles this divide.

Contemporary Citations

> Whereas knights of old wore armor of plate, the modern knights of the air wear the invisible but magic armor of confidence in technology.
> — Mike Spick

The rise of the twenty-first century brings with it digital technology and mobile health applications; spellbinding machinery needing to be balanced against the primacy of physician-patient mutuality. Two innovations that have greatly impacted the interface between micropractitioners and patients are the electronic medical record and telemedicine capabilities in the form of patient portal applications. Both are depended upon in micropractices to superintend record keeping and maintain connections with patients.

Electronic medical records or EMRs are computerized systems composed of applications designed to enable a clinician to document and store patient information. All of these electronic products promise easy access to data as time saving devices: unfortunately there is no universal software. Therefore, numerous competing companies

[100] Pellegrino, 10.

[101] Ibid., 31.

promote their own particular set of services and one must take into account implementation costs, data entry features, and resources for ongoing support in considering any system. Whatever a physician ultimately subscribes to, clinicians armed with laptop computers enter into an encounter primed to engage in clinical stenography. The interchange between doctor and patient therefore stands a risk of being undervalued.

> Currently, most systems have been designed not with clinical needs in mind but to meet the demands of the fee-for-service payment system. The software rapidly codifies diagnoses and symptoms, thus facilitating billing. But that shorthand also encourages clinical shortcuts and less face-to-face time with patients. Time-pressed doctors can fall back on the electronic record, which formats and abbreviates information in a way that physicians can absorb quickly. And because the data is in the electronic system, it is easy to assume that the information is as reliable as the patient themselves, if not more so.[102]

As medical care becomes predisposed to tools that progress toward the pedestrian in everyday encounters, the modern algorithm of medicine requires an ongoing mindfulness about the sanative connectivity that doctor and patient have in the equation. Physicians are obliged to be vigilant that the technological devices they make use of, in no way usurp the therapeutic relationship they forge with their patients. All practitioners need to maneuver technological devices to serve; if inserted as an antiseptic buffer to displace the proportionality of the patient in the correlation then technology is at cross-purposes. EMRs as records management systems should help secure information gleaned from well-established clinical discourse. When not supportive to the task at hand the screen performs as an insulator rather than as a support item. "*Screen* descends,

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[102] Paula Chen, M.D., "An Unforeseen Complication of Electronic Medical Records," *The New York Times* (April, 22, 2010).

etymologically, from 'shield': a safeguard."[103] If it is not employed as an attendant, it inevitably acts as an armored adversary to the moment.

Nonetheless, computerized tools may not be as intuitive as they need to be. Gregg points out ramifications for the physician-patient interface if the electronic medical record is not user-friendly for the practitioner. "EMR functions and requirements suggest physicians may be particularly pressured for time during patient encounters in the face of large numbers of EMR functions."[104] The prevailing use of electronic records, their ease of use, and their ability to serve both physician and patient needs to be fully considered. An electronic medical record cannot capture nuance nor should it take charge over the clinical conversation. There is no set-in-stone framework to the art of medicine; its precept of healing endeavors is positioned in concert within the clinical conversation.

Healing actions consistently rely on messaging. Whether it is the "laying on of hands" or sage advice, medicine has always been about the medium of information. This relay of guidance or instruction was once held captive by the bounds of proximity. Distance and detachment were dealt with as obstacles to work around. At one time or another, primitive methods might have called upon the swiftest sprinter to disseminate an update to the shaman. Notifications to persons presiding over activities of healing have been acted upon through the years via smoke signals, semaphores, and the telegraph. In times of urgency, people turn to communication contrivances in order to circumvent

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[103] Alice Fulton, "Screens: An Alchemical Scrapbook," in *Tolstoy's Dictaphone: Technology and the Muse*. Sven Birkets, ed.,(Graywolf Press, 1996): 103.

[104] Helen Gregg, "The Relationship between EMRs and Physician Stress," *Becker's Hospital Review* (September, 27, 2013), http:// www.beckershospitalreview.com/healthcare-information-technology/the-relationship-between-emrs-and-physician-stress.html (accessed April 9, 2014).

calamity. As advancements emerge, the transmission of information becomes more agile. In consequence, technology, however fledgling, transforms expectation.

For example, "a 1923 manual for medical practice commented that the telephone had become as necessary to the physician as the stethoscope."[105] Patients who were at a distance could now be connected to their doctor by a device that transmitted the human voice. A machine actualized this remarkable goal and created a level of connectivity that expanded the presence of the physician. In some regard, this can be viewed as a simple form of "telemedicine,"[106] which is "the use of advanced communication technologies in the healthcare context."[107] Telephone wires were at one time the height of technological achievement. Present day equipment now allows elements of healthcare delivery to exist in a wireless world.

As the sphere of healthcare rapidly transmogrifies, "advances in computer technology and the development of a global communications infrastructure portend a significant role for telemedicine."[108] "Telemedicine [uses] medical information exchanged from one site to another via electronic communications to improve a patient's

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[105] Verlin C. Thomas, *The Successful Physician,* (Philadelphia, Saunders, 1923): 146.

[106] Sam Snyder, "Telemedicine: The Future of Medicine," *Health and Medicine* (February 2014), http://telemedicineprogram.com (accessed March 21, 2014).

[107] Gerald-Mark Breen and Jonathan Matusitz, PhD. "An Evolutionary Examination of Telemedicine: A Health and Computer-Mediated Communication Perspective," *Social Work in Public Health* 25, no. 1 (01/2010): 59.

[108] Vicent L. Pisacane, PhD., "Telemedicine: Health Care at a Distance," *Johns Hopkins Applied Technical Digest*, vol. 16, no. 4 (1995): 373.

clinical health status."[109] LeRouge and Garfield assert, "telemedicine serves as vital connective tissue for expanding health care organization networks… to expand the reach of healthcare and to integrate health care services across patients and organizations."[110] Micropractices, small as they are, are highly organized, tech-savvy patterns of practice. The use of interactive telemedicine "allows clinical services to leverage information technologies, video imaging, and telecommunication linkages to enable doctors to provide healthcare services at a distance"[111] and suitably serves this pattern of practice.

Telemedicine has evolved to a degree that it can be broken down into three categories, "store-and-forward, remote monitoring, and interactive services."[112] The key characteristics for each is as follows:

> **Store-and-forward** telemedicine involves acquiring medical data (like medical images) and then transmitting this data to a doctor or medical specialist at convenient time for assessment offline. It does not require the presence of both parties at the same time… A key difference between traditional in-person patient meetings and telemedicine encounters is the omission of an actual physical examination and history. The store-and-forward process requires the clinician to rely on a history report and audio/video information in lieu of a physical examination.

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[109] American Telemedicine Association, "What is Telemedicine," http://www.americantelemed.org/ about-telemedicine/what-is-telemedicine#.VqYnUzOczjQ (accessed January 25, 2016).

[110] Cynthia LeRouge and Monica J. Garfield, "Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced?" *Interdisciplinary Journal of Environmental Research and Public Health* 10, no 12 (November 28; 2013): 6472.

[111] Ronald S. Weinstein, M.D. et al. "Telemedicine, Telehealth, and Mobile Health Applications that Work: Opportunities and Barriers," *The American Journal of Medicine* vol. 127, no., 3 (March 2014): 183.

[112] Medical News, "Types of Telemedicine," (March 21, 2014), http://www.news-medicial.net/health/Types-of-Telemedicine.aspx. (accessed 22, 2014).

> **Remote monitoring**...enables medical professionals to monitor a patient remotely using various technological devices. This method is primarily used for managing chronic diseases, such as heart disease or diabetes mellitus.
>
> **Interactive telemedicine services** provide real time interactions between patient and provider, to include phone conversations, online communication and home visits.[113]

With dynamic capabilities, the elements of interactive telemedicine can be further delineated by way of specific interfaces:

- Desktop Computers
- Laptop Computers
- Personal Digital Assistants
- Fax Machines
- Telephones
- Mobile Phones
- Videophones
- Stand Alone Systems[114]

Patient portals as utilized in micropractices harness everyday devices such as cell phones, laptops, and desktop computers to facilitate exchange of information; these modalities leverage efficiency in patient management. These conduits allow a joining together in efforts to schedule appointments, gather health information, obtain prescription refills, and access testing results. As contemporary medicine is enmeshed in gadgetry, the challenge arises for clinical surroundings with their inherent activities of technology to be in sync with patients with regard to their needs and narratives. The electronic exchange between physician and patient has to be in the most pertinent of

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[113] Medical News, 1..

[114] Edward Alan Miller, Ph.D., M.P.A., "Telemedicine and the Provider-Patient Relationship: What We Know So Far," Nuffield Council's Working Party on: *Medical Profiling and Online "Personalized' Medicine in a Consumer Age* (January 17, 2001): 44.

pipelines as context and setting impact clinical cooperation and therefore outcomes of care.

Doctoring is more than just dispensing medicine. Health outcomes can be affected by "the medium through which consultation takes place."[115] It is important to remember that the special relationship between doctor and patient rests on trust that is tied to physician competence and communication capabilities. Caring and empathic physicians strive to create an environment for the patient that allows for beneficial aid to achieve its greatest capacity. Verbal and non-verbal skills can play a significant role in a physician's ability to generate an atmosphere in which a patient feels comfortable. What must be taken into account is whether or not leading-edge technologies strive to depersonalize the physician-patient relationship.

The medical encounter itself features contextual characteristics of both physician and patient and "information exchange carries both cognitive meaning (factual information) and emotional meaning (uncertainty and anxiety)."[116] Traditional face-to-face encounters on one hand, may offer the opportunity to better process certain non-verbal cues. Eye contact, posture, proximity to the patient, and the ability to touch may help a physician create a caring atmosphere in a conventional care manner. According to Miller, "communication mediums such as secure electronic messaging serve to influence health outcomes… by supplementing conventional face-to-face contact... and

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[115] Edward A. Miller, "Telemedicine and Doctor-Patient Communication: An Analytical Survey of Literature," *Journal of Telemedicine and Telecare* 7, no. 1 (2001):1.

[116] Ibid., 11.

consultations that take place through two-way interactive video more often serve as substitutes for in-person encounters."[117] This suggests that telemedicine applications may well serve as adjunctive processes to in-person therapeutic encounters and might also be an important surrogate to a traditional office visit. Telemedicine is a mechanism to connect with patients. In the broad analysis, modalities that can serve to reinforce or enhance the physician-patient relationship should be considered on merit. The subtractive quality of telemedicine in that it limits sensory elements, should be considered against the level of connectivity that the alliance demands at any given point. When a physician needs to be present, can a physician project a "presence" in virtual space?

Coyne points out that, "the language of virtual reality involves the unitary concepts of immersion and engagement."[118] "Digital narratives present the issue of reductionism… but one must note that information technology overcomes the resistance of space, or opens up to us new spaces…[this] view is sustained in that space can be reduced to its representation on a computer screen."[119] Computer technology allows for a certain measure of freedom in overcoming the constraint of distance and the space that might separate doctor from patient. New dimensions of normative standards will have to be considered with regard to the physician-patient relationship in this new era of telemedicine. Screen time with a physician is still shared time.

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[117] Miller, 15.

[118] Richard Coyne, *Technoromanticism: Digital Narrative, Holism, and the Romance of the Real* (MIT Press, 1999): 3.

[119] Ibid., 77.

Applications of technology serve some patients better than others. Care modalities and consultation mediums must account for "patient, provider and contextual characteristics as well as patient and provider verbal and non-verbal encounter communication, and health outcomes."[120] Secure messaging and two-way video mediums need to factor in specific behaviors as they relate to patient and physician in context of the therapeutic alliance. Miller cites, "age, gender education, income, marital status, race, ethnicity, prior experiences with medical care, concerns, coping style, medical problem, and diagnosis all contribute to proper utilization of any medium of communication."[121] That medium may be face-to-face, e-mail, or telephone. Conduits of communication must always take into account the right mode for the messaging but humanistic care does not need to be devoid of technology.

> Technology in and of itself has no ontological status within medicine. It promotes neither a mechanistic worldview that precludes holistic understanding of patients as people nor a humanizing of the doctor-patient encounter. In fact, technology is utterly neutral with respect to the values that inform medical practice and shape individual doctor-patient relationships. Technology does not make (or unmake) the doctor…Technology, however "high or "low," is an instrument of diagnosis and treatment, not a signpost of treatment well-or-ill rendered. Physicians who are not patient-centered will assuredly not find themselves pulled toward doctor-patient dialogue through the tools of their specialty. But neither will they become *less* patient centered on account of these tools. Physicians who *are* patient-centered, who enjoy their patients as people, and who comprehend their physicianly responsibilities in broader Hippocratic terms—these physicians will not be rendered *less* human, *less* dialogic, because of the technology they rely on. On the contrary, their care giving values, if deeply held, will suffuse the technology and humanize its deployment in patient-centered ways.[122]

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[120] Miller, 47.

[121] Ibid.

[122] Paul E. Stepansky, PhD, "Caring Technology," Medicine, Health, and History, weblog, entry posted October 11, 2012, http://adoseofhistory.com/2012/10/11/caring-technology/ (accessed March 5, 2014).

This speaks to the art of medicine and it's calling. Physicians who fuse clinical skills and concomitant technological competence to their humanistic proclivity can in fact, register kindness and empathy through a virtual presence. If the mode of messaging aligns with the need of the moment, the physician can transmit his or her caring to their patient without becoming some sort of inferior proxy. Coyne points out: "information technology seems to provide an essential mediating technology, and it overcomes the resistance of space through its ability to represent objects and intentions and to transmit these representations across distances."[123] Representation is in some ways a matter of the language we use and the communication medium of telemedicine allows for the telegraphing of emotion through its ability to correspond and connect with patients. In other words, telemedicine capabilities provide greater options to accommodate for the impediment of distance. It grants access and provides for clinical engagement. In medicine, there are deeply rooted facets to the art of connectivity. According to Rosenfeld, there are four attributes a physician should strive to embrace in the art of healing. They are, "The Art of Doing, The Art of Thinking, The Art of Caring, and The Art of Communication."[124] All these aspects have to do with being in the moment with a patient and focusing on the task at hand. The art of care and caring requires good will whether there is a technological component or not.

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[123] Coyne, 86.

[124] Richard M. Rosenfeld, M.D., MPH, "Art," *Otolaryngology—Head and Neck Surgery* vol. 143, no. 3 (September 2010): 322.

The medical profession remains "an overlap of one-of-a-kind human skills and a vast range of state-of-the-art diagnostic and therapeutic tools."[125] For all the discussion about innovation, a physician rendering humanistic care still remains, "one pair of hands, and one pair of eyes at a time."[126] Medical machinery does not displace this wisdom. If science is about knowing and technology is about doing, then caring is about a physician's one-on-one genuine connection with the patient. As the accoutrements of the healer have evolved over time and medical machinery becomes mainstream, instrumentation and devices utilized by physicians have extended the parameters of helping and healing. As with all transformational applications, these advances can have implications both positive and negative. Technology, if properly engaged, can serve physicians well when endorsed as serving patients, rather than being employed to separate practitioner from patient.

The emotional tie-in between physician and patient is essential to humanistic care. The new reality of computer driven care modalities alters the traditional mechanics of face-to-face medical communication, but it need not pose a barrier to this special relationship. Technology transcends space and distance, breaks boundaries. It allows for the affinity of therapeutic contact between physician and patient when it would otherwise be hindered. Rapport requires the physician to be "present" and in the moment with his/her patient. Delivering health care in the form of secure messaging or two-way

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[125] Jay R. Jackson, M.D., "Is Technology Displacing the Art of Medicine?" The Physician Executive, *Journal of Medical Management*, (Special Issue: Health Care Technology, March-April 2004): 48.

[126] Ibid., 49.

interactive conferencing allows for a virtual presence to overcome geographic impediments. Communication and connectivity, as is permitted by these forms of advanced tools, may be seen as serving the humanistic propensity of medicine. The relationship of healer and the person seeking healing is transcendent and technological trajectories do not reconstitute this dyad. Humanistic care through technology and the utilization of computerized applications in the office or by phone can be realized, if the message of caring sent by the physician is clearly received by the patient. High tech and high touch need not be mutually exclusive, if the mode of messaging is applicable to the moment. Advanced technology offers options to telegraph care and caring by expanding the interconnectivity between physician and patient; it is evolving into an indispensable auxiliary to enrich the therapeutic affiliation.

Contemporary medicine embodies an array of electronic applications in the context of care pathways and the complex landscape of health care delivery constantly morphs as computer-driven technologies transform the management of medicine with regard to information gathering and distribution. Technology utilized wisely expands connectivity in the provision of medical care. As these tools become embedded into the day to day provision of care, terminology such as digital medicine, telemedicine, and computerized medicine will just end up being referred to and thought about as medicine.

In Chapter 3, this author explores physicianship and contemporary virtue.

CHAPTER 3

PHYSICIANSHIP AND DIMENSIONS OF VIRTUE IN MICROPRACTICE

The task of medicine is to cure sometimes,
relieve often, care always.
attributed to:
— Hippocrates 460 BC – 370 BC
— Ambroise Pare 1510- 1590

Medicine is an art, and attends to the nature and constitution of the patient, and has principles of action and reason in each case.
— Plato

The practice of medicine exists at a crossroads of concepts honed from ancient ideals, refinements in healing practices, and predominating parameters of scientific knowledge. Thought and therapeutics can therefore be viewed as being prevailed upon by a confluence of forces. Being both art and science, medicine is poised in a unique position along timelines. It constantly transforms through the ongoing expansion of clinical comprehensions while somehow seeming immutable to change by virtue of the abiding facets of its art. It's methods and modes of application emanate from insights into science: its practice and purpose radiate from the humanities. In the objectives of diagnosing, treating, and alleviating disease medicine "must use the languages and cognitive methods of both"[127] such that attending to the demands of the clinical conjointly with the call to care requires an orderly collective of ideals. How can a

[127] Edmund D. Pellegrino, *Humanism and the Physician*. (University of Tennessee Press, 1981): 34.

physician meet with perfect balance "the special complexities of *man as subject* interacting with *man as object* of science?"[128] To do so requires embracing the reasoned approach of humanistic medicine. Humanism in medicine "is really a plea to look more closely at what medicine *should be."*[129]

Humanistic medicine tends to be a warm and fuzzy designation. It is a gauzy term only because it is sometimes viewed as a nicety, which muddles its significance. I apply this term as a positive and uncomplicated construct to micropractice as a natural outflow of its simple design. The utility of its size is practical: its template of efficiency favors sufficient face-time with patients. Its functional capabilities expand physician presence owing to the incorporation of certain technological aids. In the course of a practice style built around utility, functionality, and sensibility, a physician is predisposed to serve patients well. In particular, these elements form a substructure that are better understood as proprietary assets of this practice arrangement. These hallmarks speak to the proclivities of those physicians who commit to medicine's inherent schema: one physician, one patient at a time.

"Medical science, basic or clinical, becomes medicine only when it is used to promote health and healing—that is, only when it intervenes in an individual life to alter the human condition."[130] "Medicine simply does not exist until its knowledge and skills

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[128] Pellegrino, 77.

[129] Ibid., 10.

[130] Ibid., 77.

are particularized—that is, used to effect some good end in a particular human being."[131] Medical care is and always has been a matter of an individual who upon feeling ill seeks out another person who provides help. The connection between these factors is of the utmost significance: the practice of medicine emanates from the sum of these two parts. At the most elemental level this is a two-party contract consisting of transactions and contentions and it is always steeped in a multitude of human dimensions. When these encounters between doctor and patient are appraised simultaneously and in the aggregate they can easily be summed up as representing the multiplex of all medical care provided today. There are activities and agreements of all sorts that are systematized; however, at their core there exists a basic medical contract between a physician and a patient. Thus, the contract always has to be custom built. It can never be massed produced regardless of system hierarchies that strive to standardize it. It is the humanism in medicine that keeps every compact between doctor and patient hand forged, always one patient at a time.

Micropractice keeps true to the basic blueprint of medicine. It is for those physicians who choose to practice in an incisive manner: simply and to the point by invariably situating themselves at the one-to-one ratio of care. Medicine itself is a benevolent and useful undertaking: it "exists when science, technology, and craftsmanship of the physician are practiced with the deepest respect for the humanity of the patient."[132] Micropractitioners apply the science of medicine and the humanistic aspect of its art in unison as clinical counterparts of treatment. This reasoning refers to a

[131] Pellegrino, 191.

[132] Ibid., 192.

particular intellectual trait that in Aristotelian terms is referred to as *phronesis:* "the virtue of practical wisdom."[133] In the clinical context it is important to comprehend the practice of medicine in phronetic terms since proper clinical interaction depends on physician fluency in the generalities of science that need to be translated into the specifics of caring for individual patients. Disregarding this tenet sets up unrealistic expectations: doctors may oversell science and patient expectations may be primed away from what is feasible. One must bear in mind that, "[m]edicine, or more properly healing, is a practical enterprise requiring a fusion of technical competence and moral judgment."[134] This reasoning about what one ought to do is advanced by micropractice wherein a proper philosophy of care additionally encompasses contemporary virtues. These tenets are comprised of a solid appreciation of caring for others that takes form in the sense of well-grounded humility in addition to maintaining a work-life balance and cultivating self-reflection. This right-minded approach allows micropractitioners to experience their physicianship with perspicacity and in circumstances of practicality. Whereas the goal of the science of medicine is undeniably to relieve suffering, treat those who present with illness, and to prevent disease when possible, it also stands to provide a degree of fulfillment for the practitioner. The unpretentious practice pattern of micropractice serves patient and physician in a coinciding manner. There is a philosophy of bi-directional

[133] Pellegrino, 84.

[134] Edmund D. Pellegrino and David C. Thomasma, *The Virtues of Medical Practice.* (Oxford University Press, 1993): 86.

advantages that mutually benefits both doctor and patient: by its very nature, it creates a space for healing.

The mettle of any medical interface and the imperatives of its activities lie in the distinctions of its convergence. Pellegrino lists five codifying features of a healing relationship that constitute its infrastructure. They are: [1] the inequality of the relationship; [2] the fiduciary nature of the relationship; [3] the moral nature of medical decisions; [4] the nature of medical knowledge; and [5] the ineradicable moral complicity of the physician in whatever happens to the patient.[135] Each component addresses an essential factor of the therapeutic association. Given the state of the suffering person and the hope of health a physician stands for, this dyad of disproportion "imposes a condition of existential inequality on the medical relationship"[136] and the physician has "the obligation to protect the vulnerability of the patient in medical care." [137] As for the fiduciary nature of the relationship, "trust is ineradicable"[138] for a physician when it comes to an encounter with the patient. These aspects speak to actions a physician must engage in and the energies that need to be expended in order to meet the requirements for the relationship between doctor and patient to be considered a healing one.

Anyone who has experienced care and concern from an understanding physician may ponder the special qualities that made them feel at ease or conveyed a sense of trust. Many patients intuitively know when they are being treated by a clinician who possesses

[135] Pellegrino and Thomasma, 42.

[136] Ibid.

[137] Ibid.

[138] Ibid., 43.

praise-worthy traits. Beauchamp and Childress highlight the "ethics of *care*"[139], which they interpret as professional right conduct in the distinct terms of *'Caring'*[140] and *'Caring for'*.[141] " *Caring* refers to… [the] emotional commitment to act on behalf of persons with whom one has a significant relationship."[142] "*Caring for* is expressed in actions of 'caregiving,' 'taking care of,' and 'due care'."[143] These ideas take into account some of the distinguishing features of enduring relationships in terms of the emotive qualities of faithfulness, allegiance, and kindness. This admixture of providing sound clinical care combined with a distinct moral underpinning represents the ideal for the practice of present day healing. It is this ideal, the affinity to merge scientific knowledge with warm-hearted care that best describes what it means to be a good doctor. Walker asserts this embodiment may be nurtured from underlying attributes. "The great medical virtues- compassion, fidelity, justice, and integrity- gradually and frequently build on simple virtues such as tact, self-awareness, good humor, reverence, and simplicity."[144] Their value associated with medical excellence can be explained as follows:

> Tact follows a path toward compassion… Self-awareness allows for a physician to see herself for who she is [thus] she is better able to see patients for who they are… This requires a recall of one's wants and emotional state when decisions were made. Good Humor allows for a perceptive ability to size up a situation and

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[139] Tom L. Beauchamp, and James F. Childress. *Principles of Biomedical Ethics,* 7th ed. (Oxford University Press, 2013): 35.

[140] Ibid.

[141] Ibid.

[142] Ibid.

[143] Ibid.

[144] Francis O. Walker. M.D. "Cultivating Simple Virtues in Medicine," *Neurology* 65, no. 2 (November 2005): 1678.

> its implications… Reverence is the antidote to hubris… Simplicity counterbalances therapeutic zeal and leads to humility.[145]

Exploring Ethos

> Excellency, then is a state concerned with choice, lying in a mean, relative to us, this being determined by reason and in the way which the man of practical wisdom would determine it.
> — Aristotle

The undertaking of care of a patient is a circumstance of commitment and acts of ethical conduct concerning that patient are about deciding what should be done and then doing it. Beauchamp and Childress frame a physician's actions around the principles of autonomy, beneficence, nonmaleficence, and justice. Accordingly, they outline the therapeutic relationship and the warrants within, especially for the comportment of the physician:

> Once this relationship is initiated, the patient gains a right to care that other persons who are not the physician's lack. The patient does not have this status independent of the established relationship, and the physician does not have the same obligation to those outside such a relationship. This relationship may deepen and gain new dimensions of status as the parties come to know and trust one another. Trusting and caring relationships in which both parties understand and agree are paradigm cases of rights and obligations established and maintained through relationships.[146]

These commissions place an obligation on the part of the physician to respect the patient in his/her care, to do no harm, to assure that the provision of care is for the good of said patient, and to do so within a partnership of trust. Yet, the architecture of the

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[145] Walker, 1678-1680.

[146] Beauchamp and Childress. 77.

alliance between patient and doctor is not fully anatomized through this lens. The mainframe of this biomedical ethical stance is designed to ask "what to do." It does not address the dynamics of "how" the relational aspects of the consultative interchange affect the human experience or even how to prioritize between principles. It does not direct attention to the emotive dimensions within the clinical encounter for either actor, despite the fact that Beauchamp and Childress address the potentiality that the "relationship may deepen and gain new dimensions of status as the parties come to know and trust one another."[147] Plainly, the elements of time and continuity of care need to be factored into the rubric in order for the relationship to strengthen; otherwise the interface between physician and patient is in consequence, impersonal and perfunctory. Therapeutic relationships that flourish and strengthen do so by effectuating excellences and these excellences involve an understanding about knowledge of practitioner motivation and modes of expression.

One of the ways to describe how a physician carries through on right-minded acts is ostensibly applied to the practice setting. Micropractice is shaped by the office footprint and the performable workload determined by the individual physician. This right-sizing of physician capacity allows a clinician to direct care strategies towards patients in a minimally disruptive and maximally supportive way. A small-scale office engenders streamlined processes thus enabling micropractitioners to honor the significance of attention: enacting proper actions are particularized without tumult.

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[147] Beauchamp and Childress. 77.

Practicing the art of medicine amidst the chokeholds of big business medicine many times confines physicians to mechanical actions to ensure the bottom line. This enslaves their behaviors rather than consistently situating the clinician at the precise point to fully be attuned to patients' narratives. The noted philosopher and physician William James once said, "We carve out order by leaving the disorderly parts out."[148] This statement easily corresponds to the strivings of micropractitioners. The streamline manner by which they practice medicine minimizes distractions and helps keep focus on the dyad. Physicianship can then take the form of knowing and feeling on a personal level allowed for by habitude, the buffer of time, and minimal disruption.

Consider the vaulting of corporate health care delivery, which has appropriated so many things from industrial assembly lines that were never intended to be applied to therapeutic relationships: patient partnerships being the most conspicuous exemplification. What separates fast-paced traditional offices from the stripe of micropractice is that routine efficiencies in big business can be mechanical. Conversely, the mechanisms of micropractice keep physicians well-disposed and on point: keen familiarity with patients is woven into the milieu. Rested within the mechanics of micropractice, clinicians are able to establish bona fide partnerships with their patients. This consociation aligns with Balint's metaphor of the relationship being a "mutual investment bank."[149] In the wake of the physician and patient investing time and trust in

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[148] Academy of Ideas, "William James Quotes," http://academyofideas.com/2013/12/William-James-quotes (accessed April 10, 2016).

[149] The Balint Society, "Balint quotations," http://balint.co.uk/balint-quotations/ (accessed April 16, 2016).

the transactions of the relationship, beneficial rewards accrue for both. These activities serve the physician fittingly although these actions must not be emotionless. Mechanical actions are not virtuous: aptly, the motives and means of patient-centric efforts are. The norms of micropractitioners meet criteria for both motive and means regarding practicality and virtuous conduct: by providing care in a humanistic manner micropractitioners also realize professional gratification. Micropractice facilitates good intentions and achieves desired consequences. If habits of excellence are a function of the individual in their environment and the environment affects the conduct of an individual, in a de facto sense this expands perspective on those systems of thought that seek to define precepts on values.

I contend that the mindsets of long established ethical stances result in positions that are confining when applied to clinicians in micropractices. In Kantianism, "An action is good if it is done on the grounds that it is right to do it."[150] Utilitarianism "judges the good of the action not in terms of motives, but rather in terms of consequences that flow from it."[151] The mediating philosophy of a pragmatic approach "seeks to eliminate the one sidedness of each of these views by combining them."[152] "[T]o be good an act must be done from a good motive and have good consequences—where both motive and consequences are definable in terms of human experiences."[153] The set-up of

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[150] Edward C. Moore. *American Pragmatism: Pierce, James, and Dewey*. (Columbia University Press, 1961): 214.

[151] Ibid., 215.

[152] Moore, 215.

[153] Ibid.

micropractice melds the conduits of focused patient care with physician fulfillment. Desiring to practice medicine according to one's penchant of placing the physician role in direct correlation to the patient in each encounter whilst achieving professional satisfaction in the process of helping patients as an end result, sums up the mediation and yield of the micropractice concept.

Decidedly, being patient-centric is a tall order: the practice of medicine in the domain of primary care is about attentiveness to each patient's story and clinical chronicle: the patient being "a series of one."[154] Proper engagement by the physician is important because "[p]atients exhibit a higher degree of autonomy in the primary care setting. They are mobile, less depersonalized, less dependent, less compliant, and set limits as to what they will do."[155] These circumstances require that the practitioner not only possess clinical wisdom and grasp nuance but also have the advantage of time. The degree to which a physician offers generosity of time indicates the extent to which the instrumental value of patient autonomy is respected in the therapeutic relationship. Suitable "breathing room"[156] to actualize the redeployment of physician energies is clearly granted by the factor of time. In the ideal:

> The role of the family physician in first contact care allows the opportunity to understand and share in the patient's earliest experience of sickness, before the sickness has become organized and defined...the primary (comprehensive, continuing, personal) care delivered by family physicians as the everyday norm of their practice, not sporadically when the occasion demands, adds a

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[154] Stephens, 9.

[155] Ibid., 86.

[156] Wasson, Interview, August 10, 2015.

dimension of time to compassion.[157]

In comprehensive first contacts and continuing care medicine there is a "premium placed on the enrichment of social and personal services such as counseling, patient education and patient advocacy."[158] "This means that the family physician deals in services more than products, is more concerned with management than with treatment, and with caring more than curing… tasks are more undifferentiated and overlapping being fundamentally communicative in nature… [i]t is more affective and relational."[159] This managerial scaffolding requires habits pivoted to awareness and watchfulness that simply do not occur to this extent in medicine's numerous specialties and sub-specialties. This represents the particular character of primary care medicine.

Advancing this line of thought calls for the physician to practice self-reflection and have awareness of biases so that there is an enlightened sense of self. These are quality measures. They allow a physician to fully engage with patients; humanize medicine. These are excellences. They impact the disposition of the physician. Characteristics that matter most to patients are traits reflective of those practitioners who honor time and attention in a healing environment. The following are considered important to patients and are descriptive of an ideal doctor:

1. Takes time.
2. Well rested.
3. Up-to-date on the latest research.
4. Doesn't judge or dismiss your concerns.

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[157] Stephens, 49.

[158] Ibid., 87.

[159] Ibid.

5. Easy to reach.
6. Respects your time.
7. Sincere and empathetic.
8. Actively listens.
9. Trust and comfort.[160]

These attributes encompass personal and professional sensibilities, utilities, viabilities, and functionalities. To transmit any of the above one must have qualities of being practical, capabilities of serving a purpose well, have good sense, and follow through with pragmatic judgments that are executed in a useful way to a good end.

The next section explores how education may diminish or develop humanistic traits.

Examining Education

Educating the mind without educating the heart
is no education at all.
— Aristotle

Becoming a physician is a long and arduous journey. Each year 16,000 students earn an M.D. degree[161] while 4,200 new osteopathic physicians graduate.[162] The educational requirements in these respective medical school curricula are regarded as allopathic; therefore, for the purposes of this text, no delineation between the two

[160] Best In Care, "9 Traits to Consider When Looking For a New Doctor," State of Health: The Florida Hospital Blog, (March 31, 2016), https://www.floridahospital.com/blog/9-traits-consider-when-looking-new-doctor (accessed March, 31, 2016).

[161] Association of American Medical Colleges, "Medical Education 2013," http://www.aamc.org/initiatives/meded/ (accessed March 9, 2014).

[162] American Association of Colleges of Osteopathic Medicine, "Osteopathic Medicine and Medical Education in Brief," http://www.aacom.org/about/osteomed/Pages/default.aspx (accessed March 9, 2014).

professional degrees will be made. Each directs four years of accredited coursework in evidence-based scientific study, and upon graduation, a newly minted physician faces three to seven years of professional training as an intern and resident, and if desired, one to three years of a fellowship in a specialty field. Medical education generally begins with rigorous academic course work and progresses on to clinical experiences. The time, intellectual, and physical energies expended to accomplish this professional goal are second to none in terms of its rigors and formality. In some respects, the path to becoming a physician parallels that of an honored craft. Interns, residents, and fellows are engaged as apprentices and journeymen by clinician-teachers before becoming board certified master craftsmen themselves. But does this traditional biomedical approach securely place a student-doctor in the position of being a physician who practices humanistic care?

Along the path to becoming a physician, one hopes humanistic traits are nourished and allowed to flourish but "the culture of clinical training is often hostile to professional virtue."[163] Tensions can be exacerbated between engaging the responding skills of being "present" with a patient and listening in an empathic manner versus employing objectivity and detachment in the technical arena that is today's health care delivery environment. The professional milieu of a student-doctor shapes views and values depending on the prevailing culture of the organization in which one finds oneself: "although medical education favors an explicit commitment to the traditional values of

[163] Jack Coulehan, M.D., MPH, and Peter C. Williams, J.D., Ph.D. "Vanquishing Virtue: The Impact of Medical Education," *Academic Medicine* vol. 76, no. 6 (June 2001): 602.

doctoring—empathy, compassion, and altruism among them…commitment to behaviors grounded in the tacit values of detachment, self-interest and objectivity...within the hospital system are potent."[164] Upon entry into the complex world of contemporary healthcare, students studying medicine bring with them a vast assortment of personal competencies and beliefs. Once they have completed their studies and emerge as independent physicians their values can be just as stratified. Coulehan and Williams theorize:

> some re-conceptualize themselves primarily as technicians and narrow their professional identity to an ethic of competence, thus adopting tacit values and discarding the explicit professionalism. Others develop non- reflective professionalism, an implicit avowal that they best care for their patients by treating them as objects of technical services (medical care). Another group [may] be immunized against the tacit values and thus, they internalize and develop professional virtue.[165]

The ethos of compassionate physicianship is something one has to aspire to. It is not an appointment automatically gained through medical education, rather it is an affirmation made by each physician. Whether these guiding beliefs are developed through habit over the course of one's medical career or are intrinsic to one's character, it is never an entitlement simply granted along with one's degree. Notwithstanding, "[t]he responsibility of insuring that the physician becomes a humane practitioner is truly the legacy and potential encumbrance of all physicians."[166]

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[164] Coulehan, 598.

[165] Ibid., 604

[166] Stephens, 49.

The following physician-patient interactions illuminate an inadequate versus an efficacious interchange.

Vignette

Amelia is a 75 year old patient with a history of type 2 diabetes, age-related macular degeneration, and osteoporosis. She is widowed and lives alone in a one-bedroom apartment. She enjoys the outdoors and walks around her neighborhood for exercise and to control her diabetes.

Amelia presents to her primary care physician after having been treated for a non-displaced fracture of the third metatarsal of her left foot at the local hospital emergency department. She has not been able to walk in the morning and blood work drawn in the hospital shows her HbA1c is elevated. Amelia's physician, who is doubled booked for all patient encounters this day, takes a standard history and physical, and hardly makes eye contact with her. She informs Amelia she will have to transition to insulin therapy. Amelia fidgets in her chair. She is given information about the diabetes educational program at the hospital but she feels rushed during her brief appointment. Upon her follow-up visit two months later, it is discovered Amelia has not attended any diabetes training classes.

This scene plays out over and over in doctors' offices every day. There is a presenting problem and standard protocols to follow. What is missing is clinician engagement conjoined to the voice of the patient. What might this clinical interface have looked like in a micropractice?

Amelia presents to her primary care physician after having been treated for a non- displaced fracture of the third metatarsal of her left foot at the local hospital emergency department. She has not been able to walk in the morning and blood work drawn in the hospital shows her HbA1c is elevated. Amelia fidgets in her chair. Her physician notices her unease. She reviews the lab results with Amelia and spends additional time with her. She discovers Amelia is frightened at the prospect of transitioning to "needles." The doctor listens to her fears and anxieties about the current state of her health. She offers support to Amelia and allows her to voice her concerns regarding her diabetes and the prospect of insulin therapy. She does not rush her patient. Amelia's doctor has a patient-focused practice and office milieu. There is generosity of time for each patient. The pace of the practice offers "breathing room"[167] for Amelia's physician to refocus her energies on each of her patients. Amelia feels her physician has "heard" her and understands her worries and apprehensions. They discuss the classes offered at the local hospital. The doctor asks Amelia if her son can drive her, if not she will provide information to her on the community health access van. Upon her follow-up visit, Amelia conveys to her physician that the diabetes training classes were very helpful.

> Being patient-focused makes it easier for a physician to do the work they aspired to do at the outset of their career. Mechanical and impersonal interfaces with patients produce a commodity; they don't actualize medicine. If all we see is the illness, patients may feel that the essence of who they are is being overlooked. If we are distracted, patients may feel unworthy of our attention: if we are too rushed, patients may feel undeserving of our time. And if we deem ourselves more important, patients may feel they are unimportant.[168]

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[167] Wasson, interview.

[168] Harvey Max Chochinov, MD, PhD., "Humility and the Practice of Medicine: Tasting Humble Pie," *Canadian Medical Association Journal* 182, no. 11 (August 2010): 1217.

Patients are neither clients nor components on a conveyer belt. A "patient is a "petitioner, a human in distress, and an especially vulnerable human."[169]

As with Amelia's physician in the second scenario, her practice of medicine was deftly applied to a particular person, her patient, at a particular time. If this physician were to see a similar patient with a similar problem the unique interactions that took place between she and Amelia could not be repeated. "Medicine in essence…is the science of the particular case"[170] and [i]f medicine is indeed...science particularized in a unique way in the clinical situation, then it must by definition be humanistic.'[171] The physician spoke directly and honestly with Amelia about her condition: she demonstrated benevolence in the encounter. There is physician excellence evident in the second scenario. "[P]hysicians who are mindful, informative, and empathic transform their role from one characterized by authority to one that has the goals of partnership, solidarity, empathy, and collaboration."[172] The down to earth manner of the physician spoke to her approach with her patients, her humility, which essentially is the foundation of what it means to be a healer. All these things dispose the patient to work in partnership with the physician to the ultimate ends of medicine, the caring and cure of the patient.

In Chapter 4, I present original research on micropractitioners, which expands knowledge and insight about this subset of clinicians and their pattern of practice.

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[169] Pellegrino, 225.

[170] Pellegrino, 191.

[171] Ibid., 192.

[172] Ronald M. Epstein, MD and Richard L. Street, Jr., PhD., "The Values and Value of Patient-Centered Care," *Annals of Family Medicine* 9, no. 2 (2011 March/April): 100.

CHAPTER 4

MICROPRACTITIONERS AND THE 5 Ws: WHO, WHAT, WHERE, WHEN, WHY

Physicians who choose to practice medicine within the construct of a micropractice have never been the subject of any focused research. This investigational study was undertaken to collect data on this particular physician population and to examine the results through a humanistic lens. Inquiry into this cohort of physicians yielded valuable information regarding key factors germane to the who, what, where, when, and why of micropractitioners. This groundwork engaged in the cultivation of a scholarly perspective utilizing mixed method research (quantitative and qualitative) in order to capture data and report findings. The entirety of statistical information is contained in the appendix.

Sample

Upon securing approval from Drew University's Institutional Review Board to run this study, I collaborated with Ideal Medical Practices (IMP) to conduct a web-based survey using their listserv. Ideal Medical Practices is a non-profit organization, which maintains an online association of clinicians who identify with the micropractice model. A letter of introduction and invitation to participate in the study was sent to the 377 email addresses on the listserv. A link to the eleven-question survey was provided. Data collection officially began in May 2015 and ended in June 2015. One hundred and fifty surveys were opened in this time frame and 68 responses were obtained. One physician

chose to submit a paper response advancing the total number of respondents to 69. This represents a response rate of 40%. Commentary sections were provided for the qualitative field in order to uncover the voice of the physician, decipher underlying thematic patterns, and to offset any biasing effects of the survey design. In addition, a joint telephone interview was conducted in August 2015 with Dr. Gordon Moore and Dr. John Wasson, two physicians who have championed this model of practice. The interview assumed a semi-structured approach in order to add insight and assess overarching messages.

Quantitative Data: Who, Where, and When

Survey items 1-3 captured demographics regarding the respondent's age, gender, and practice location. These data values are applied to provide information about who micropractitioners are (expressed as gender), where are they located (delineated as geographical locus), and when do they practice as micropractitioners (devised as an age range). These values are reported as frequency distributions. The sample population's characteristics indicate this subset of physicians is mostly female (56.72%), with the greater measure of ages being 45 to 54, (33.82%), and with the majority of practices (53.03%) located in suburban areas.

Interestingly, whilst physicians who are female represent "less than one-third of the active physician workforce"[173] and a little more than "1 in 3 primary care physicians

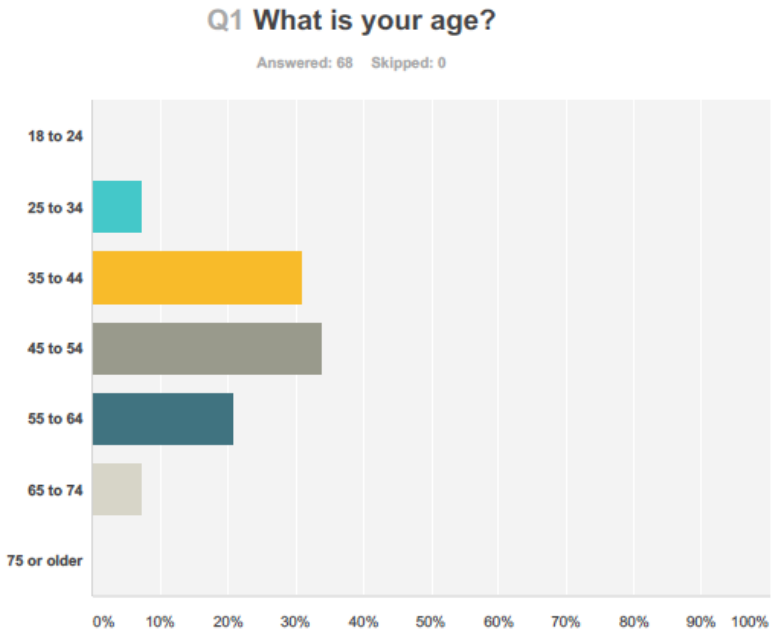
[173] Association of American Medical Colleges, *2012 Physician Specialty Data Book*: Center for *Workforce Studies,* http://www.aamc.org (accessed May, 23, 2016).

are female,"[174] this sample indicates there is a majority of females practicing medicine as micropractitioners. Current physician workforce statistics list the gender ratio in primary care medicine as "63.1% male and 36.9% female."[175]

Data values for both practice locale and age are stand-alone units of measure for this study. The fidelity of data collected was higher than that available from a broader source thus precluding direct comparisons. The demographics as collected offer first findings about the "who," "when," and "where" of micropractitioners.

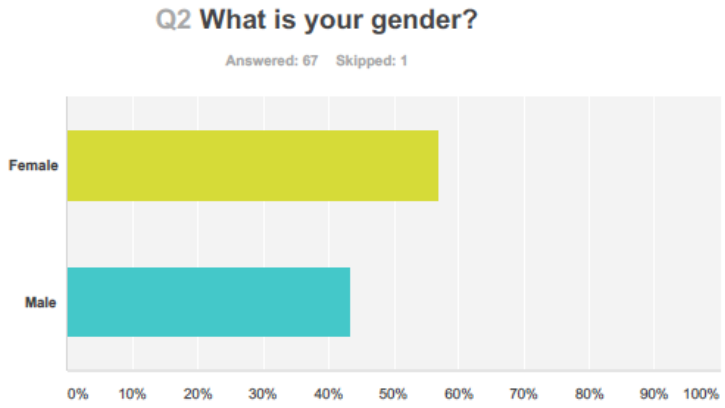
[174] Ha T. Tu and Ann S. O'Malley, Center for Studying Health System Change, Tracking Report No.17. http://www.hschange.com/content/934 (accessed May 23, 2016).

[175] Association of American Medical Colleges, *Physician Specialty Data Book* (November 2014): 12.



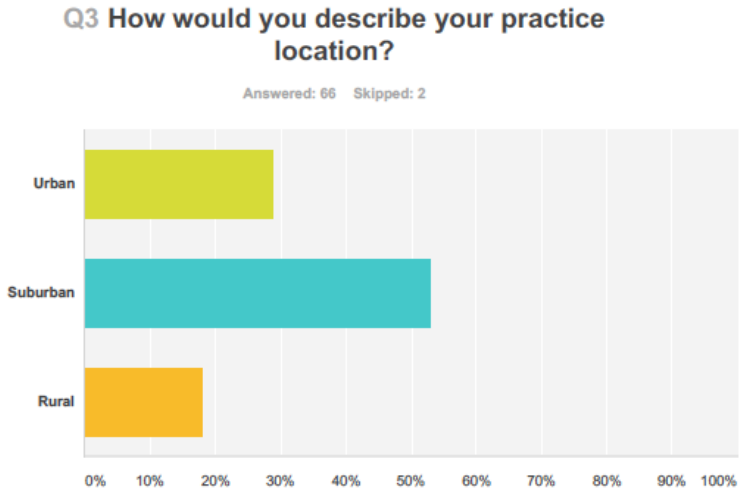
Answer Choices	Responses	
18 to 24	0.00%	0
25 to 34	7.35%	5
35 to 44	30.88%	21
45 to 54	33.82%	23
55 to 64	20.59%	14
65 to 74	7.35%	5
75 or older	0.00%	0
Total		68

Figure 1. What is your age?



Answer Choices	Responses	
Female	56.72%	38
Male	43.28%	29
Total		67

Figure 2. What is your gender?



Answer Choices	Responses	
Urban	28.79%	19
Suburban	53.03%	35
Rural	18.18%	12
Total		66

Figure 3. How would you describe your practice location?

Qualitative Data: What and Why

Although gender, age, and where you situate yourself in life can act as placeholders and shape what is important to you, practice preferences are very much defined by what is meaningful professionally to the practitioner. The means and manner of micropractice as a pragmatic choice for clinicians intent on building strong physician-patient relationships are suggestive of a virtuous practice philosophy. Qualitative data examines agreement variables for likely professional propensities and evaluates physician comments for thematic patterns.

Questions 4 through 11 elicit information about micropractitioner dispositions relevant to the therapeutic relationship and its conduits of connectedness as well as perspectives on the occupied position of the physician: “what” is important. Commentary analysis addresses the “why” in the study. Survey remarks were indexed as input/output data and categorized as corresponding to dimensions of quality of care and physician excellences. Information gleaned from the joint physician interview added insight into the results of the survey instrument. Statistical analysis for each question is noted at the bottom of each illustrated figure. Weighted percentages are displayed in addition to the means and standard deviations.

Respondents tended to agree with all queries: the average of the means were in the range of 4 for expected values across the board. Survey takers strongly agreed with inquiries connected to the occupied physician role in the therapeutic alliance. Information obtained about conducting a patient-centric practice, providing enough face-time for patients, and the importance of continuity of care had the highest means. The lowest

means were recorded for those questions connected to expectations for work/life harmony.

For the sake of practical reporting I arranged queries 4 -11 and the commentary data from each into three groupings. Questions 4, 5, and 6 are assembled around the vitality of the physician-patient alliance and relationship-focused care (Group1). Questions 6 and 7 are paired pertinent to the use of technology and clinical connectedness (Group2). Questions 9, 10, and 11 are organized around the physician as person in context (Group3).

Group1

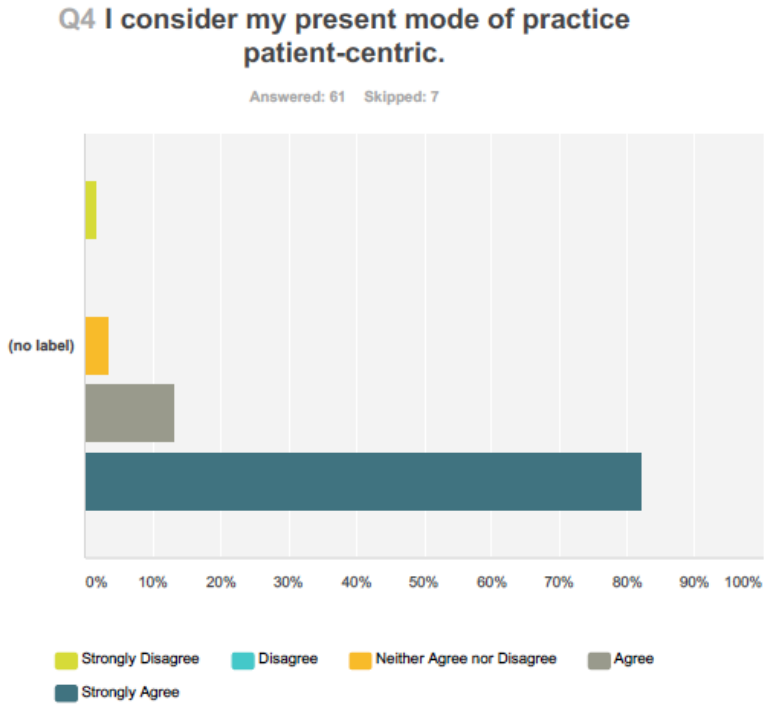
Nearly 82% of respondents strongly agreed that they rate their practices as emphasizing patient-centered care. This physician population overwhelmingly reported that they regard the care they render as relationship-focused. Of the 61 respondents who answered this question, 39 chose to comment. Data extracted from the feedback revealed physician attestations as to why they felt as they did. Twenty-one respondents emphasized the importance of time appropriated to individual patients, 14 mentioned the importance of easy and direct access to the physician in this regard, and 4 commented on practice design in aiding proper physician engagement. Data analysis from the commentary was classified as follows:

Input:

- Generosity of time
- Access
- Physician engagement

Output:

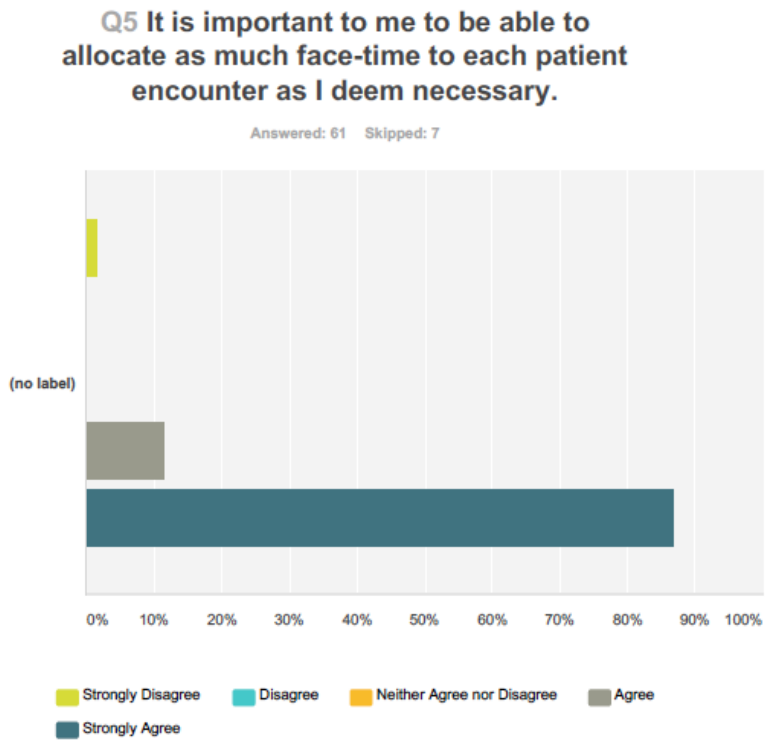
- Dimension of quality of care.



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	3.28% 2	13.11% 8	81.97% 50	61	4.74

Basic Statistics				
Minimum	**Maximum**	**Median**	**Mean**	**Standard Deviation**
1.00	5.00	5.00	4.74	0.68

Figure 4. I consider my present mode of practice patient-centric.



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	0.00% 0	11.48% 7	86.89% 53	61	4.82

Basic Statistics				
Minimum	**Maximum**	**Median**	**Mean**	**Standard Deviation**
1.00	5.00	5.00	4.82	0.59

Figure 5. It is important to me to be able to allocate as much face-time to each patient encounter as I deem necessary.

Nearly 87% of respondents strongly agreed that sufficient time with patients is important. Of the 61 responses to this query, there were 37 registered comments. The sum total of the comments emphasized generosity of time as significant to the provision of proper care. In addition, 3 comments highlighted the importance of listening skills, 3 noted the importance of practice design as well as the importance of “breathing room” for

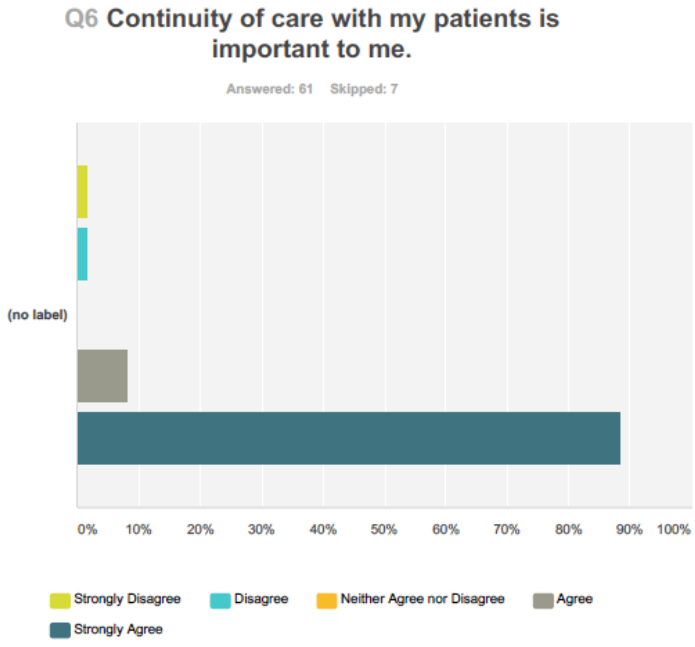
the physician in the course of clinical engagement with patients. Commentary was indexed thusly:

Input:

- Generosity of time
- Communication/Listening skills
- Efficiency (of practice and practitioner)

Output:

- Dimensions of quality of care.



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	1.64% 1	0.00% 0	8.20% 5	88.52% 54	61	4.80

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.80	0.67

Figure 6. Continuity of care with my patients is important to me.

Over 88% of micropractitioners strongly agreed that continuity of care is important. Physicians felt knowing patients across timelines is a therapeutic asset and a valuable component of care. Of the 61 physicians who responded to this query, 34 explained why continuity is fundamental to their practice. Micropractitioner commentary stressed relationship building, trust, and knowing a patient across timelines as hallmarks of primary care medicine. Particularly thought-provoking notations identified were that a physician “cannot outsource relationships” and continuity of care with patients is the “backbone” of primary care. Commentary was indexed as follows:

Input:

- Vitality of physician-patient relationship
- Trust
- Communication

Output:

- Dimensions of quality of care.

Group 2

Queries 7 and 8 refer to physician access and the use of technological assistance.

Over 62% of physicians strongly agreed that being reachable for patients needs after regular office hours is important to them. I linked physician availability by technological means to a generous and accommodating connectivity with patients. Of the 61 participants who answered this query, 37 commented. All respondents had provisions in place for physician access 24/7. Although 35 physicians made personal cell phone

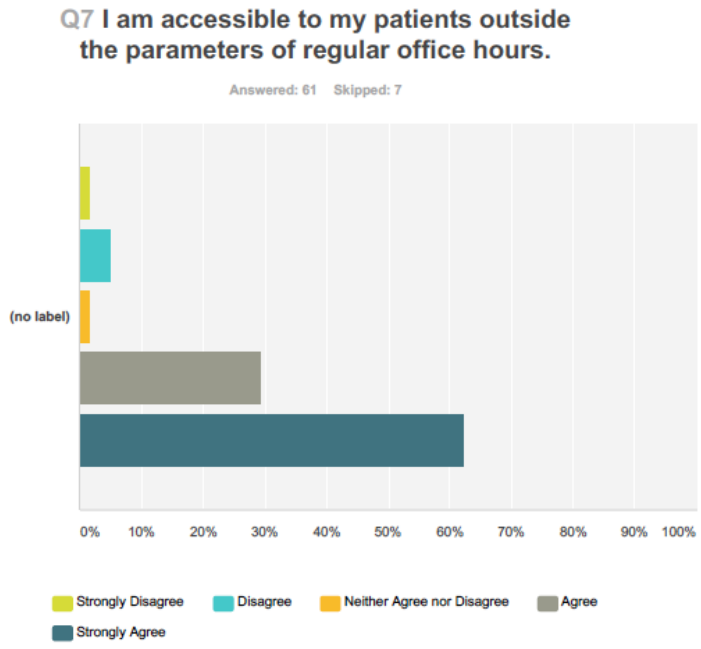
numbers available to patients, 2 physicians did not in order to preserve boundaries with their private lives. Communication and connectivity were selected as values tied to the to the clinical relationship. Commentary was indexed as follows:

Input:

- Access
- Communication

Ouput:

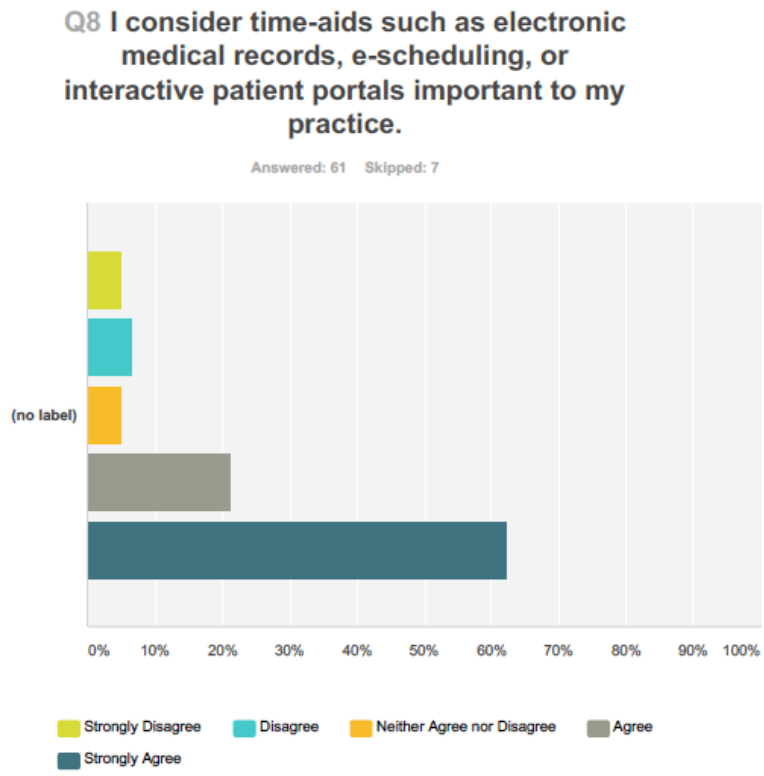
- Dimensions of quality of care



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	4.92% 3	1.64% 1	29.51% 18	62.30% 38	61	4.46

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.46	0.88

Figure 7. I am accessible to my patients outside the parameters of regular office hours.



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	4.92% 3	6.56% 4	4.92% 3	21.31% 13	62.30% 38	61	4.30

Basic Statistics				
Minimum 1.00	Maximum 5.00	Median 5.00	Mean 4.30	Standard Deviation 1.14

Figure 8. I consider time-aids such as electronic medical records, e-scheduling, or interactive patient portals important to my practice.

Over 62% of physician participants felt strongly that technological time-aids were important to their practice. Although the preponderance of respondents utilize applications of technology applications in order to create ease of access for patients and increase physician efficiency, commentary elicited varied physician viewpoints related to available technology. Engaging technology to assist in the management of one's practice

is a personal choice over a set of many alternatives. Of the 61 physician responding to this query, 37 commented. Twenty participants felt strongly that electronic medical records were a time-saver and contributed to better patient care. One particular comment noted "technology strategically integrated into a practice allows for decreased overhead and streamlining of procedures which, secondarily allows more time for the patient." Four physicians felt they had not yet found the right EMR for them. Seven comments about patient portals and e-scheduling were connected to broadening the touch-points of care. Interview statements by Dr. John Wasson can be positively connected to comments regarding the expectations of technology. When employing technology the practitioner should: "1) have more time to have a better practice; [and] 2) use things smart."[176] This perspective encapsulates the overall data items for this query. Values were categorized as follows:

Input:

- Wise use of technology
- Relationship building

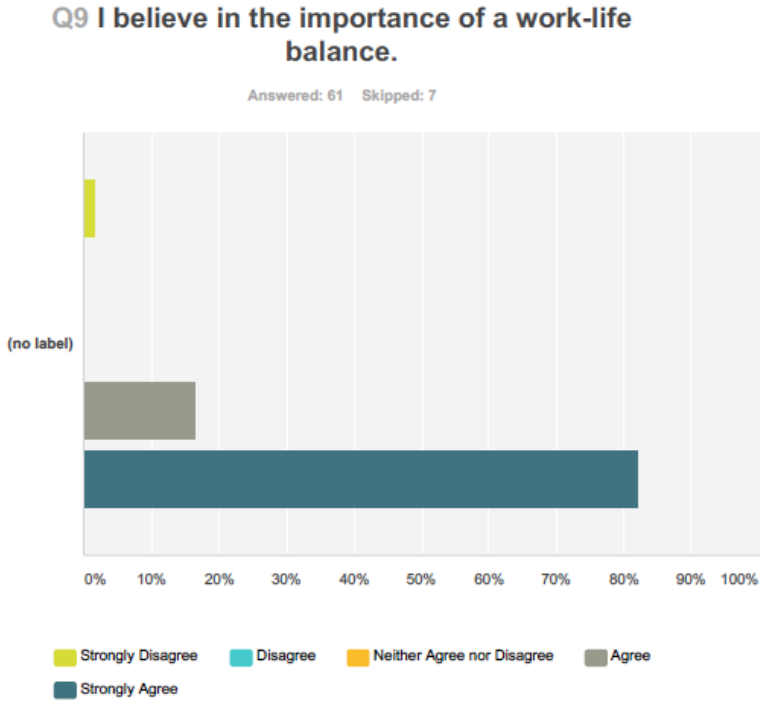
Output:

- Dimensions of quality of care.

[176] Wasson, interview.

Group 3

Prioritizing career and personal life, building down time, being grounded, and protecting energy are examined in queries 9, 10, and 11. These statements sought to elicit information as to the physician as person.



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	0.00% 0	16.39% 10	81.97% 50	61	4.77

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.77	0.61

Figure 9. I believe in the importance of a work-life balance.

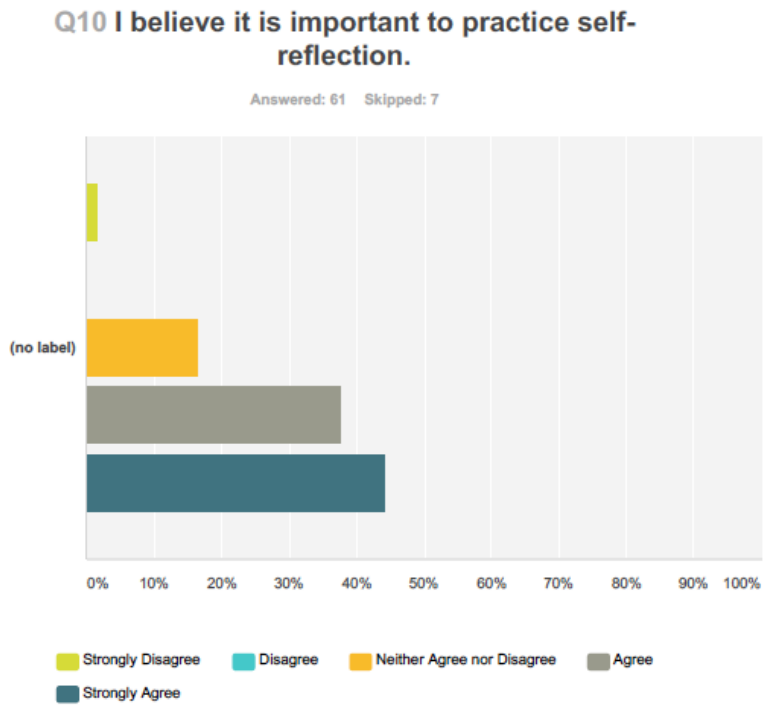
Nearly 82% of survey participants felt strongly that a work/life balance was important. Medicine is a demanding profession and prioritizing career and personal life requires making choices in order to prevent burnout. Of the 81 survey participants who responded to this query, 31 commented. Remarks indicated there were challenges faced in attempts to create harmony between being a physician and managing a personal life. All of the respondents felt that the mandates of medicine require great energy. Remarks indicated that professional and personal lifestyle harmony was a challenge to be met. Interesting comments that stood out were, “Burned out providers make lousy healers,” and having a “multifaceted life…promotes emotional wellbeing.” One physician wrote that their “work is my way of worship.” Another wrote, “Doctors are strongly selected for and repeatedly taught that you as a doctor trumps all else in life. As a profession we need more balance but primary care medicine is not a 9-5 profession.” Data was categorized as follows:

Input:

- Coping skills; protecting energy

Output:

- Physician excellence



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	16.39% 10	37.70% 23	44.26% 27	61	4.23

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	4.00	4.23	0.84

Figure 10. I believe it is important to practice self-reflection.

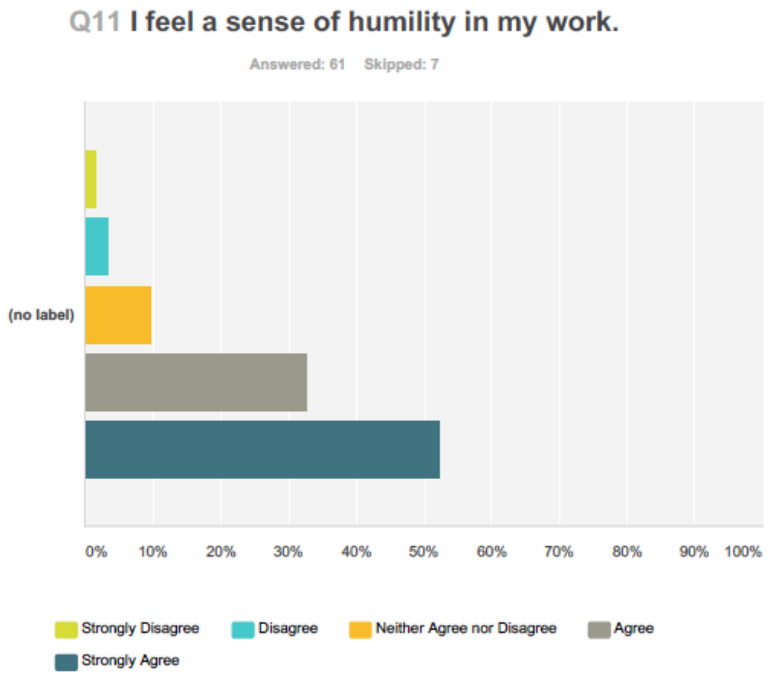
Nearly 45% of survey participants strongly agreed that it is important to practice self-reflection. Sixty-one physicians responded to this query and 23 commented. Remarks indicated that physicians felt a sense of mindfulness was helpful either personally and/or professionally. Overall comments were tied to assessing oneself in order to improve personal or professional life. Data values related to looking inward were categorized as follows:

Input:

- Being grounded

Output:

- Physician excellence



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	3.28% 2	9.84% 6	32.79% 20	52.46% 32	61	4.31

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.31	0.90

Figure 11. I feel a sense of humility in my work.

Nearly 53% of physician respondents strongly agreed that they feel a sense of humility in their work. Of the 61 physicians who responded to this query, 29 participants commented. Humility in its many facets has moral implications and is seen as a virtue. Several comments aptly encircled the point in question. One physician noted, “Medicine done well is a constant act of service and is therefore humbling.” Another commented, “My work is a service-oriented mission for others.” Another respondent wrote that it is “Humbling to be invited into people’s lives at most vulnerable points.” Responses were classified as processing things outside oneself and developing a sense of context for one’s place within the sphere of clinical practice. Data was categorized as follows:

Input:

- Perspective of your place in context

Output:

- Physician excellence

Interview

Close readings of the August 2015 interview with Dr. G. Gordon Moore and Dr. John Wasson garnered information on the finer points of micropractice in addition to providing a platform to corroborate input classifications from physician comments. The input categories of: 1) generosity of time; 2) physician engagement; 3) communication skills; 4) efficiency; 5) vitality of the physician-patient relationship; and the 6) wise use of technology were discussed and in alignment with the long view that each of these physicians share regarding the facets of quality for micropractice.

Additionally, within the parameters of the transcribed interview, prominent subject matter was broken down into statements that captured information relevant to the convergent study. This provided topically related insights, which are put forward as follows:

1) Micropractice is a practice option for clinicians who wish to devote generous time with patients. This takes into account "breathing room"[177] for the physician to pause and reflect on the clinical work being done.
2) Manageable patient panels permit space for better physician and patient engagement. Ergo, there is enhanced patient focus and physician capableness. This allows for a clinical environment where issues may be uncovered that otherwise have the potential to be overlooked in hurried time frames.
3) Simple and effective assessment forms/questionnaires can solicit information and channel the voice of the patient, bringing a measure of confidence and collaboration to the clinical moment. It brings patients "into the mix."[178] The How's Your Health[179] survey being an example given by Dr. Wasson.
4) EMR selection is a personal choice for a physician and has to be utilized to make the day easier and meet the immediate needs of the physician rather than for national aggregation data.

[177] Wasson, interview.

[178] Moore, interview.

[179] How's Your Health Survey (howsyourhealth.com) is an online assessment form that helps a patient create an action plan that guides the individual to improved health based on personal health status. As free service through Dartmouth College, it is intended as a health information tool for a patient to share with their physician. Dr. Wasson is Professor Emeritus of Community and Family Medicine and the Herman O. West Chair, Dartmouth Medical School.

5) Approaches to interacting with people start at a very "*ad-hominem,* very personal level."[180] Micropractitioners are interested in meaningful one-to-one clinical interactions with patients. This is foundational to this practice pattern.
6) Three reasons micropractice can fail are:
    a. geographical factors where typical insurance reimbursements make it very difficult to remain independent.
    b. unfortunate choices in technology which prove exceedingly expensive.
    c. lack of organizational skills of the micropractitioner.

Discussion: Strengths, Limitations, Implications

This original research consisting of a self-designed survey instrument was devised to answer primary investigative questions about who, what, where, when, and why of micropractitioners. The findings offer a first look at demographic information and general practice proclivities of this physician cohort. The principal strength of the study is that it is the first of its kind and it reveals compelling information about the physicians who practice medicine as micropractitioners. Over and above its robust response rate of 40%, it opens up a door to future research. It lays a foundation to explore further the concept of micropractice and those clinicians who choose to practice medicine within its construct.

The limitations of the study may be argued in the structure of the wording for queries 4 -11. While acknowledging that the construction of the statement menu could

[180] Moore, interview.

encourage answer preference, this author also recognizes that any technically perfect survey item can still limit information from a respondent. The comment section of the survey instrument was incorporated in order to allow for voluntary and unprompted feedback. The objective being to garner well-grounded results on why the respondents answered queries as they did. Content analysis converted the raw contextual data into principal categories through an uncomplicated systematic means. A simple coding schedule was implemented for feedback remarks and the analysis provided evidential support about the activities and attributes of the clinician authors. This yielded actionable insights about the commentary and allowed for inductive inferences.

Keynote themes excavated from the contextual groupings brought to light that micropractitioners are by the distillation of practice prescription, physicians who are dedicated to engaging in a dynamic physician-patient dyad, are clinicians who take into account ease of physician access that is enriched through varied technologies, and who strategically effectuate a meaningful professional life by way of reasonable patient panels and small office footprints. The implications of this exploration give rise to the physician as assuming the primary role and values of a healer and fulfilling the core expectation of medicine itself. Micropractitioners preserve the values of a healer, in changing times, because they link the roles of healer and professional by way of practice design and their commissions as clinicians in conventional care. The concept of professional medicine as a means to organize the delivery of complex service to a greater populace can always be reduced to the role of the physician that includes being a healer. It is this role of physician as healer that is primary to the practice of medicine and it is in this capacity that

humanistic care is experienced and carried out. Micropractitioners emerge through the findings of this study as physicians who provide proper and humanistic care that is intended to be well-timed and well-suited for their patients.

In the constellation of the clinical constituency involved—physician and patient—and the actions involved- caring and cure- and the infrastructural conditions- office composition- micropractitioners are seen as practicing medicine in a straightforward manner. This common sense approach is built up from many pragmatic parts. As *ad rem* healers, the research indicates: they engage patients with generosity of time, listen, have ample clinician access, employ the smart use of technology, and aim to build strong therapeutic relationships across time lines. They endeavor to be grounded by seeing themselves in context and they believe in a work/life balance. In effectuating their physician roles as they do, they practice medicine not only in a way meaningful to them as healers, they demonstrate physician excellences as well.

CHAPTER 5

SUMMATION, RECOMMENDATIONS, CONCLUSION

> Wherever the art of medicine is loved, there is also love of humanity.
> — Hippocrates

An Introspective Accounting and Summation

The practice of medicine is best appreciated as a distinct micro-system: a two-party interchange of doctor and patient dedicated to healing. Always dynamic in its mechanics, the substance and energies of this dyad are invariably linked to the position of the physician and how that role is administered. When there is an astute application of the science of medicine conjoined with the proper sentiments of its art, the practice of medicine resultantly becomes an enlivened force that is asserted at the convergence of physician with patient. At that moment, the practice of medicine distinguishes itself as "the most humane of all the sciences... the most scientific of the humanities."[181]

Micropractitioners practice medicine within the construct of a classical healing dyad. They discharge their clinical duties at the constitutive level. They do not separate the treatment of the patient from the physician-therapist. They do not outsource the physician-patient relationship.

In relation to all of medicine, micropractitioners may represent a form of "old school" but they are not an anachronism. Every form of medical practice is connected to the past. From Hippocrates onward physicians have always had a two-fold committal: to

[181] Pellegrino, 17.

button down the prevailing scholarship of the day and to apply that expertise to the treatment of a particular patient with caring. In contemporary medicine this carries forward. It entails the adroit merger of two distinct roles: the role of the doctor, a member of a profession based on the mastery of an ever-changing complex body of scientific knowledge; and that of the healer, derived from antiquity as someone who serves their fellow man with compassion. As medicine progresses, the charge to interweave these two corresponding functions is embedded into every advance, notwithstanding that the primary undertaking of a physician is in the role of a healer. Hence, modern medicine is a derivative of everything that has come before it.

Micropractitioners preserve what they need from the lineage of medicine and its laudable facets while meeting conditions of present-day demands. They practice medicine at a personal level: the matrix of their workspace supports this end. They combine their scientific capabilities with well-suited technologies. Micropractitioners do not dismantle the dyad in their deliberations concerning operational functions. Unlike large and complex health care organizations, which engage in efforts to stabilize patterns of action and the flow of human experiences through the division of services, the process management of a micropractice is simple, the physician "wears many hats."[182] In their nano surroundings the picture is clear about how to plan and execute objectives, the most important being the conservancy of a strong therapeutic partnership. Medicine is shaped by a combination of forces: social, political, and economic. Even as these factors strive to

[182] Michelle Eads, in "What's a micropractice?' *Medical Economics*, Wayne Guglielmo, ed. (December, 2006).

set boundaries on its dominion, physicians within the purview of their professional autonomy can set out to practice their craft in varied ways. They can choose to be salaried or independent. They can determine how they wish to be remunerated: third party reimbursement or direct fee for service. They can opt to work in any configuration or size of practice. What is notable about micropractitioners is that the *modus operandi* of their small-scale design, which by construct restrains large-scale earnings, is replete with a recompense of personal and professional satisfaction. These rewards are a draw to physicians who seek an ongoing fulfillment in medicine as they serve their patients. Medicine, in theory, in order to be satisfying both professionally and personally, has to be considered a calling: you have to have a sound sense of self and a strong sense of purpose. If the profession of medicine today seems at times to fail to redeem what a doctor should be and under what circumstances a patient qualifies to see an actual physician, one can look to micropractitioners: they know who the doctor is.

Research Conclusions

This study set out to answer fundamental questions about physicians who provide medical care as micropractitioners. Its aim was achieved. The compilation of data as discussed in Chapter 4 offered a first look profile of micropractitioners. The importance of this research emphasized the mainspring and motives of this physician cohort. This investigation showed that micropractitioners approach the practice of medicine with sensibility and responsiveness by keeping a sharp focus on the utilities and details of the physician-patient relationship. Their application of technology has a practical purpose: it

is not employed to supersede the presence of the physician. As a matter of course, micropractitioners administer their physicianship in a down-to-earth manner and practice medicine with attributes of humanistic caring.

Recommendations for Future Work

This study of micropractitioners draws attention to a number of areas on which future exploration would be beneficial.

1) Given the changing landscape of medicine, a longitudinal study would document progress of micropractices which are counterpoised against the labyrinthine framework of complex health care delivery systems. The investigation could demonstrate and gauge the long range viability of this model.
2) While current spheres of medical education furnish the essential instrumentality of clinical education, examining how the roles of the physician and the physician-healer could be integrated stereoscopically throughout medical school, would contribute to physicians becoming not only competent in clinical methods but also more patient-centered, more reflective in their practice as are the micropractitioners of this study. I was contacted in January, 2016 by a Brown University medical student interested in micropractice so there is an interest and a measure of regard for this practice pattern in the upcoming generation. Additionally, throughout the course of writing this dissertation, I have been a featured speaker regarding my research for two

IMP events. The reception for both national forums was well received and proved to be of interest to this medical student.

3) Based on the quantitative data, particular attention given to a gender study regarding micropractitioners would be enlightening. Since the results of this research indicated that the majority of micropractitioners are female the question arises—is there a component to micropractice and its infrastructure that serves as an appeal to those physicians who are female?
4) Encouraging physician networks is important to independent physicians, thus enabling ways to share resources. Ideal Medical Practices, the peer to peer affiliate for micropractitioners, graciously allowed me the opportunity to conduct my research. It is launching numerous organizational initiatives over the next three years. A macro study examining the success or failure of their objectives would grant greater perspective on the identity and brand of micropractice.

Conclusion

This dissertation is a groundwork study in the examination of micropractitioners and their pattern of practice in primary care medicine. It brings into focus the habitudes of this physician subset and their fidelity to the undiluted role of the physician within the clinical relationship. This academic discourse begins the scholarly history on this subject matter. I hope that it will play a part in future research as the ongoing narrative of micropractice physicians continues to unfold.

APPENDIX A

CODING, PATTERNS, CATEGORIES

TEXT CODING - COMMENT SECTION

Symbol	
T – T	Text to text
T – S	Text to self
T – PP	Text to practice pattern
T – P	Text to profession
I	Infer
2/2	Synthesize
C	Confirms/Corresponds

TEXT PATTERNS - (Information Input)

Access
Efficiencies
Communication/Listening skills
Generosity of time
Grounded
Perspective
Physician engagement
Protecting energy
Relationship building/trust
Vitality of physician-patient relationship
Wise use of technology

CATEGORIES – (Outcome Classifications)

Dimensions of quality of care
Physician excellences

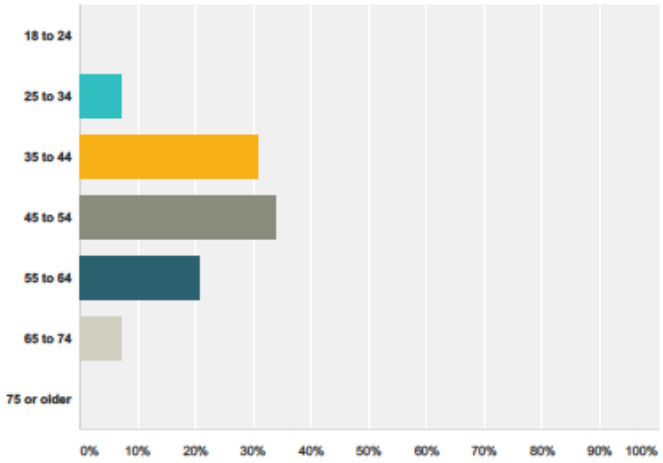
APPENDIX B

MICROPRACTIONER PHYSICIAN SURVEY

(SurveyMonkey results following 26 pages)

Q1 What is your age?

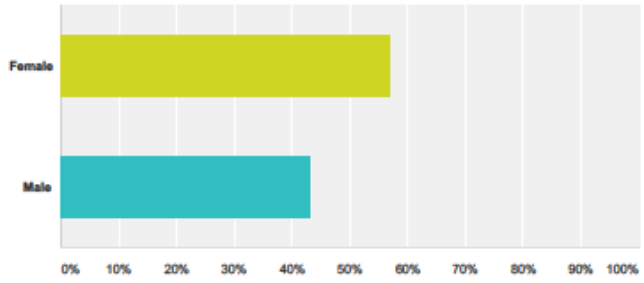
Answered: 68 Skipped: 0



Answer Choices	Responses	
18 to 24	0.00%	0
25 to 34	7.35%	5
35 to 44	30.88%	21
45 to 54	33.82%	23
55 to 64	20.59%	14
65 to 74	7.35%	5
75 or older	0.00%	0
Total		68

Q2 What is your gender?

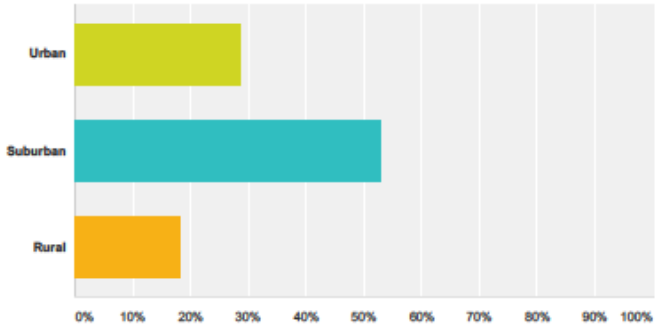
Answered: 67 Skipped: 1



Answer Choices	Responses	
Female	56.72%	38
Male	43.28%	29
Total		67

Q3 How would you describe your practice location?

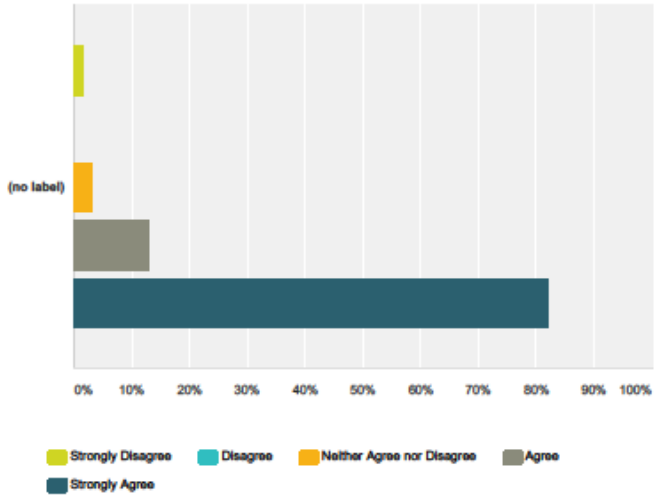
Answered: 66 Skipped: 2



Answer Choices	Responses	
Urban	28.79%	19
Suburban	53.03%	35
Rural	18.18%	12
Total		66

Q4 I consider my present mode of practice patient-centric.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	3.28% 2	13.11% 8	81.97% 50	61	4.74

Basic Statistics				
Minimum 1.00	Maximum 5.00	Median 5.00	Mean 4.74	Standard Deviation 0.68

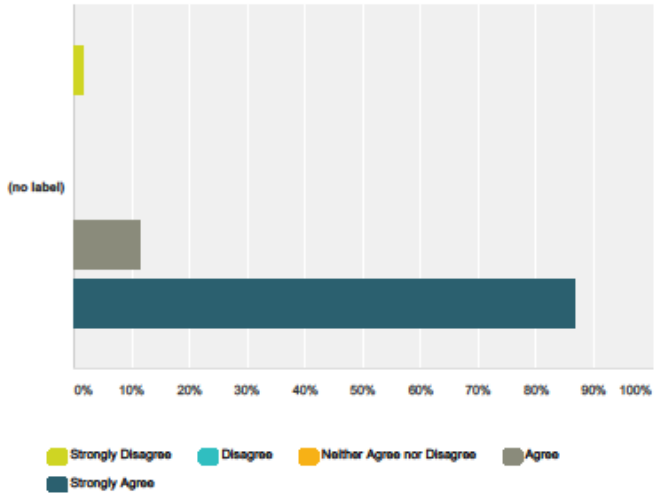
#	Please explain your response in a few sentences:	Date
1	When they need it. What they need. From a perspective appropriate to their level of understanding.	6/30/2015 1:52 AM
2	I spend time with my patients , I try to meet their needs in a timely fashion	6/29/2015 11:50 PM
3	I do family medicine and the longer I do it I think family refers to my patient doctor relationship.	6/29/2015 4:58 PM
4	Low overhead creates more time with patients.	6/5/2015 12:09 PM
5	We put patients first, accommodate them as much as possible, I personally check their meds each visit. They have my cell phone and home number. I am currently taking care of many families for 3 and 4 generations.	6/3/2015 7:08 PM
6	Patients are able to get care directly from me when they need care (appropriate care at appropriate time). Most lines of communication are direct between me and my patients. If a patient doesn't communicate directly with me, there is only one potential staff person between them and me. I am available 24- 7 to talk with directly. Patients can always see me for same day and same week appointments. I have appointments long enough (regular non acute appointments are between 30minutes and one hour) to have time to talk and listen with patients.	5/31/2015 2:00 PM
7	All decisions about changes are made with the patients' interests put first.	5/28/2015 7:23 PM
8	The office focus is on the patient and patient care. Anyone who calls for a same day appt is seen.	5/28/2015 12:51 PM

9	I spend more time than average with patients, and they are my focus.	5/27/2015 1:20 PM
10	we strive to provide the care people feel they need when they need it. a real person answers the phone that knows the patient. we offer same-day appointments. we see people for free that fall through the cracks. patients always see their doctor. all this is easy in a solo practice;-)	5/20/2015 3:19 AM
11	Everything I do revolves around making the experience personalized and amenable to patients. My whole style of care is to individualize care to a specific patient's needs and wants.	5/18/2015 8:26 PM
12	We cater appointment times to patient care needs and what we need to address. We also cater management to their needs specifically while still following treatment algorithms as lain out by our certifying board. Lastly, because we are small, patients always get to their care team to have their issue managed effectively.	5/17/2015 12:47 PM
13	The approach to my patients is unique for each patient based on their circumstances.	5/17/2015 7:04 AM
14	Solo practice, individualized care. Do not use coverage except hospitalized care.	5/16/2015 6:35 AM
15	My goal is to try to make things as easy as possible for my patients to get the medical care that they need, within reason.	5/15/2015 11:38 PM
16	High on quality interactions. Being one person, my hours are limited compared to a typical group practice that has evening hours.	5/15/2015 9:43 PM
17	If I didn't have patients, I wouldn't have a practice!	5/15/2015 8:11 PM
18	My practice is designed with low overhead in order to allow longer patient visits and short to no wait times because these are some of the factors most important to patients. We also strive to always have same day access for established patients. This is only possible by keeping costs down since I have to be able to cover expenses and make a living.	5/15/2015 6:42 PM
19	Instead of the practice being built around the convenience of a large office staff or the organization that owns everything, I can easily make my practice suit the needs of just my patients and me. I realized I wasn't using my second exam room but I did need more space for kids to play while their parents sat with me. I didn't need a committee to decide what to do. One weekend I rearranged and now have a family room full of toys and books and each kid gets to take home a book whenever they come. Much better use of space! Every decision in my office can be made similarly.	5/15/2015 5:47 PM
20	we aim for superb access for patients, and try to treat them as individuals with problems, rather than as diseases who need to be fit into protocols.	5/15/2015 4:50 PM
21	My practice is highly available. Same day and next day appointments are highly	5/15/2015 3:42 PM
22	I keep to set appointments that start on time and end on time. I draw blood within a minute and send it off. My billing process and paperwork and very simple. I listen take time and partner with patients. They have direct access to me by portal and no one else covers for me.	5/15/2015 3:21 PM
23	ontime uptodate accessible	5/15/2015 12:01 PM
24	1. Patients are given open access to the practice scheduling online, 2. patients are not forced to wait at appointments because we do not overbook and we leave plenty of time for each visit 30-60 minutes so as to not run over. This gives time to explore patient concerns fully. 3. Patient preference is always respected, even when we do not agree and this does not usually lead to their dismissal from the practice.	5/15/2015 11:35 AM
25	whole practice is set up in multiple ways to make it easy for patients to communicate their needs in many and legion ways with me	5/15/2015 11:34 AM
26	When patients call my clinic, I answer the phone. When they have a question or concern they know that I am the one handling it directly. Patients are easily able to get appointments when they need them and when they come in for appointments they feel that all of their needs are addressed in that one appointment	5/14/2015 10:23 PM
27	The whole purpose is to take care of the patient.	5/14/2015 4:51 PM
28	I work to make things easier and more satisfying for the patient by accommodating their schedules, giving them as much time as they need, and working with them in their own way.	5/14/2015 2:12 PM
29	Appointments are available outside of normal clinic times. I believe my role is to educate, advice, and coordinate. The patient is the center of their care.	5/14/2015 12:27 PM
30	I decide how long I spend with patients andhow time is scheduled allowingspawned as necessary when a patient has special concerns. This allows a more relaxed atmosphere, and I think patients are better able to open up about their worries. They are also able to be honest and I think they are more accountable in the setting.	5/14/2015 1:01 AM

31	I have set up the practice to focus on all aspects of what the patient wants and needs. I provide same day access, short waiting times, long visits, and coordinated referrals to specialists when necessary. I even have a health coach whose services are free to my patients who need extra help in improving their confidence in managing their health.	5/13/2015 9:20 PM
32	All calls and visits are performed by the MD. Low patient volume means long, involved consultations and visits.	5/13/2015 6:31 PM
33	I prefer 'relationship centered' - a balance between my needs and the patients.	5/13/2015 1:37 PM
34	I have much longer than typical appointment lengths, high amount of direct availability to patients, and describe my style as collaborative discussing options in a a way that allows patients to make the best decisions for them.	5/13/2015 1:10 PM
35	I do my best to address the medical and psychological needs of my patients. That said- increasingly the bureaucratic oversight of third parites demands more and more of my time and energy even during a medical encounter.	5/13/2015 12:55 PM
36	OUR TAG LINE IS SMALL TOWN YOU CENTERED MEDICINE. I TRY TO COME UP WITH AS FRIENDLY PT POLICIES AS POSSIBLE GIVEN MY LIFE. EASY ACCESS, CONVENIENT TOWN, FLEXIBILITY, AND INCREASINGLY MORE SERVICES. I WOULD LOVE TO OFFER MEDS IN HOUSE BUT NJ STATE WILL NOT LET ME.	5/13/2015 12:15 PM
37	It was designed to be so from the start.	5/13/2015 11:49 AM
38	I strive to be available to my patients, to spend more time with them, and to be accessible as much as possible.	5/13/2015 11:37 AM
39	When people come for a visit I may have an agenda but I almost always ask them first what they want to do at the visit. I see everyone the day they call. I try really hard to walk along witht hem and their beliefs to give them care and do not dismiss people	5/13/2015 11:29 AM

Q5 It is important to me to be able to allocate as much face-time to each patient encounter as I deem necessary.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	0.00% 0	11.48% 7	86.89% 53	61	4.82

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.82	0.59

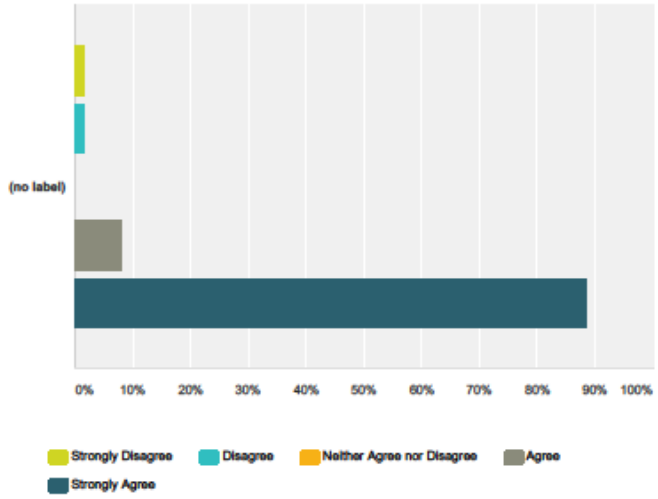
#	Please explain your response in a few sentences:	Date
1	The ability to spend time with patients when they need it improves health and prevents many future health problems (as well as future visits). It also fits my personality and work style best.	6/30/2015 10:06 AM
2	More frustrating for me to cut short. Time	6/30/2015 1:52 AM
3	I live in an area where many people wait for the doc to has the questions. sometimes it takes time to get the full story out.	6/29/2015 4:58 PM
4	See above.	6/5/2015 12:09 PM
5	I schedule 30 minutes per patient and since I am only in the office 3 days a week we schedule any same day needed appts at the end of the day if no open slots	6/3/2015 7:08 PM
6	My schedule has enough breathing room that I can visit longer when needed and see extra patients when needed without compromising the care I give to anyone, including myself.	5/31/2015 2:00 PM
7	Many problems cannot be adequately addressed during brief visits. If all issues cannot be addressed at one visit it is important that there are very brief wait times for follow-up.	5/28/2015 7:23 PM

8	I choose a low overhead model of practice to increase face to face time.	5/27/2015 1:20 PM
9	It is important to respect the other patients in the practice by trying to run on time. So there are limits on patient visit time if the longer time is unexpected	5/20/2015 1:25 PM
10	It has been a decade since an administrator told me I was not seeing enough patients in a day. #dontmissit and I sometimes even allocate as much face-time as the patient deems necessary!	5/20/2015 3:19 AM
11	So much of what I do is counseling and that simply requires time.	5/18/2015 8:26 PM
12	See response above	5/17/2015 12:47 PM
13	As Osler taught: "Listen to your patient, he is telling you the diagnosis." Being face-to-face allows that to happen.	5/17/2015 7:04 AM
14	Within reason (not over 1 hour), when seeing pt, answer all questions and provide written documentation.	5/16/2015 6:35 AM
15	Enough time to do the job right enables good morale for patients and doctors. It fosters meaningful interactions where there is opportunity to work on tough problems.	5/15/2015 9:43 PM
16	I left my old job in assembly line medicine due to pressure to see more and more patients faster and faster.	5/15/2015 8:11 PM
17	Health care is complex and many of the functions essential for improving the health of patients require time. It takes time to obtain a history adequate to assess often complex health problems, time to think, time to explain enough that the patients can understand their health enough to participate in their care, and the all important time to build the trust essential to a therapeutic relationship.	5/15/2015 6:42 PM
18	Only my very analytical patients, often with careers like engineering, are able to make a nice list, run through the points, and be done. The majority of patients meander, think of new things, need me to address their emotional reaction to things as well as the facts. That all takes time. Plus, at a family physician I care for the whole family. That often means addressing how a patient's diagnosis affects their family members, my other patients in the room.	5/15/2015 5:47 PM
19	Face-to-face time allows much better assessment of the patient.	5/15/2015 4:50 PM
20	I don't want to feel like I am stressed and behind all day. If I don't listen I may make the wrong decision in terms of testing, referral or procedures.	5/15/2015 3:21 PM
21	Often thats 3 minute total incl check in And tge pts live that quick service	5/15/2015 12:10 PM
22	By not having clinical support staff, all of the clinical time is spent with the doctor which allows most all of a patient's concerns to be raised in a way that is comfortable for them.	5/15/2015 11:35 AM
23	I do this booking 1- 2 hours for home visits 1 hour for PE with 10 minute buffers will book longer if it takes longer for a particular patient 30 minutes with 10 minute buffer for regular visits that's often almost enough time!	5/15/2015 11:34 AM
24	Medicine was never meant to be delivered in 10 or 15 minute increments, especially not primary care. When I worked for a large healthcare system and relinquished control of my schedule to administrators, I spent all day compromising my values about what optimal health care delivery looks like. I learned the art of body language to communicate that I was out of time and needed the patient to stop talking. This is not why I went into medicine. I am much happier in my micropractice, where I can be as thorough as I want to be.	5/14/2015 10:23 PM
25	The work needs to be done regardless of the amount of time I have. Frequently people need a lot of time or are due for labs/exams that they didn't schedule for	5/14/2015 4:51 PM
26	Always any amount they need.	5/14/2015 2:12 PM
27	Talking to the patient and getting to know them improves diagnostic accuracy and builds trust.	5/14/2015 12:27 PM
28	this has been difficult to maintain given decrease reimbursement for our time. Using a medical record further challenges me since a computer can be very distracting. I have found it necessary to allocate more time to appointments, but have also been able to use my support staff to perform a lot of the data entry I used to do. This allows me to connect with the patient, gather appropriate information about their condition, and give them enough time to feel heard and understood.	5/14/2015 1:01 AM
29	Starfield warned that we need to be on the patient's agenda, not our own. When I am rushed for time, I immediately jump to my agenda. When that happens, I am no longer practicing patient centered medicine.	5/13/2015 9:20 PM
30	Lay people can't determine the seriousness of their condition if I can't take the time to explain it to them	5/13/2015 6:52 PM
31	See above.	5/13/2015 6:31 PM
32	Even taking vitals, etc that is normal done by MA's allows patients time with me and allows immediate discussion and recognition of any abnormal (or sometimes normal) results.	5/13/2015 1:10 PM
33	I spend time with patients. One hour for first or annual visit and 1/2 hour for follow-ups. Also buffer visits so that time is truly dedicated to patient contact.	5/13/2015 12:55 PM

34	GENERALLY NEW PATIENT NEED 60-90 MINUTES WHICH IS IMPOSSIBLE. I CAN FLEX TIME BASED ON A PT PERSONALITY AND THAT MAKES PEOPLE FEEL LIKE THEY ARE LISTENED TO AND I CAN GIVE THEM THAT FLEXIBILITY.	5/13/2015 12:15 PM
35	If face time includes email and phone calls as well.	5/13/2015 11:49 AM
36	Yes, I think not having support staff to room patients and do vitals has helped me be with my patients longer. Also I schedule 30 minute visit for most older patients on multiple medications and I often will block spots in my schedule if I see that it is filling up too much.	5/13/2015 11:37 AM
37	Obvious Medicine takes time tot hink and it takes enormous time to explain	5/13/2015 11:29 AM

Q6 Continuity of care with my patients is important to me.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	1.64% 1	0.00% 0	8.20% 5	88.52% 54	61	4.80

Basic Statistics				
Minimum 1.00	Maximum 5.00	Median 5.00	Mean 4.80	Standard Deviation 0.67

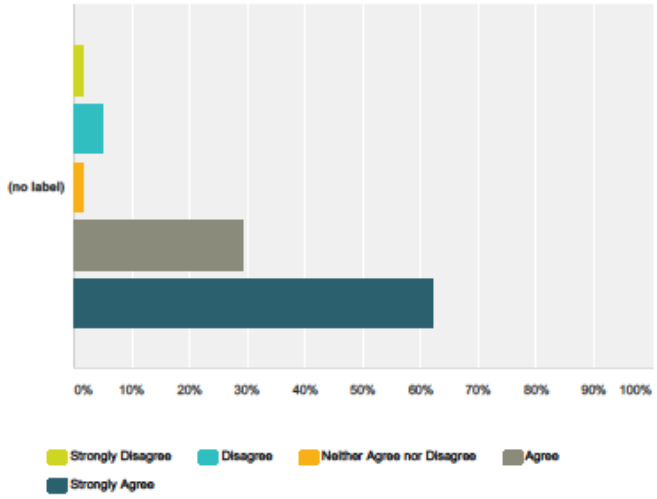
#	Please explain your answer in a few sentences:	Date
1	Starting over with each patient is a painful process when moving practices or doing urgent care work. The relationship that develops over time is crucial to the healing that takes place in primary care practice.	6/30/2015 10:06 AM
2	My LPN and I know our patients	6/30/2015 1:52 AM
3	Sometimes it is the only way to get the correct diagnosis	6/29/2015 4:58 PM
4	I keep my panel size small (approx. 600 patients). I know them all.	6/5/2015 12:09 PM
5	recent story- one of my long time mod. alzheimers patients with multiple meds and problems went to the local express care for a sore foot. they sent her to the hospital for an xray 25 min away. they called her and said it was broken. she saw the ortho. he was worried about an open wound on her leg. he told her she needed to see a cv surgeon but it would take several months to schedule an appt. he told them to take her to a tertiary care hospital 90 min away. they did vascular studies and said good circ no dvt. she is cultured after 2 ab no growth. 5 weeks later I see her without anyone ever telling me or sending me records although every place says in their notes see pcp. the hole is now 2 cms. still don't have the xray report. lots $ poor results	6/3/2015 7:08 PM

6	All of my patients carry my contact information and know to provide this to all providers collaborating in their care. I provide ED doctors with patient background information and my contact information when I send someone to the ED. I communicate with hospitalists in the same way. I request discharge information from EDs and hospital stays and request discharge calls when appropriate. I send consult notes with appropriate background information to facilitate best care by specialists. I ensure I have adequate information from specialist visits either through their notes and records or via direct calls to fully understand specialist thoughts and plans. I keep very up to date medication lists that I provide to all providers in care collaboration. I elect to pay subscription fees to institutional facilities to allow myself access to their EMR systems as I have found this is the only way to make my above systems possible.	5/31/2015 2:00 PM
7	Continuity not only greatly enhances patient care it also contributes to my job satisfaction.	5/28/2015 7:23 PM
8	For most things continuity is important but for minimal type of things patient convenience might outweigh continuity	5/20/2015 1:25 PM
9	that's why I went into primary care, and it's one reason I went solo over 10 years ago	5/20/2015 3:19 AM
10	Because so much of what I do is counseling and lifestyle modification, that requires building of trust and consistency of message over time to allow patients to make changes at their own level.	5/18/2015 8:26 PM
11	Efficient and complete evaluation and therapy need continuity. Less than that is disruptive to a process of healing.	5/17/2015 7:04 AM
12	See #2	5/16/2015 6:35 AM
13	Makes the job easier and more satisfying.	5/15/2015 9:43 PM
14	I love getting to know patients and their families.	5/15/2015 8:11 PM
15	Lack of continuity is one of the major causes of unnecessary and often repetitive testing, medication errors and poor patient outcomes. It usually takes several visits for a physician to know and understand a patient and several visits for patients to trust their doctors enough to tell details that they may be embarrassed or ashamed about or to trust them enough to follow their instructions. Good continuity of care allows each encounter to be more productive rather than subjecting the patient and doctor to a never-ending series of first dates.	5/15/2015 6:42 PM
16	I know my patients very well so I can provide better care. I know what procedures have already been done, who has hypocondriasis (and the best way to calm them down), who can be trusted to give an accurate report over the phone and who needs to be seen because she says she's fine even when she's blue.	5/15/2015 5:47 PM
17	I find it wasteful and often harmful when continuity is broken.	5/15/2015 4:50 PM
18	Because I have follow up, I can start with less aggressive options and then be available at the next step.	5/15/2015 3:21 PM
19	Continuity is key to trusting relationships. I frequently hear that from patients when they explain why they have left a traditional practice to come to our ideal medical practice.	5/15/2015 11:35 AM
20	yes of course this is too obvious one doctor knowing the patient well is worth 3 specialists madly ordering tests	5/15/2015 11:34 AM
21	I take care of entire families and in these longer appointments, really get to know them. It gives me insight into what may be at the root of their health issues.	5/14/2015 10:23 PM
22	the patient and I have a plan we are following, if someone else sees the patient they don't know our plan.	5/14/2015 4:51 PM
23	Knowing my patients helps me prevent chronic diseases from worsening, quickly address acute issues, and prevent unneeded ER care.	5/14/2015 2:12 PM
24	Fragmented health care is poor health care. Too many providers and hand offs increase medical errors. I also find the relationship developed between my patients and myself with continuity of care is what I enjoy most.	5/14/2015 12:27 PM
25	I have considered changing practice models, but I'm reluctant because I have cared for some patients for over 20 years, and they are on Medicare and I would not be able to continue their care. Likewise I have had patients that due to some difficulty will end up on a Medicaid program, and have enjoyed continuing their care through whatever tragedy they have suffered. I love caring for all generations and find it a little frustrating that there are so many pediatricians I see much less of the children. It is quite fun to have an aunt, grandchild, grandmother, and mother all in the same room for a visit. I find I can be objective but still have a fairly intimate, casual relationship when this bond has been created. my patience help me understand the barriers that they work with, often improving the medical recommendations. This is truly how to practice the art of medicine.	5/14/2015 1:01 AM
26	This is perhaps the most important aspect of family medicine. We cannot outsource relationships and relationships are strengthened through each visit, each concern, and each problem addressed over years. When you know your patient, you will advocate for them and go out of your way for them. If they are just another number, you have no reason to see them (other than money).	5/13/2015 9:20 PM
27	I like to know what is going on so that any interventions are in my patient's best interest	5/13/2015 6:52 PM

28	I find it much easier for both patients and doctors to be familiar with each other. My patients know (and hopefully like) my practice style, but I also know them. Who needs to be prodded to gets tests, who needs to have their tests and results ASAP or they will be suffering just from not knowing.	5/13/2015 1:10 PM
29	I believe patients get better care when it is longitudinal, but patients often choose to get care from multiple sources-specialists. It becomes very important to coordinate and assess appropriateness of care.	5/13/2015 12:55 PM
30	IT'S FAMILY MEDICINE. PERIOD.	5/13/2015 12:15 PM
31	This is the back bone of primary care and the joy of my work.	5/13/2015 11:49 AM
32	I am constantly trying to get records from specialists who see my patients. If patient is hospitalized, I log in to the system and follow them daily.	5/13/2015 11:37 AM
33	Obvious UNsafe any other way	5/13/2015 11:29 AM

Q7 I am accessible to my patients outside the parameters of regular office hours.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	4.92% 3	1.64% 1	29.51% 18	62.30% 38	61	4.46

Basic Statistics				
Minimum 1.00	Maximum 5.00	Median 5.00	Mean 4.46	Standard Deviation 0.88

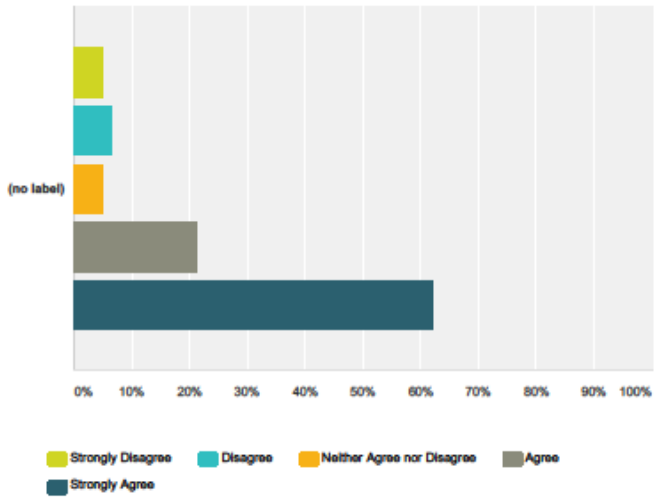
#	Please explain your response in a few sentences:	Date
1	Because I have a small practice, I am able to be reasonable flexible in seeing patients when they need to be seen. I have found having set "standard" hours (for me 9-2 on school days) sets the expectation that that is when I can normally see people but I often see people at other times. This "bonus" availability is then appreciated for what it is.	6/30/2015 10:06 AM
2	They know my van. My children. My church	6/30/2015 1:52 AM
3	I am in the office 5 days a week and often call after hours, but my private time after this I no longer let patients call 24 /7 as it was taken advantage of it n the past	6/29/2015 11:50 PM
4	I carry my cell phone and encourage texting. If I walk away from my phone I check to see if I missed a recent call.	6/29/2015 4:58 PM
5	I am on call 24hours 7 days a week for my patients except for when I am away.	6/5/2015 12:09 PM
6	I answer my cell phone and home phone or they can call my receptionist who is a paramedic. they respect my time off and I do not encourage non emergency calls so it works.	6/3/2015 7:08 PM
7	I have a patient portal system and a pager cell phone that is direct to me.	5/31/2015 2:00 PM
8	Having access to one's primary provider for urgent problems enables much better health care quality and efficiency.	5/28/2015 7:23 PM

9	They can email me, message me on the secure portal and everyone has my cell phone. I even have patients who text me.	5/28/2015 12:51 PM
10	I am available by text, email, cell phone. 24/7	5/27/2015 1:20 PM
11	while we don't offer weekend or evening hours, we do stay late or arrive early if needed. we offer email access directly to the physician and each individual team member, and we do provide telephone access after hours to a provider on call, though not always me. I feel that in order to be there for my patients when I am working I need to preserve time for myself when I am not.	5/20/2015 3:19 AM
12	all patients can access my cell phone and email anytime they need. I certainly don't check email always after business hours but there is always an auto reply updating patients if my response time will be anything longer than 12 business hours. At least 50% of the time, I do monitor email on nights and weekends and frequently respond. Patients can always call my cell if they don't hear back from email in a time they feel is needed.	5/18/2015 8:26 PM
13	I have no nurse triage line after hours	5/17/2015 12:47 PM
14	Patients email and have my cell phone number for appropriate situations.	5/17/2015 7:04 AM
15	Encourage calling after hours if needed, but with same day/next day appointments, most don't need it.	5/16/2015 6:35 AM
16	For urgent telephone advice.	5/15/2015 9:43 PM
17	After hours, my office phone has the option to speak to me at any time and the call forwards to my cell phone. I also have a robust patient portal that allows for messaging at any time.	5/15/2015 6:42 PM
18	All my patients can page me at any time. They can also use the patient portal, though I don't check that overnight etc.	5/15/2015 5:47 PM
19	24/7 access via cellphone, email, portal, Skype, texting, FaceTime.	5/15/2015 4:50 PM
20	I answer portal messages as quickly as possible. They can always leave a phone message. If there is an urgent need they can contact me on my cell. I have 1-2 Saturday mornings per month.	5/15/2015 3:21 PM
21	24 7 365	5/15/2015 12:10 PM
22	While we rarely see patients outside of our scheduled office hours, this does not mean that we have to deny patients service. As a result of open access, online scheduling that allows patients to self-service their scheduling needs after hours, they can be comforted by the fact (even in the middle of the night) that they will have access to the doctor, usually the next day. When the needs are urgent, the provider cell phone number is always on the office answering machine so they can contact the provider directly after-hours. If patients do decide to go to an after-hours urgent care, this is their choice and not due to a lack of provider access.	5/15/2015 11:35 AM
23	cell phone 24-7 email and virtual visits liberal schedule with evenings 2 nights a week and every other saturday have come in on night weekends and holidays to meet patients with needs	5/15/2015 11:34 AM
24	All my patients have my cell phone number and know they can call me anytime. I don't have regular clinic hours on evenings and weekends but sometimes do go in after hours or do a home visit if there's something urgentz	5/14/2015 10:23 PM
25	Patients can always contact me on my cell phone or via email or the portal. Many use the portal (which is really required for Hippaa security) and I read the messages when I am in the office next. Some don't like or understand that it isn't instantaneous. I also am available at any time for patients, but some want my time for non urgent reasons or to avoid an office visit (which is free for them, but costs me money and obviously free time) So this may mean for certain very demanding patients I may not be quite as accessible as they would like (that is all the time and for free)	5/14/2015 4:51 PM
26	They can call/text/email me 24/7. I will see them almost anytime they need it if it is urgent and am flexible during more typical business hours to fit their schedule.	5/14/2015 2:12 PM
27	I purposefully put my office within 5 minutes of my home in order to facilitate after hours visits.	5/14/2015 12:27 PM
28	Because my patients respect me, and we have a team relationship. It is unusual for them to call, but when they do I am who they speak to. I usually remember them, and without even looking at the chart know their history. This helps too quickly decide what the next strategy needs to be, whether to give advice over the phone, advise them to seek emergency or urgent care, treat over the phone, or tell them to wait until the next office opening as I can reassure them this is not urgent.	5/14/2015 1:01 AM
29	I can be reached 24/7 via my cell phone	5/13/2015 9:20 PM
30	Most can call me at any time	5/13/2015 6:52 PM
31	By phone	5/13/2015 3:21 PM
32	I am directly available by cell phone to all of my patients who are overall very respectful of my time away from the office.	5/13/2015 1:10 PM

33	Patients have my personal cell phone and are encouraged to email me via portal or business email. They can text directly via TextSecure. The first thing I do after my personal toilet is to look for emails or texts from patients.	5/13/2015 12:55 PM
34	EVISITS, CELL, EMAIL, PATIENT PORTAL, ONLINE BOOKING.	5/13/2015 12:15 PM
35	They all have my cell phone number	5/13/2015 11:49 AM
36	Most patients have my cell phone. I often meet patients after hours or on weekends if my schedule allows it.	5/13/2015 11:37 AM
37	24/7 access	5/13/2015 11:29 AM

Q8 I consider time-aids such as electronic medical records, e-scheduling, or interactive patient portals important to my practice.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	4.92% 3	6.56% 4	4.92% 3	21.31% 13	62.30% 38	61	4.30

Basic Statistics				
Minimum	**Maximum**	**Median**	**Mean**	**Standard Deviation**
1.00	5.00	5.00	4.30	1.14

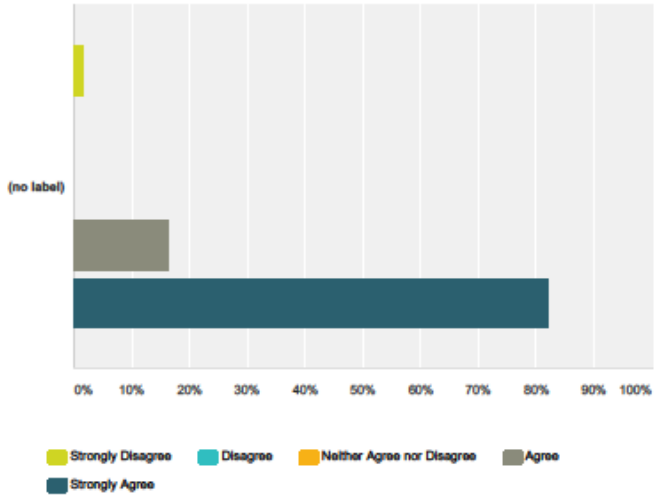
#	Please explain your response in a few sentences:	Date
1	Best EMR. Intuitive. EMDS	6/30/2015 1:52 AM
2	I just don't do computerized charting , we have a computer for billing and scheduling	6/29/2015 11:50 PM
3	My patient portal is not working well yet and e-scheduling is not yet available but I would not practice without EMR now.	6/29/2015 4:58 PM
4	EMRs are NOT a time saver but they do mean I don't have to hire a lot of staff. I have not established a patient portal yet. Unlike the standard practice, patients can access me with a question, not a nurse or midlevel who doesn't know them. I can get them any part of the record they need.	6/5/2015 12:09 PM
5	EHR great for recall and scheduling. my typing sucks. most of my patients are old and while they know what a computer is they don't own one and we still use telephones here.	6/3/2015 7:08 PM
6	I value my free time and this is the only way I can both be available to patients and have personal time.	5/31/2015 2:00 PM
7	Many patients are more comfortable with electronic communication.	5/28/2015 7:23 PM

8	I don't use e-scheduling because I adjust time to fit the patients. I know my patients well, and I know how long they will need.	5/27/2015 1:20 PM
9	easier access to information and lower overhead	5/20/2015 1:25 PM
10	ehr offers many tools that increase efficiency, but systems designed with administrators in mind rather than clinicians are counterproductive. I haven't turned on our patient portal functionality yet since no one has asked for it and I am not going to badger people to use it just for my own selfish meaningful use benefit.	5/20/2015 3:19 AM
11	e-scheduling is mandatory. The electronic records certainly help but I now know my patients so well, there is a lot I can do without them. The portal for my company is awful so I primarily just use email.	5/18/2015 8:26 PM
12	EMR is literally 3 times the work for myself and staff. It also hurts my interaction with my patients.	5/18/2015 3:37 AM
13	Allows me to work more effectively with little staff.	5/17/2015 12:47 PM
14	I think that email communication is essential. Sometimes video chat is appropriate.	5/17/2015 7:04 AM
15	Critical; access and process labs, X-rays through portal connections and EMR.	5/16/2015 6:35 AM
16	I have not yet found a good electronic health record. E-scheduling gives up control in the schedule for avoiding tough scenarios like difficult or complex patients back to back, or multiple new patients in one patient care session. I would like to try a portal but one that exists as a stand alone and not as part of an EHR. I have not found one yet.	5/15/2015 9:43 PM
17	Technology can save time for the office as well as for the patient. The patient who use the portal to schedule appointments, send messages, review their medical records and request refills appreciate the time it saves them as well. I have also found that patients are occasionally more willing to send me a message with a question than to call because they don't want to bother me and I can often write a quick message back far more quickly than a phone conversation would take.	5/15/2015 6:42 PM
18	The majority of my patients use the patient portal regularly. After every appointment I send a summary or to do list. All labs go to the portal. My patients usually schedule their own appointments through the portal. Once they got used to it, they all prefer it to the guessing game trying to figure out a time that works.	5/15/2015 5:47 PM
19	However, current design of EMRs, especially modifications to meet Meaningful Use criteria have made them almost unusable and have made it impossible to get the quality metrics I was easily able to get before the Government-inspired destruction of the EMR industry.	5/15/2015 4:50 PM
20	I love EHR.	5/15/2015 3:21 PM
21	Efficient use of technology is what frees us up to spend more time with patients while meeting the documentation demands of modern practice. The level of service we provide through e-scheduling and prompt communication of results through the patient portal are also essential benefits of our practice.	5/15/2015 11:35 AM
22	yes use all of these and they make my life and my patient's lives easier	5/15/2015 11:34 AM
23	Yes, I use an EHR including the Portal, where some patients schedule their own appointments online and many email me. This makes practice much more efficient since I have no receptionist.	5/14/2015 10:23 PM
24	an EMR lets me document efficiently and send my own bills, I don't need staff to maintain it, the portal helps keep everything in the chart and hippaa secure. I like the eschedule because patients can schedule without my help or after hours.	5/14/2015 4:51 PM
25	Couldn't function without them. Keeps me focused on patients, not paperwork.	5/14/2015 2:12 PM
26	Getting the patient involved in their health care helps. However, I'm not convinced that electronic medical records is time saving.	5/14/2015 12:27 PM
27	I have not yet gotten an adequate ePortal, or scheduling but I look forward to having these tools. I use an electronic medical record for the last 10 years, and it is invaluable. It has decreased the amount of time necessary to process much of patient care related documentation. unfortunately this is occurred at the same time that the demands by outside agents to provide excessive documentation which is often not necessary has escalated. I haven't realized significant improvement in administrative time as a result, but probably am not as compromised as some providers with the changes that have occurred in the medical community. My patience like that even though we are a small practice, they have access to tools like a patient portal and they look forward to having electronic scheduling when we can accomplish that. I think they are less impressed with the electronic record, partly because it is distracting. They are pleased that it is usually easy to give them documentation that they request, and reference reports that have come in.	5/14/2015 1:01 AM
28	Technology strategically integrated into a practice allows for a decrease in overhead and a streamlining of procedures which, secondarily, allows more time for the patient.	5/13/2015 9:20 PM
29	I can access the information I need from anywhere	5/13/2015 6:52 PM

30	EMR yes; no e-scheduling except by portal requests; few patients use the portal	5/13/2015 3:21 PM
31	More than half of my appointments are scheduled on-line which is both convenient for my patients (who can also change and reschedule when needed) but also decreases the amount of time spent from a business standpoint (I am totally solo so have no staff).	5/13/2015 1:10 PM
32	Scheduling perhaps most helpful. EMR has many benefits. Patients still being sold on portal. Advantages over email not proven to me although encryption is supposed benefit. Logging in not so easy.	5/13/2015 12:55 PM
33	IT ALLOWS METO BE ACCESSIBLE AND MAKE MY LIFESTYLE MANAGEABLE WHILE USING GOOD TECHNOLOGY. I SEE AND WORK ON THEIR CHARTS FROM WHEREVER.	5/13/2015 12:15 PM
34	To the extent that they save me overhead so that I can survive financially with a smaller panel of patients and they increase patient access to my care.	5/13/2015 11:49 AM
35	Patients love the portal.	5/13/2015 11:37 AM
36	computers help with basics like remembering allergies or dose adjustmetns for renal funciton the rest is +/-	5/13/2015 11:29 AM

Q9 I believe in the importance of a work-life balance.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	0.00% 0	16.39% 10	81.97% 50	61	4.77

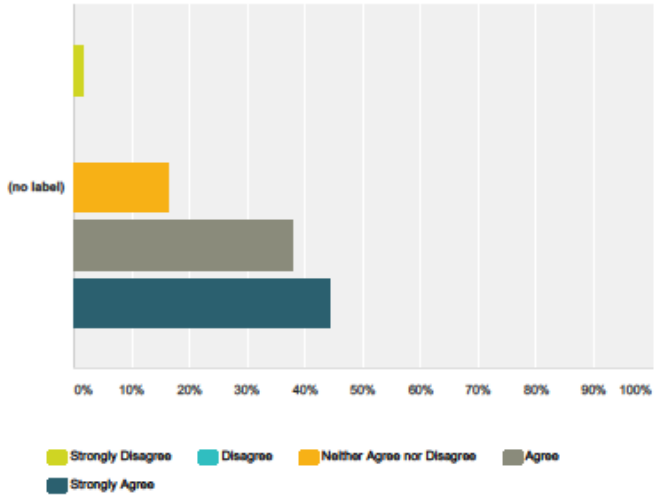
Basic Statistics				
Minimum 1.00	Maximum 5.00	Median 5.00	Mean 4.77	Standard Deviation 0.61

#	Please explain your answer in a few sentences:	Date
1	Eight children and a full practice only possible with scant statging	6/30/2015 1:52 AM
2	But my work is my way of worship. My favorite activity but I know I need family and Bahai interaction in groups	6/29/2015 4:58 PM
3	Unfortunately I am currently not practicing this.	6/5/2015 12:09 PM
4	when my patients complain that every time i go out of town they get sick I tell them if i didn't go out of town to dance i would get sick. I was gone for 2 years from my home county. most of my patients lived. some traveled to see me and some waited for me to come home. some got very bad care and didn't live to see me come home. but most survived. so while i love seeing patients- for everyday int he office i spend most of a day at a computer doing the back work. that i hate.	6/3/2015 7:08 PM
5	A lack of a good work-life balance can easily lead to burn-out.	5/28/2015 7:23 PM
6	I am struggling with this--too much work as I've become busier.	5/27/2015 1:20 PM
7	the day I opened my solo practice I intentionally began a new hobby. we offer great access when we are in the office so I don't feel guilty taking time away from the practice when needed for personal reasons and people respect this and accept the tradeoff compared to trying to access care in a huge system. because I have interests outside of medicine I come to work energized to serve.	5/20/2015 3:19 AM

8	I am trying to make sure I set barriers and allocate enough time to non-work related issues. While I'm "on call" more in this model, I actually probably spend more time not doing patient related care than in prior settings.	5/18/2015 8:26 PM
9	Although I agree, it is very difficult not to get overwhelmed with the huge demands of the practice. The problem is not so much with the patient care but is due to regulation and insurance company demands.	5/17/2015 7:04 AM
10	Agree. But with smaller practices, I find that it is easier to keep balance as I know all pts. This is my practice for the last 11 years, vs when working in multi primary provider practices.	5/16/2015 6:35 AM
11	For most it brings personal enjoyment to have a multifaceted life with enriching relationships with family. Also to serve in multiple roles (parent, friend, child, community leader) in enriching, and promotes emotional well being.	5/15/2015 9:43 PM
12	I have a husband and 4 children at home. I have to fight daily to keep some semblance of balance and I am rarely confident I am doing it well.	5/15/2015 6:42 PM
13	My son has special needs and my "normal" daughter is just plain special to me. I started my practice partly to help the community (I'm a DPC-IMP and see mostly uninsured and underinsured) and partly for the sake of my family. I love the flexibility to be available for them.	5/15/2015 5:47 PM
14	I believe, but find it hard to accomplish, personally. Taking the time to answer this questionnaire is a great example.	5/15/2015 4:50 PM
15	This has made me healthier and happier. Doctors should be able to control their schedules.	5/15/2015 3:21 PM
16	I get th and fri to be stay at home dad plus wknds	5/15/2015 12:10 PM
17	Burned out providers make lousy healers. Setting barriers around your personal life is critical, but just as important is feeling capable and effective in one's work so that it is rewarding.	5/15/2015 11:35 AM
18	yes, but I don't have it ! luckily I love my work but there is too much of it	5/15/2015 11:34 AM
19	I was around a lot of burnt out doctors in my training and vowed to not turn out that way. I started my micropractice less than 2 years out of residency and feel it was the single best decision I could make to prevent burnout. I have control over my schedule and my life. I take time off when I want. I play tennis in the middle of the day if it's slow. It's a great feeling.	5/14/2015 10:23 PM
20	I currently work too much, so I am a hypocrite, but if I keep it up, I'll get resentful of the people I am supposed to be helping.	5/14/2015 4:51 PM
21	Love that I can adjust my schedule to meet my family's needs.	5/14/2015 2:12 PM
22	My practice is new so I'm not sure how well I'm doing with this.	5/14/2015 12:27 PM
23	I like to work when I am rested, and as a single mother, sometimes family life takes precedence. Often family has to take back burner to work responsibilities at other times. I make sure to have community outlets, recreation, and even go to yoga scheduling time out of clinic for a long lunch at least once a week for this. It is challenging to find enough time to meet my personal needs, but when I do I function better at work.	5/14/2015 1:01 AM
24	My office is integrated into my life. When my kids were younger, if they were sick, they would watch videos in the room above the exam room. I have a schedule which is sustainable and does not leave me exhausted at the end of the day. The office is close enough so I can go home for lunch every day. I feel my office is an important part of the community and my community is an important part of my practice.	5/13/2015 9:20 PM
25	My family is just as important to me as my patients, as is some down/me time	5/13/2015 6:52 PM
26	I have 2 afternoons per week that I use for volunteering at my son's school, taking care of me (appointments, etc). Also because I control my schedule, it is not difficult to block time for a performance, cut my first appointment of the morning due to need to get in a run on a weekday morning, etc.	5/13/2015 1:10 PM
27	I see patients about 40 hours a week. I perform office business about 20 hours a week. I ride my bike Monday, Tuesday, Friday and most Saturdays and Sundays. I sail Tuesday evening in the Summer. I attend my kids' events. I volunteer in the community.	5/13/2015 12:55 PM
28	I HAVE 3 CHILDREN UNDER 5. MY OWN PRACTICE AND I STILL MOONLIGHT. I NEED THAT. AS A FEMALE, THERE ARE EVEN MORE UNSAID PRESSURES.	5/13/2015 12:15 PM
29	Doctors are strongly selected for and repeatedly taught that you as a doctor trumps all else in life. As a profession we need more balance but a primary care medicine is not a 9-5 profession.	5/13/2015 11:49 AM
30	I participate in tennis 4-5 days/week, chaperone kids trips, volunteer there. I work 3/4 time in the office to be able to do that. I take one day off each week as well.	5/13/2015 11:37 AM
31	Obvious:)	5/13/2015 11:29 AM

Q10 I believe it is important to practice self-reflection.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	0.00% 0	16.39% 10	37.70% 23	44.26% 27	61	4.23

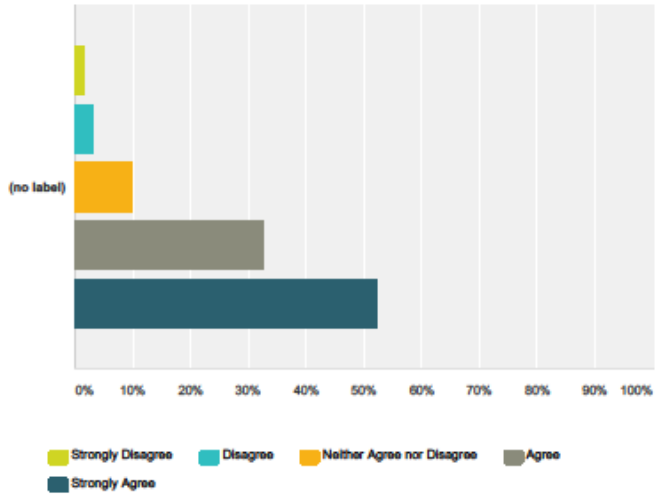
Basic Statistics				
Minimum 1.00	Maximum 5.00	Median 4.00	Mean 4.23	Standard Deviation 0.84

#	Please explain your response in a few sentences:	Date
1	The un examined life is not worth living	6/30/2015 1:52 AM
2	try to pay attention to doubts and keep them in mind to research. I know I am not God but I have confidence in His support.	6/29/2015 4:58 PM
3	I practice mindfulness but not enough.	6/5/2015 12:09 PM
4	that is life	6/3/2015 7:08 PM
5	For me, practicing relationship based care as I do, working on myself and knowing me is key to being an effective provider.	5/31/2015 2:00 PM
6	I'll have to thing about that some more.	5/28/2015 7:23 PM
7	I am currently in self-reflection, trying to decide whether to continue practicing medicine at all. Insurance companies make it too difficult.	5/27/2015 1:20 PM
8	My partner and I joke about this. Too much self reflection can make you depressed. Being oblivious to your failings can keep you happy:)	5/20/2015 1:25 PM

9	self-reflection helps me understand my strengths and weaknesses so I can work to improve patient relationships and care provided.	5/20/2015 3:19 AM
10	I definitely agree but not at the expense of distracting from the present.	5/18/2015 8:26 PM
11	How else can you learn and improve?	5/15/2015 9:43 PM
12	Self reflection, in the sense of looking at ways I can improve, is always important. More philosophical self reflection rarely tops the priority list.	5/15/2015 6:42 PM
13	I keep a couple blogs and love writing through things.	5/15/2015 5:47 PM
14	This is of more personal importance than professional.	5/15/2015 11:35 AM
15	yes see where you are and then make a goal to change if this is important to you	5/15/2015 11:34 AM
16	I've always been a fan of self-reflection and mindfulness techniques, though I admit I don't practice them as regularly as I'd like.	5/14/2015 10:23 PM
17	If you don't know why you do what you do, you are likely to get off your path	5/14/2015 4:51 PM
18	It's always important to reassess all important aspects of our lives.	5/14/2015 12:27 PM
19	we are taught to be fairly defensive, and justify their decisions and treatments.I have found it very helpful to reflect with the patients when a decision didn't turn out favorably. I often explain that I'm not sure about a diagnosis, and that we are making the best guess with the data we have, and will have to adjust if the plan based on that doesn't work out.sometimes I do this with the patient, but I often reflect on my decisions, thought process, even where I am on a particular day spiritually and how it affects my practice.	5/14/2015 1:01 AM
20	John Wasson has said we need "breathing room" to make changes in what we do. Having a lower volume practice allows me the time to continually reassess what I am doing and how I am doing it. Though I may not make the right decisions, having the time to periodically reflect helps tremendously.	5/13/2015 9:20 PM
21	I agree it is important, but I might say that it is something I don't always take as much time to perform.	5/13/2015 1:10 PM
22	This is an area I could/ should develop.	5/13/2015 12:55 PM
23	As long as you don't make yourself crazy.	5/13/2015 11:49 AM

Q11 I feel a sense of humility in my work.

Answered: 61 Skipped: 7



	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Total	Weighted Average
(no label)	1.64% 1	3.28% 2	9.84% 6	32.79% 20	52.46% 32	61	4.31

Basic Statistics				
Minimum 1.00	Maximum 5.00	Median 5.00	Mean 4.31	Standard Deviation 0.90

#	Please explain your answer in a few sentences:	Date
1	Humbling to be invited in to people's lives at most vulnerable points	6/30/2015 1:52 AM
2	Humble that I am in a profession where I mean more than I am worth and where I am expected by some to be perfect and if I get sued twice I settled out of court due to cost and time required to defend myself. Sometimes it feels like trying to walk a tight rope over a precipice but when I am with a patient face to face or on the phone with a "partner" patient I am very happy and challenged. My father died at age 44 from Emphysema and I heard my mother say to my Dad "it is just as important for me to talk to the doctor as it is for you." And Dad said "Well it happened so fast" He was a wonderful sick person and he "just knew I wouldn't be happy if I didn't try to get into medical school. Mother said "Honey, no matter what you do you have to give some things up."	6/29/2015 4:58 PM
3	There is some pride in what I do but I am here primarily for my patients.	6/5/2015 12:09 PM
4	learn something new everyday from my patients and staff person and their families	6/3/2015 7:08 PM
5	I am deeply honored in the role that I have chosen. It is hard and requires much time, energy, money and personal commitment. And it it truly a place of honor. When I remember that, it provides me energy for all that is required of me. It is much more than paperwork and prescribing.	5/31/2015 2:00 PM
6	I have seen several poor outcomes result from provider over-confidence. A dose of humility is always healthy.	5/28/2015 7:23 PM
7	I am constantly re-examining my knowledge base and questioning myself.	5/27/2015 1:20 PM

8	Humility is not one of my strengths	5/20/2015 1:25 PM
9	I don't expect anyone to call me "doctor". I value coworkers as partners in our team and make sure they know that. It is humbling that patients entrust their stories to me, and I feel a responsibility to confidently respond based on best evidence.	5/20/2015 3:19 AM
10	There is a lot I cannot fix and that can be troubling.	5/18/2015 8:26 PM
11	As soon as I don't, I have some humbling episode to remind me!	5/17/2015 7:04 AM
12	The definition of humility: a modest or low view of one's own importance; humbleness. In relation to the larger perspective of the US medical system, I am a speck of dust. In regards to my patients' lives, I think I am an important partner/advisor on how to maximize their health, and a ready source of help when they need medical attention.	5/15/2015 11:38 PM
13	A good bit of a patient's outcome is out of our (doctor and patient) control. I believe in a higher power that ultimately determines the outcome.	5/15/2015 9:43 PM
14	I can't meet the general expectations of the public as the general expectations of physicians are of superhuman proportion. However, I frequently find that when I have a relationship with the patient, they learn me as much as I learn them and they understand and appreciate my humanity. As a physician, I see people at their most vulnerable and my words and actions have more power than I care to wield. To think that power comes from me would be foolish and dangerous.	5/15/2015 6:42 PM
15	Being a physician is who I am. It is such a privilege to know the details of people's lives, to be involved in their best and worst moments, to help them with their habits. I cannot be judgmental anymore except with people who are judgmental. Life is just so complicated	5/15/2015 5:47 PM
16	I am always amazed at what my patients can accomplish for themselves.	5/15/2015 4:50 PM
17	My 1 staff is as important as I am. I don't know what's best for my patients; they do. It's their life and their body. I could always be wrong.	5/15/2015 3:21 PM
18	Medicine done well is a constant act of service and is therefore humbling. One must set aside themselves daily to truly listen and connect with patients if one hopes to have a meaningful healing relationship.	5/15/2015 11:35 AM
19	yes every day I am always amazed how often I can be wrong and not see things correctly	5/15/2015 11:34 AM
20	Medicine is vast, the human body complex far beyond our understanding. My practice allows me time to read, learn, and ponder those mysteries.	5/14/2015 10:23 PM
21	Nobody is going to do what I say just because I say it, making a change to habits requires the person who's habits need to change to give input	5/14/2015 4:51 PM
22	While it is hard not to be arrogant, I often feel the privilege of providing thevenue for patients to make their own changes. I honor everyday their ability to make health conscious changes, and feel privileges to be a catalyst in that. Even though I am often much more knowledgeable about health issues, it is fun to see their unique ways of implementation.	5/14/2015 1:01 AM
23	I am idealistic--probably to a fault. I realized long ago that the most important person in the doctor-patient relationship is the patient and it is their appointment, not mine. That is the reason I set up my practice the way I have. Interestingly, what I have found is that if I meet their needs, then most of my needs are met as well.	5/13/2015 9:20 PM
24	I like that I can help the people who really need me, and reassure the ones that "think" they need me :)	5/13/2015 6:52 PM
25	I don't have one boss; I have 1500 bosses. I work for them. My work is a service-oriented mission for others.	5/13/2015 3:21 PM
26	Because I am my only employee I do everything. I answer the phones, take out the trash, etc. Some days I would love to delegate frustrating tasks that are "below my training" but it also makes me more respectful of the time that it would take someone else to perform it as well. If I ever choose to have an employee it is one of the lessons I hope I don't forget. I am also very grateful that my residency program had us do a few rotations with our clinic nurses so that we had to give shots, run strep swabs, etc. I think any physician should have to know the details of test they run and things that they ask their delegates (nurses, assistants, admins, etc) to do.	5/13/2015 1:10 PM
27	No, not in the conventional use of this term. I would characterize myself as proud of my work. This term is often misused. I suspect that the question is asked in a Biblical sense- I try to be patient and tranquil working within America's boiling caldron of medical care.	5/13/2015 12:55 PM
28	I am honored by the trust of my patience and all to aware of my own fallibility.	5/13/2015 11:49 AM
29	Medicine is like gardening Tries to teach you patience and humility	5/13/2015 11:29 AM

05/17/2015 20:38 [redacted]
05/15/2015 05:18 [redacted]

Micropractitioner Physician Survey

Demographics

Age:

Practice Location:

Gender:

Urban - Suburban - Rural

By Submitting This Survey I Am Consenting To Participating In This Study

Please circle one of the following for each answer and then if you wish please do so:

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

1. I consider my present mode of practice patient-centric.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences: 24/7/365 patient access directly to MD.
1° PCP - spends time to determine what is most important to the patient
utilizes functional medicine - addresses DT / addresses cause

2. It is important to me to be able to allocate as much face-time to each patient encounter as I deem necessary.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences:
QUITE FRANK. AN ENCOUNTER IS LIKE A BOX OF CHOCOLATES - YOU NEVER KNOW WHAT YOU ARE GONNA GET. PTS ARE INCREDIBLY SMART & A "LIST" OF DIAGNOSES. UNLESS THE NURSE

3. Continuity of care with my patients is important to me. IMPORTANT IS @ THE END.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences:
WE NEED TO BUILD SUCCESSIVELY ON EACH VISIT... NOT START FROM SCRATCH. YOU CAN ONLY DO THIS EFFECTIVELY IF GOOD CONTINUITY

05/17/2015 20:38 [redacted] [redacted] [redacted]
05/15/2015 05:18 [redacted] [redacted] [redacted]

4. I am accessible to my patients outside the parameters of regular office hours.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences:

My cell phone #is on the answering machine

5. I consider time-aids such as electronic medical records, e-scheduling, or interactive patient portals important to my practice.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences:

Enhances communication – most pressures in 1° care due to poor fragmented information

6. I believe in the importance of a work-life balance.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences:

Lack employee practice mainly for this reason. As well as to have routine visit MD/PA interrupted

7. I believe it is important to practice self-reflection.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences:

Need time to do this - employee practice around little of this

8. I feel a sense of humility in my work.

Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

Please explain your response in a few sentences:

APPENDIX C

INTERVIEW TRANSCRIPTION

Transcription of Interview with Gordon Moore, M.D. and John Wasson, M.D. August 10th, 2015

Mary Grassi (MG): I wanted to first start out by saying I know that you, Dr. Moore, know that I am doing my dissertation on micropractice. What I was hoping to do was to talk to the both of you because you are obviously marquee names in micropractice knowledge.

What I am asking because I did send out a survey instrument to, I think, 377 physicians who were affiliated with Ideal Medical Practice, and I got, I think, 69 responses. One-hundred and fifty of those e-mails were opened. What I wanted to do was to invite the two of you to participate in a part of my research study about micropractice. I wanted to make sure that I was appropriate in this because it is following the Drew University Institutional Review Board protocols. In inviting you to participate in my research study about micropractice, I wanted to formally say that it is being conducted by me, Mary Elizabeth Grassi, who is a doctoral student in Medical Humanities at Drew University and the Caspersen School of Graduate Studies in Madison, New Jersey, and that talking to you is part of my data collection for my dissertation.

What I am doing is collecting qualitative data on the micropractice model because there has been such limited investigation done to date on this mode of practice. Obviously, the benefit to your participation will be to help contribute to the knowledge concerning the micropractice medical model. My study is minimal risk. Hopefully, you'll be able to complete this in about 20 minutes. I am asking if, when I ask you these questions, would you allow me to record them and transcribe them on my desktop computer? Obviously, it would be password-protected. Only answer the questions that you're comfortable responding to. The information would be available to my dissertation committee. Any data that I present within the dissertation would be directly attributed to you unless you wish to remain anonymous. I am the principal investigator. Dr. William Rogers, who is the associate dean of the Caspersen School, and Dr. Kate Ott, who is the chair of the Drew University Institutional Review Board, are two people that you can contact at either advisor@drew.edu or researcher@drew.edu. By beginning my interview, I am going to ask if you agree to participate in my interview?

Dr. Gordon Moore (DGM): Yes, sure, I am perfectly comfortable with how it is all laid out.

MG: Okay, thank you.

Dr. John Wasson (DJW): Wait a minute. My comment is, could you tape-record you saying that I was marquee in something? Just because I'd love to play this at home.

MG: Okay, all right.

DJW: Otherwise, I agree.

MG: Okay, thank you. I wanted to first read my abstract to you as it stands right now. My abstract from my dissertation is that physicians who practice within the micropractice model comprise a group of practitioners who embrace a practice design that allows for greater interaction with patients. This mode of practice favors active clinical engagement, upholds the physician-patient relationship by granting greater face-time with patients, supports better physician access, and endorses continuity of care. Physicians who choose micropractice are able to reinforce the physician-patient alliance by way of a distinct algorithm. Modest patient panels and the use of small office spaces, coupled with supplemental technologies that serve as time-aids contribute to a physician's capacity to better interface with their patients. My dissertation explores the concept of micropractice by situating this practice model within the context of relationship-focused care and exploring how physicians experience their physicianship within this milieu. The author establishes the position that micropractice can serve as a paradigm for humanistic medicine. Micropractice is illuminated as an exemplar for physicians who are determined to keep vital the affinity shared between physician and patient.

That is the beginning of my abstract. I did conduct a study of physicians who self-identify as micropractitioners utilizing a survey consisting of 11 questions. Three questions collected data on demographics, and eight questions structured on a 5-point Likert scale captured information regarding facets of practice style and characteristic approaches to the micropractice model of medicine. In addition, the study examined commentary, two questions for general themes. This is the basis for my interview with you. Actually, Dr. Wasson, you are mentioned in my survey instrument by a physician, who, I believe, in question number 10, said that you feel that a physician needs "breathing room." That is one of the questions that I wanted to ask you about. Do you ever remember mentioning that?

DJW: Yeah, I think Gordon and I used that term numerous times.

MG: I am trying to locate that particular [response]. It says that, "John Wasson has said that we need breathing room to make changes in what we do. Having a lower-volume practice allows me the time to continually reassess what I am doing

and how I am doing it. Though I may not make the right decisions, having the time to periodically reflect helps tremendously."

I wanted to ask you maybe to elaborate on that a little for me.

DJW: Well, again, Gordon and I have used that term that, in contrast to the typical "churn them through" medical practice, a patient every five minutes, if you don't create space both for you and the patient on an individual basis, in other words as the patient is in front of you, and for yourself intermittently with any staff you might have to sit back and look at what your practice is doing, you're basically a robot producing a product that you don't necessarily know is meeting anyone's needs. I think the respondent there hit several of the points, as well. The issue for Gordon and me was, "How do you create breathing room?" Gordon should augment this.

DGM: Yeah, I think you nailed it. I came into this looking at the process of people working together in practices, doing time and motion studies, and the like. It was a common observation of mine, and shared by others, that we're all working very fast, and there's not a lot of time to reflect on the work and think how to make it better even though there were occasional times when many people would try, and the common lament of wanting time like that. Early in the days of the Ideal Medical Practices project, we thought that that was an observation that we could share with others so they could consider how to find breathing room. That was one of the early tools we disseminated. I like to type up long, long things for people to file away and consider important in their life.

MG: Okay. One of my initial questions, going back to the family practice management article, that you had authored, Dr. Moore, in 2002, I wanted to know in "Making the Leap", do you have any other thoughts or information about the evolution of micropractice?

DGM: Yeah, I haven't looked through it lately. My recollection of the sequence that led me to that, was starting in residency and asking around, "How do you treat strep throat?" and getting a different answer from each person I asked, and thinking, "That was a little silly," so finding time in the residency to meet every other week in the afternoon with third-year residents to consider medical evidence and distillation of clinical guidelines and to pocket cards that can help steer better care deliver. That then led to working on process improvement, which eventually led me to the Institute for Healthcare Improvement where, as a participant in the Ideal Medical Practices project, I met John on faculty, and had been working with teams from the University of Rochester Medical Center, who I collaborated with on in improving access and relationship vitality and use of technology to enable care delivery. In that, I was struck by the opportunity to try to do it all. Doing

that without waiting around for the permission of others, led me to the idea of going out on my own to do it because I've seen that if one of the other faculty had said that one of the greatest percent of practice overhead is salary and benefits of the staff and if value of that exceeds the time I spend with patients, I potentially reduce staff time, the number of staff, make use of technology, spend more time with people, and enjoy it and make ends meet. The origin was in the work of a lot of other people coming together figuring out how to put the pieces together.

MG: In listening to you, there have been some physicians that I've spoken with involved in being independent, going solo, trying to reduce costs, they have faced what they consider "insurance hurdles." There are some who have said to me, "I may consider converting to a concierge medicine model." Some physicians have indicated that they even thought of leaving medicine or are thinking of it because of a lot of hassles either foreseen or unforeseen that they have endured going or "becoming independent" rather than being "autonomous," so to speak. My question would be, do you envision a segment of micropractioners converting to such a model in medicine?

DGM: We've already seen that. My choice was to do it within the context of insurance-based reimbursement, so the typical billing mode. I was lucky in Rochester, New York that the cost of operating a practice didn't exceed revenue that I could generate delivering care at a pace that worked right for me. The observation, anecdotal, that we had as folks read the article and we started communicating on a Yahoo! ListServ, we found that there were others who were unsuccessful in doing that. We postulated that the lack of success could indicate parts of the country where the typical insurance reimbursement made it very difficult for someone to remain independent, or, alternative hypothesis, that some people made unfortunate choices in technology that ended up costing them a lot of money. For instance, various EMR systems cost a five-year lease, as an example. This is all anecdotal, but we felt that there were a number of ways to fail with the best of intentions. Some clinicians just don't have the organizational abilities to do all the practice management and practice and do it in the context of saving lives. You have to wear a lot of hats when you're working in a small practice and you're self-employed. Some people do well with that and others don't.

MG: In talking about EMR, there is a lot of controversy because they don't talk to each other. You said that with the best of intentions one can fail. Are there any EMRs that seem to be easier or better than others for someone in solo practice?

DGM: Opinion and discussion on the Yahoo! ListServ around that, and there are a few themes that came out, but I wouldn't say there is universal adherence to any of them. One theme that I caught was one I mentioned around high cost. There was a general sense of the participants that lower cost is better. There is a lot of love

of Amazing Charts, not that I want to toot anyone's horn as having a connection to them. You know, $1,000 to get on board and an annual maintenance fee that was pretty cheap, and it did most of what the clinicians wanted, that's pretty cheap compared to $10,000 for some other products.

What I am describing is an approach to EMR that served the immediate need of the individual and not necessarily the national interest of data aggregation and fee forward reporting and sorts of other things. The EMR discussions and choices were made at a very local, personal level.

DJW: The only additional point to make on the technology side is that most of the technology that is continuously been promulgated and pushed through various mechanisms so that it is a requirement now of practice, have started from top-down big organizations, that mentality and mind. The guys and gals working from the patient up are left with nothing or they have to buy the big horse, because the smaller charts don't add all the functionality that supposedly the big ones do, but actually the big ones don't do a damn thing from the patient's perspective, usually. That's why the "How's your health?" thing was put, we built that, and also built so that it could do a lot of the practice improvement work, which is what Ideal Medical Practices were about. It wasn't just, "Let me get out in the practice and save a little more time with patients." It also was, "Let's look at what the time we spend with patients is actually producing." To do that, you have to have the patient's voice and find out what matters to them and see how well you're meeting it. The EMRs just don't do that. We were tying three things. First thing was, "have more time to have a better practice and not be so crazy busy." Number two, use things smart. And number three, build for a better future. Each one of those, as Gordon says, for someone to do that and wear multiple hats, it's a tough challenge.

MG: One of the things that I'm looking at in my data and how I am building my chapters for the dissertation was being very surprised at the response for gender. Fifty-six percent of the respondents were female, which leads me to think about medical education and flexibility. Some of micropractitioners feel that micropractice does allow them face-time with patients but also allows them a lifestyle where there is a level of flexibility. The respondents also were 53% suburban, so I am trying think, "What does that mean?" as far as practice location, and that might be connected with some of the things you said, Dr. Moore, about insurance reimbursement.

Also, I am looking at the patient-centric aspect and the ability to listen, both in clinical listening skills and patient narrative listening to that individual patient. Those are some of the things that I am tying into micropractice, especially individuating with the patient and also with that relationship-centered care,

talking about what it takes to build trust with a patient. I'm also talking about the specialism of the physician, because in micropractice the physician is not estranged from routine care. Part of my postulation is the doctor is not incidental to care and does not necessarily have to be estranged from routine care, obviously tying that into generosity of time with the physician and the access and continuity of care. Also, talking about interpretive abilities in the face of uncertainty, so I am making a point about the talent of a physician and the specialism of a physician. I am using that dyad, the one-to-one partnership, because a physician will always remain one set of hands and one pair of eyes. This is what I am building in the dissertation regarding the micropractice model. I want to hear from both of you, realizing, as I said, the genesis of micropractice coming from you, do you think I am heading in the right direction?

DGM: Yeah, I'll take a stab at it. Forgetting some of the construct in the early part as you built it, if you could just give me a set of chapter headings again and I want to build it the way you describe it. You had said early on about the patient-centeredness. One of my intentions in this was to find a way where an average clinician could be great, and what can we do to make the environment supportive of even average clinicians. One tool that we used to do that was to systematize the way that we engage people and get them into the mix. That was John's tool. That is a systematic intervention to solicit the patient's voice in a way that delivers behaviorally-sophisticated indicators. "Behaviorally-sophisticated" because they indicate what action to take on the part of the clinician, and they have heavy impact on the individual in ways that they care about. For instance, people who say, "I have a significant amount of pain," like four or five on a Likert scale "pain" is probably going to get in the way of treatment plans for hypertension, diabetes, smoking cessation, or whatever. That's one of those indicators that tend to underpin all of what we're doing. There are a handful of things like that. "Patient confidence" is that key indicator as a marker, for instance (also called patient "activation" or "engagement", what will you), to mark the degree to which an individual is likely to be successful in their plans. While these things are very important, they're not routine and systematically addressed in the typical patient encounter. To be patient-centered we use the "How's your health?" tool as the vehicle for soliciting that information and the vehicle for tracking how we're doing over time because it became, then, an interesting way of measuring on an on-going basis how I'm doing in a way where I can tease it out by illness burden or by finance without my own practice. The data was all right there. It became a really easy way to measure, a really easy way to people at significant risk, a really easy way to engage people where they are. For instance, we did a little test where we're looking into making referrals to specialists. We asked the question, "On a 1-10 scale, how would you rate the importance of this?" Then we asked the clinician to rate that. From the divergence number at times, interesting questions would arise. Why do you rate it

so low? Why do you rate it so high? Patient-centeredness is the core of what we're thinking about in terms of creating a structure of support for clinicians to make it easier for them to do the work that they want to do in a way that engages deeply with people.

It also gets past some of the typical frustrations. In a typical medical model where I'm being judged externally on the rate at which people with diabetes achieve certain indicators, over which I have marginal, if any, real control, we get judged because we have clinicians who either want to write off patients and discharge them from the practice or call them non-compliant, and instead we've flipped the whole paradigm on its head and asked people what matters to them, what gets between them and the outcomes that are important. The whole approach to practice, the whole approach to interacting with people starts at a very ad-hominem, very personal level, just because of the tools that we were using and the practice, regardless of EMR. Obviously EMR can make your day easier and your billing cleaner. That's really the essence. John, I don't know if you want to add anything, or, Mary, if you wanted to follow up on that?

MG: What I'm hearing, then, is are you talking about high performance and optimally-driven small practices where the doctor-patient dyad is, in-fact, fortified? That's what I am interested in because there's a part of a chapter where I am talking about round-table health-care delivery, where you have the physician role the PA, the RN, the MA, and I am trying to look at the fact that where you have something like team-based care that you have to reconfigure the doctor-patient dyad somehow. When you're looking at team-based care, for me, and my postulations are that at every juncture along that care path everything has to be flawless given everyone's skillsets and things like handoffs. When you're looking at a very small solo practice and you're looking at that one-on-one and you're individuating the generalities of science, so to speak, that's what I am hearing from you, that there're generalities of science, you're individuating it to a specific patient, at a specific time, during a specific encounter; therefore, are you allowing a physician to basically be the most that they can be, given not only their education and academic background, but adding that space between the space that I see, that "wow" factor when you see a physician who is very empathic or very much tuned-in to you, your story, your illness, that's where I am going.

DGM: That is where I was going. I don't know if John has got different ideas on that. The idea of recognizing that clinicians as people are likely to be variable in their empathy with different individuals, so let's systemize the means for unmasking issues that are very important and then create a venue in an encounter, face-to-face or phone, when those can be addressed. Without the same time constraint maybe we can go a step further, a little bit deeper.

MG: Okay. One of the things that I want to look at in my research is really understanding the specialism of a physician. You're in the face of uncertainty and you have to make a "call." Some of my respondents in my survey instrument talked about the uncertainty that they face with diagnoses and working within that dyad in order to care and cure, so to speak. These are the things that I am trying to bring into focus with the dissertation data in order to look at physicians. What is the talent of a physician? I think, sometimes in the corporatization of healthcare delivery that it seems to be lost.

DGM: Yeah, that's… The hesitation that you hear in me is that issue of physician versus nurse practitioner versus PA can be a political hot-potato, as well. I think that there are some differences in training and likely differences in selection of individuals who want to go into one versus another mode of becoming a professional clinician. The physician training is what I know. I think most primary care physicians are folks who like the idea of dealing with individuals and all the complexity of stuff that goes on with humans, they're facing illness, life, what have you. The frustrations that I sensed personally and that I found is shared by others is not having the time to get into things and then just having to throw a prescription at somebody to get out of the room so that I could keep my productivity seems to be the deal I made when I went into med school. And I found others that shared that, and I think that's where a lot of interest came out of what I did in my little practice story. I didn't get into it for that reason. I was looking for something deeper. What came out of a lot of conversation over time was what a lot of [physicians] wanted to feel like they were engaged with individuals and it was meaningful for both. Most of the folks trying that through this micropractice route were looking for that breathing room to take extra time.

MG: At this juncture, I think you've answered the questions that I hoped to have answered. I want to make sure that as I validate my journey with this dissertation, keep pace and make sure I am writing something on a level that will be very fruitful and worthwhile. I think the both of you have been extremely gracious, and you have given me generosity of time. I thank you wholeheartedly.

DGM: Sure, happy to help.

DJW: Two things I wanted to emphasize that I heard Gordon. I'm a geriatrician. If you look at Medicare, consider Medicare is going to say, "Start having conversations with your patients who are very ill or near death." That's coming up, starting this January. Think about that for a minute. What possibly is a physician or any clinician going to do? They're going to say, "Hey Mabel, you're not doing well. You're going to die. Do you want to talk about it?" It's going to be highly variable. Part of the issue is the unresolved tension that team-care fragments care and fragments the message. An individual doctor has a chance of staying

individually in-tune with the patient, but there is such variability among individuals that they may miss the point, too. The additional point of micropractices or almost anything we do, team care or small-practice care, eventually has to be about a matter of how you find out what really matters to patients and how you respond to it in a somewhat standardized way. Absent that, you're just kind of still having high-variation care that may or may not serve the patient's need. That is still an unresolved tension in the bulk of micropractices and in the larger practices. Keep an eye on that.

The only other point to keep an eye on, as you describe your response rate of 53% female, does it give an idea of what the original 350 or whatever number it was you mailed out to was.

MG: That I don't know. The only thing I know is that when the survey instrument went out, 150 opened the e-mail, and of the 150 who opened it, 69 or 70 responded.

DJW: Okay, well that's it. I have to go back.

MG: Thank you so much. And thank you, Dr. Moore. I am so, so grateful.

DGM: Happy to help.

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VITA

Full Name: Mary Elizabeth Grassi

Place and Date of Birth: Wilkes-Barre, Pennsylvania, December 29, 1951

Parents Names: Joseph Kosar, Helen Casey Kosar

Educational Institutions:

	School	Place	Degree	Date
Secondary:	Elmer L. Meyers High School	Wilkes-Barre, PA	Diploma	June 1969
Collegiate:	Pennsylvania State University	University Park, PA	BS	June 1973
Graduate:	Marywood University	Scranton, PA	MSW	May 1976
Graduate:	Drew University	Madison, NJ	DMH	May 2017