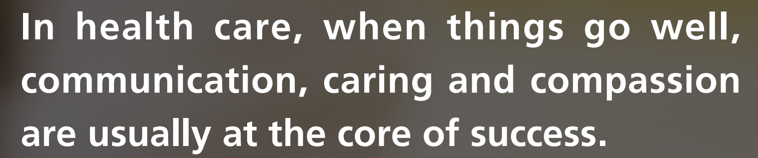
IMPROVING THE PATIENT-PHYSICIAN RELATIONSHIP — AND HEALTH CARE ITSELF — THROUGH COMMUNICATION

A collaboration of the American Association for Physician Leadership® and The Beryl Institute


In health care, when things go well, communication, caring and compassion are usually at the core of success.

INTRODUCTION

PATIENTS AND PHYSICIANS: AN ENDURING PARTNERSHIP

Regardless of their varied backgrounds and the circumstances that bring them together, patients and physicians ultimately are pulling in the same direction toward one shared objective: the best health care — and the best health care experience — for the patient.

As with any relationship, though, differences can lead to friction and frustration — doctors wanting patients to take care of themselves, patients wanting doctors to fix them — which can impede that objective.

To that end, The Beryl Institute and the American Association for Physician Leadership — whose missions include serving as independent champions of patients and physicians, respectively — worked together on a project to examine the patient-physician relationship and explore ways to better define the "optimal patient experience" and improving what currently exists.

We posed open-ended questions about the subject to seven patients and seven physicians with assorted experiences — inpatient, outpatient, generalist, specialist — in an effort to identify and reinforce areas of alignment and to recognize gaps to be targeted as areas for improvement.

One prevailing theme emerged: Communication can be better. Much better.

Currently, there is an unintended but detrimental disconnect between the two parties. It does not apply to all physicians and all patients, but it does exist — and it affects the relationship many patients have with their physicians. Patients uncomfortable with their physicians or the care delivery processes might choose to avoid caring for their health entirely, to their own detriment if not that of their community.

Well-meaning physicians sometimes give their patients too much credit. That is, they believe patients understand more than they do. For example, an oncologist can explain to a new cancer patient that a tumor is malignant or benign, and the news is met with a puzzled look or a blank stare. Or worse, patients nod and pretend to understand when in fact they aren't sure what either word means.

But word choice is just one element of communication. The patients in this study voiced a strong desire to be educated by their physician and to have a voice in their health care treatments. They want to be heard and to feel comfortable asking questions. For patients, a good patient-physician relationship isn't optional, it's essential — an ideal with which the physicians in this study agree.

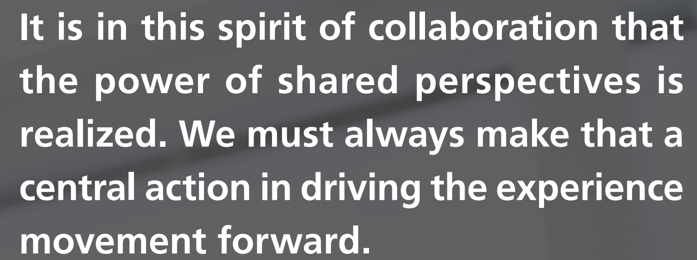
As Emily Follman, a patient from St. Louis, Missouri, says in response to a question about her expectations of physicians: "I would expect them to be generous with their time, if they need to be. I would expect them to show that they're interested, and show partnership capability. I would expect them to tell me pros and cons, and provide all the information that I need to be a good advocate for my own health care. I would expect them to be accessible, so if I have a question, after I leave or after hours, I can have a way of talking to somebody at a later time. I would expect them to just be honest with me."

Follman touches on many of the key points addressed by both the patients and physicians in this study:

- Generosity of time to discuss medical issues and concerns.
- Collaboration is a partnership that requires honest dialogue.
- Provide all the pertinent information and best treatment options — pros and cons included.
- Communication access to the doctor after office hours.

This project shows physicians want to work with patients to help them meet their health care goals, and patients want to understand and be heard. They want the collaborative relationship that begins with good communication. Accordingly, physician leadership plays an important role in this dynamic. Organizations with physicians in leadership positions should be prepared to facilitate cooperative, collaborative relationships between patients and physicians — and be cognizant of both parties' points of view.

Ultimately, communication is an essential component of health care. When things go incredibly well, communication, caring and compassion are most often at the core of success. Equally, however, when things go horribly wrong in health care, communication problems also are usually at the core.


It is in this spirit of collaboration that the power of shared perspectives is realized. We must always make that a central action in driving the experience movement forward.

COMMENTARY

THE POWER OF SHARED PERSPECTIVE

By Jason Wolf, PhD, CPXP
President of The Beryl Institute

I often have shared the simple-but-significant concept that, in health care, we are human beings caring for human beings. This may be no more critical than in the relationship of physician and patient, yet all too often, the powerful simplicity of our humanness gets lost in the process of medicine itself. When patients become diagnoses and physicians become providers of procedures and protocols, we run the risk of removing ourselves from the heart of health care, that of meeting people in need where they are and engaging the true purpose that led those delivering care to this important work.

This is a delicate but fundamental balancing act that must be maintained in the health care environment today and one grounded in the definition of patient experience itself. If experience is about the sum of all interactions, then it behooves us to focus on and commit to excellence in these moments of encounter.

This balancing of perspective, of the voices critical to a health care interaction and experience, is what we look to explore and highlight in this paper. In understanding what experience means and how it can be affected from the perspectives of both patient/family members and physicians, we can identify the clear points of alignment and the gaps between these perspectives that can help to elevate a conversation for both understanding and action.

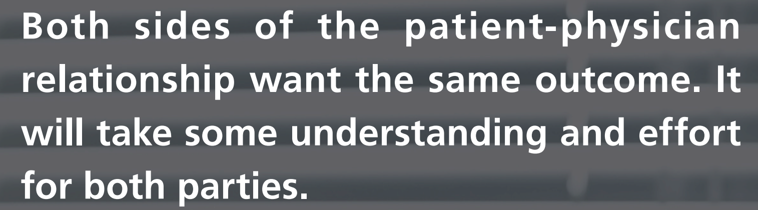
Our initial intent, in understanding the role of physician leadership in patient experience, pushed us to not just clarify how physicians play a role in experience excellence, but how the relationship between those delivering and receiving care represents the very heartbeat of health care. It also acknowledges an emerging perspective we have had at The Beryl Institute as we have looked at the critical needs of both the recipients of care and those providing care in working to achieve the best experience. This unwavering commitment to the human experience in health care reinforces an idea we have long believed — that all voices matter. And to understand those voices, we must never be afraid to ask what matters to them.

In this report, you will find thoughtful and honest perspectives from both sides of the care interaction, with some common themes and some clear focal points for action that can be addressed. In all of that, what remains evident and is reinforced in this work is that a conversation on experience is an important one and something we must constantly be willing to have as we strive to provide the best in outcomes and the best environment in which to work in health care.

With that in mind, I challenge you to consider what level of inquiry you can conduct within the walls of your own organization to understand the perspectives of those for whom you care and those who provide care. There is great power in inquiry as it broadens the opportunity for awareness and ultimately action. So, while the core themes that emerged in our exploration will serve as an insightful guide for consideration in your own organization, you must never hesitate to dig for deeper understanding within your own walls.

When we take the time to reach beyond our core question — in this case, the role of physician leadership in patient experience — to the perspectives that both shape and help us realize how this plays out in organizational life, we honor the insights of others and commit to greater possibility for ourselves. It is in this spirit of collaboration that the power of shared perspectives is realized. We must always make that a central action in driving the experience movement forward.

My greatest of appreciation to our colleagues at the American Association for Physician Leadership for their commitment to and collaboration on this paper. This effort not only helped produce a valuable contribution on shared perspectives in patient experience, but reinforces the value of collaboration among individuals and organizations globally as we push the experience movement forward. By walking these footsteps together, we will learn and grow our efforts. That is the essence of the lessons learned from the very individuals who contributed their voices to this paper and who commit their time to ensure the best in experience overall.



Both sides of the patient-physician relationship want the same outcome. It will take some understanding and effort for both parties.

COMMENTARY

THE INFLUENCE OF PHYSICIAN LEADERSHIP

By Peter Angood, MD, CPE
President and CEO, American Association for Physician Leadership®

Even within the complexity of contemporary health care, the patient-physician relationship remains *the* most critical cornerstone. Historically, Sir William Osler, a Canadian physician who also gained immense influence within the United States and the United Kingdom, originally consolidated the ideology for this core aspect of our industry; its influence has existed for the better part of two centuries. The current education and training paradigms for physicians, set by Abraham Flexner's 1910 report supported through the Carnegie Foundation, further cemented the ideology and helped deeply set the attitudes and expectations for the tenor of the patient-physician relationship in our society — attitudes and expectations to which both the physician workforce and the general public still closely ascribe.

We refer to physician leadership in this perspective — not because all physicians are in formal, titled roles within organizations, but because society continues with the expectation that, at some level, all physicians are still leaders. Certainly, the profession continues to be viewed as the most trusted and highly regarded of all professions. Therefore, the importance of the influence created by physician leadership, as it specifically relates to the patient-physician relationship, is critical for successful relationships at both the direct patient level and the organizational level.

However, the complexity of health care also has evolved significantly over the past century or two for a host of reasons. Within all countries, regardless of payment models, numerous sectors compete for influence and success. For example, academia and basic science research continue to expand the scientific knowledge of medicine at rapid rates, while technology, pharmaceuticals, device innovation and digital communication all create equally competing influences. As a result, both physicians and the public now perpetually must balance their expectations for the traditional patient-physician relationship with the rapid pace of change and complexity of the industry. For both parties, it is a complicated balance to achieve, and no plateau in this complexity is likely to occur.

Fortunately, the focus on patient-centered care and shared decision-making has resurfaced in the past five to 10 years. This trend is creating positive influences and is gradually penetrating all components of the industry. The difficulty, unfortunately, is that both are extremely difficult to achieve in the current health care environment. One almost can make an argument that true "patient-centered care" is actually a disruptive innovation to our industry — that the levels of complexity actually hinder patient-centered care, and that it requires not only innovation but *disruptive innovation* to help us get onto a track of successful patient-centered care with solid shared decision-making. (Just something to consider.)

A responsibility of physician leadership, therefore, is to help create and facilitate the environments, the expectations and the experiences for improved patient-physician relationships. As in any exchange of goods or services, the onus is on the delivering agent to provide the optimal customer experience — one often based on societal expectations and cultural influences. From those physicians who participated in this project, it is clear they want to be able to provide that experience.

In an age of plentiful information, patients also have new and evolving responsibilities. Several ideas presented in this project are important to grasp, and the recommendations we offer will be helpful for patients as they learn how to adapt to a changing health care industry. The suggestions are not complex or difficult — they are based simply on the tenets of open communication and an improved understanding of the competing issues the physician workforce maneuver daily.

Both sides of the patient-physician relationship want the same outcome — better quality, safety and efficiency of care within an environment that is caring and compassionate while providing improved communication. It will take some understanding and effort for both parties, but the eventual outcomes will be tangible and for the betterment of our collective approaches in achieving improved health and care.

This perspective, in conjunction with The Beryl Institute, is an early step to gain better clarity on the issues that both patients and physicians consider as they reflect on an ideal patient-physician relationship in today's market. Physicians remain focused on their strong ideals for compassion and caring. Patients, clearly, also want to receive compassion and caring from their physicians. And yet, both parties also recognize several competing issues get in the way of an ideal patient experience.

Successful collaboration being demonstrated between groups such as The Beryl Institute and ours can, if orchestrated well, become the predominant influence in establishing the new paradigm for patient-physician relationships. It has been a privilege for us to participate in this initial project.

COMMUNICATION IS KEY, BUT OBSTACLES EXIST

Communication between patients and physicians is a two-way street that requires participation, listening and understanding by both parties, and it can be the difference between a favorable or unfavorable patient experience or outcome.

It's not always a smooth road, as patient and physician both must navigate obstacles along the way. This includes communication barriers (such as confusing medical terms), thought-inhibiting illness or injury, too little information (or too much), a patient's fear of asking questions or being told their questions are stupid, and a lack of pre-appointment preparation — to name a few.

Recognizing and understanding the reasons behind these problems is the first step for patients and physician leaders in their efforts to navigate and overcome them.

As Kym Martin, a cancer survivor and patient advocate from Washington, D.C., explains, the onus is on both patient and physician to make it work. She and her physician share responsibility for her experience. "If I walk in anxious and uptight," she says, "that tension is going to feed the encounter I have with whoever I'm dealing with, whether it's the administration, the nurse or the provider. … We can't just expect the physician leaders and the care team to take the full load of the patient experience."

Here are some of the communication issues that patients and physicians often encounter in their interaction with one another — the perspectives and positive results that can come from understanding each other.

WORDS GET IN THE WAY

It's true: Some patients don't show up for appointments on time, don't know their medical history, don't follow instructions and don't take their medications. It would be easy to blame the patients entirely, but …

"But in some ways," says Pamela Hofley, MD, medical director and associate chief quality officer at Dartmouth-Hitchcock Medical Center in New Hampshire, "I think we as providers haven't taken responsibility for making sure that people understand everything that we've told them or given them to follow up or take their medications and understand their medical history."

CHOOSE WORDS CAREFULLY

Here are examples of terminology physicians often use, and alternatives that patients would better understand:

MEDICAL SPEAK	TRANSLATION
Adverse impact	Side effect
Atrial fibrillation	Irregular heartbeat
Benign	Harmless
Carcinogenic	Cancer-causing
Cardiac	Heart-related
Chronic	Something that happens again and again
Edema	Swelling; buildup of fluid
Femur	Thigh bone
Fracture	Broken bone
Glucose level	Amount of sugar in the blood
Hemorrhage	Bleeding
Hypertension	High blood pressure
Immune system	The body's natural defenses against germs and sickness
Malignant	Spreading or uncontrolled growth
Morbidity	Sickness
Myocardial infarction	Heart attack
Neuropathy	Nerve disease
Orally	By mouth
Plasma	Blood
Respiratory system	Your breathing
Suture	Stitches
Tibia	Shin bone

Sources: NPSF; Centers for Disease Control and Prevention; U.S. Department of Health and Human Services; The Joint Commission

"We assume people know what we're talking about when they don't. Then we become frustrated when people don't do what we ask them to do, but I don't know that we've done a good enough job as providers of explaining it."

For centuries, the patient-physician relationship was a paternalistic model in which the patient sought the help of doctors — revered, respected and authoritative professionals whose decisions, as a matter of course, were accepted without debate by compliant patients.[1] This enduring, asymmetrical paradigm, however, shifted about 30 years ago when patients began to assume a greater voice and choice in their own health care decisions.

Suddenly, it wasn't enough to be a skilled surgeon or an experienced family physician. The patient-physician relationship was evolving into something more relational and conversational. Listening, understanding, negotiating and compromise were added to the long list of responsibilities for physicians, who now had to take into account the patient's goals and wishes while making shared decisions.

While not fully embraced by all patients, shared decision-making is imperative to most. "Partnership, to me, is the key word in everything," Follman says. "No matter who the provider is or at what level, they are partnering with me. They're expert in some things, I'm expert in myself and my child. We all work together to get the best outcome."

Which inherently requires good communication. The art of conversation, especially health-related conversation, is not simple. Messages and instructions can be misunderstood, misconstrued or even dismissed — consciously or subconsciously by physicians and patients alike — a disconnect that is neither intentional nor necessarily apparent to either party at the time.

Katherine Dietrich, DO, medical director of palliative care services at St. Vincent Hospital in Billings, Montana, remembers counseling patients with the seemingly obvious instructions that they adopt a "low-sodium diet" — only to discover they didn't know *sodium* meant *salt*.

Most Americans speak at about an eighth- or ninth-grade level; for them, the words physicians use might as well be a foreign language. A study of hundreds of emergency room patients revealed that 79 percent didn't know that the word *hemorrhage* was the same as *bleeding*; that *fracture* was another word for a *broken bone*. Uneducated or undereducated patients? Not exactly. Of the 249 patients surveyed, 112 were college-educated.[2]

UNINFORMED DECISIONS

Even as the patient-physician relationship has evolved to the extent that dialogue between the two parties isn't just accepted but expected, "conversations" sometimes remain one-sided: Doctors talk while patients listen — without question and without questions.

"The patients defer or punt to the doctor," explains Vikram Khot, MD, and medical director of behavioral health at Novant Health System in Manassas, Virginia. "The No. 1 problem, I think, is that the patients are not being educated enough."

That's where physicians step in, Khot says. He advocates what he refers to as the "informed consent process," in which the doctor fully discusses and educates the patient about treatments and treatment options, so decisions can be rendered and agreed upon based on facts and clearly defined options. This, Khot says, would be "the most important enhancement" of the patient-physician relationship.

"If you ask what should you do for your knee, and the doctor says, 'Here, I'll give you this medicine. It's brand new, it just came out,' " he says, the physician should follow up by providing answers to questions such as these:

- What are the risks and benefits of this medication?
- Can we do something that's just physical therapy?

STATIC INTERFERENCE

The basic components of just about any communication model include the intended message of the speaker, the "noise" that adversely affects the message, and the interpretation of that message by the receiver or audience. "Noise" is divided into four categories:

1. **PHYSIOLOGICAL:** A patient who is ill, injured or medicated may lack the ability to listen, understand and retain information.
2. **PHYSICAL:** Environment distractions such as others talking nearby, or a doctor's office or hospital room that has poor lighting or is too warm or cold.
3. **PSYCHOLOGICAL:** A patient who is mentally preoccupied — perhaps with a life-altering diagnosis
4. **SEMANTIC:** Medical jargon or unnecessary technical language (doctor talk).

Source: ThoughtCo.com

- Can we avoid surgery?
- Can we look at alternatives — and then look at the risk and benefit of each alternative?

"And I think what's not happening is full participation in informed consent" before an educated decision is finally reached, he says.

A clear sign of communication failure is when the patient is shocked to learn of the potential dangers of a particular medication — not from the prescribing doctor, but from the pharmacist — and their reaction is: "Oh, my God, my doctor never told me about this!"

Informed consent, Khot says, brings a greater likelihood of a better encounter, a better outcome, fewer return visits with problems — and less doctor shopping. "Completely participating in informed consent is such a huge task," he says. "If you ask any physician, whether it's in urgent care or outpatient, there's often a long printout with legalese, but there isn't a good discussion about what we can do for you."

The concept of informed consent is fully embraced by patients such as Kristen Terlizzi, from San Francisco, California, who appreciates the information and outcomes that arise from those kinds of conversations. "I certainly don't want a doctor who's just rattling numbers, but who's able to skillfully navigate that bedside manner of making you comfortable while also giving you information that alludes to a larger breadth of knowledge," she says. "I want them to be able to communicate with me at a level that I can understand — being able to present the risks, being able to present pros and cons for treatment alternatives, and being able to empower me, the patient, with the right information that I need in order to ultimately make my own decisions about my care."

FEAR OF ASKING QUESTIONS

One might think the first instinct for patients who don't understand their physician's explanations or instructions would be to ask questions, but it doesn't always work that way. Why? Because they are sometimes afraid or intimidated by the doctor. Potential causes:

- They don't want to be perceived as being undereducated. They might even nod and pretend to understand everything the doctor is telling them to disguise the fact that they don't.
- Embarrassment, if they can't financially afford the doctor's suggested treatment, including costly prescriptions.
- Anxiety or phobia resulting from previous poor medical experiences — theirs or someone they know.
- Sense of inferiority to an authority figure.

All of those can lead patients to defer or default to their doctor's expertise. But whatever the reason, the end result can have consequences for the patient.

"If we tell them to take metoprolol twice a day and they don't know which one metoprolol is," Dietrich says, "they probably should ask us and make sure that things are very clear and not be embarrassed to get more help if they need it.

"But there are also a lot of patients who I think are afraid to ask for additional help," she says. "Like, 'I can't afford those medicines.' Well, maybe that medicine is too expensive but there are three other options that are cheap. And I think that if they were able to identify their issues for us, that, a lot of times, we can actually help maybe more than they even think."

INABILITY TO RETAIN INFORMATION

Other reasons why patients don't fully grasp or retain what their physician is telling them include pain, dementia, language barriers, medical parlance and shock from a diagnosis.

Patients sometimes are so sick or in such pain that their ability to process and retain information is substantially diminished. Beau Nakamoto, MD, medical director of neurosciences at Straub Medical Center in Honolulu, Hawaii, says patients "might be under such pain that [they miss] 50 percent of what you tell them." Consequently, it's no surprise when they fail to follow instructions and are readmitted for the same problem, having made no progress since their previous visit.

Harsha Polavarapu, MD, a general/colorectal surgeon at Blessing Physician Services in Quincy, Illinois, concurs. "Let's say they were diagnosed with colon cancer," he says. "They may think they are at the end of the road and expect the future to be bleak and grim, but in reality, it's totally curable if it's caught at an early stage." Misconceptions and lack of understanding, coupled with the shock of diagnoses, can overwhelm the patient's thought and get in the way of the fact that the patient has a positive prognosis.

Dietrich says she feels compassion for such patients. "Some of them, I really do feel like they mean well," she says, "but they might have dementia and don't remember what was said to them. Some of it is circumstance and sometimes underlying medical illnesses make it hard for patients to follow instructions."

In any case, Colleen Inouye, MD, a private-practice OB/GYN in Kahului, Hawaii, and former chief of staff at Maui Memorial Medical Center, suggests patients bring a support person — friend or family — with them who can take notes for the patient.

"They certainly should not be embarrassed to bring another person if English is not their best language," she says. "It helps especially with cancer patients. I'm always the one who tells them, 'I don't have good news for you. You have to come to the office so I can talk to you.' Then they bring someone with them, which I always welcome because I know whatever I'm telling them otherwise is going to go in one ear and out the other. All they're is thinking, 'Oh, my God, I've got cancer.' So, the other person is writing everything down, which is good."

Inouye also suggests allowing patients to record their conversations as a reference if they have questions later. Some physicians object to recordings, but "to me it's perfectly fine," she says.

TOO MUCH INFORMATION

It can be a struggle to strike a perfect balance between too little information and information overload. The patient needs enough information to make educated decisions, but too much information can be confusing.

Much of the angst patients experience about health care is the cost. Part of the problem is how billing and insurance coverage information is presented, explained, not explained or overexplained.

Just because a procedure is "routine" doesn't mean it will be inexpensive. Patients want to know in advance how much they will be paying out-of-pocket, and if the primary treatment option is too expensive for them, are there other effective and more-affordable options? The multiple pages of health insurance policies and hospital bills often confuse and overwhelm patients who typically have limited understanding of premiums and deductibles and how they affect their costs.

Helen Ying of Portland, Oregon, for example, has been a patient at Kaiser Permanente, where a specialist advised her that the lifetime of nosebleeds she had endured could be remedied with a cauterization. "I didn't even know what the term meant," Ying admits.

The doctor explained it was "a simple procedure" with no side effects, but what wasn't communicated was how much the procedure would cost. So Ying agreed to the cauterization. "It was a shock when I got the bill," she said. "It would be so helpful to know what the cost is, and what my options are if I didn't want to go to the expense of having this procedure."

Revealing medical costs in advance can put patients more at ease and assist in making decisions that work best for them.

Similarly, in an attempt to be thorough, doctors often provide informational handouts to patients as they check out that are typically several pages long. These, too, can be overwhelming. Nakamoto suggests handouts should use common, easy-to-understand language and that staff should review the information with the patient:

- "Are you clear on why you saw this doctor?"
- "Are you clear on what he thought the diagnosis was?"
- "Are you clear on what medicines you're taking?
- "Are you clear on what tests you're taking, and why?

And, it is possible to give too many treatment options to patients. It's another form of information overload that confuses patients more than it helps them. In extreme instances, even two choices can be one too many. The Virginia Commonwealth Massey Cancer Center, for example, conducted a study that revealed

PATIENTS AS PARTNERS

When it comes to understanding and chronicling health history, patients have several resourceful ways they can assist their providers.

SMARTPHONES: Physician Colleen Inouye gives her patients lessons on how to put their entire health history, including current medications, on their mobile devices. "If you go to the emergency room, you may be too stressed and forgetful [to remember] all your medications," she says.

ELECTRONIC MEDICAL RECORDS: They allow physicians to review a patient's history in advance of an appointment. That allows most of a patient visit to be spent on the patient, says physician Beau Nakamoto.

INFORMATION CARDS: Inouye proposes that the United States adopt a system similar to one used in Taiwan, in which a person's health history is embedded on a card that can be updated with each doctor visit.

HANDWRITTEN NOTES: Written records are plenty helpful, especially when moving from one doctor to another. Inouye suggests patients keep a log of such things as headaches, blood pressure and medications.

“when patients are presented more than one colorectal cancer screening option, there is a greater chance of confusion and, therefore, a greater chance of neglecting screening recommendations.”[3]

The example illustrates another side of the coin: Physicians should use sound judgment and cull the information when presenting those options to the patient.

Terlizzi, for example, talks about a “communication barrier” with a physician after her son’s reattached finger looked no better a month later. “He just started spouting out all these things we could do about it and gave me way too many options. It overwhelmed me,” she says.

“I don’t want to know every single possible thing we could do. I want to know what you think we should do, and why, and what the other alternatives are — what the pros and cons are within a context that’s realistic for the situation — and help me make guided decisions.”

LIMITED TIME TO TALK

According to a national survey conducted in 2017 by The Physicians Foundation, 95 percent of patients are satisfied with their primary care physician, but only 11 percent of patients — and 14 percent of physicians — believe they have enough time together.[4]

COLLABORATION, NOT CRITICISM

Christine Abbott, a patient from Georgia, says she’s lucky her doctor understands that lifestyle changes aren’t easy. He put together a plan to help her with her pre-diabetic issues, but it was her decision whether or not to follow his advice.

“It was wonderful,” she said. “It took a village to get me where I need to be. I needed [a doctor] to listen to what’s going on in my life because I’m a big stress eater, and when I’m under stress, I tell you, I’m not going to stick to my pre-diabetes diet. What you need to do is help me get through my stress and then help me get back on track. You don’t say, ‘She’s noncompliant. We’re just going to write her off.’ You have to say, ‘We have to help you find different ways of handling your stress. In the meantime, if you have to eat that bagel, go ahead, but understand you’re going to have to come back.’ ”

As David Gilchrist, medical director of family practice and addiction medicines at UMass Memorial Healthcare in Worcester, Massachusetts, explains: “Most patients don’t realize that most physicians have only 10 to 13 minutes with you for an appointment to get everything done. On average, they spend only about 7.3 minutes, according to studies. So, if you really need more time, ask if they have 30-minute appointments or extended appointments. If they don’t, ask if you can book an appointment at the end of the session so that you don’t feel the rush of the other patients waiting behind you.”

Such arrangements require anticipation and planning on the part of both patient and physician.

“Ideally,” says Christine Abbott, a patient from Augusta, Georgia, “the doctor and I have planned ahead — we’re a team. I try to plan ahead of time what I need to have done so when I’m actually at the appointment we’re thinking treatment options or discussing what changes I’ve made in the past few months and what effects they’ve had. It’s having that proactive experience — know why I’m coming.”

Even doctors can relate. “My dad is kind of a perfect example of somebody who didn’t know what medicines he was on,” recalls Dietrich, the Montana physician. “He didn’t know the doses. He didn’t know how frequently he took them. He just set out the pills in his pillbox and took them, but when he went into the doctor and the doctor asked him what he was on, he had no idea. And it just made life so much more difficult for those physicians, I’m sure, to adjust any medications or do the proper testing because they didn’t really know what he was taking. And his response was, ‘Well, it’s in the computer, so look it up’ — not realizing that there is no central database that we can look up what their doctor in another city gave them most of the time.”

MESSAGE DELIVERY AND RECEPTION

A 2017 article in the *Harvard Business Review* acknowledges that some busy health care professionals feel the demands of their jobs make it impossible, or at least impractical, to devote the kind of time allowed for “genuine conversations” with their patients. But failure to actively listen to patients, the article argues, “poses real risks,” including overlooking important information that otherwise might have avoided mistakes in the first place and contributed to better decisions.[5]

The idea among some doctors that they’re too busy to engage in healthy conversation contrasts with what most patients say is not just a vital component of the patient-physician experience but a non-negotiable expectation.

"One thing that is really important is that the patient is heard and understood, able to voice their concerns and feels they have a rapport with their physician," says Terlizzi, the patient from California. "That my doctors actually listen to me and are able to provide recommendations that feel personalized to me.

"I like to have a physician who is taking the knowledge that they have from their greater practice and using that in conjunction with who I am, how this affects me and what treatment is realistic for me in order to figure out how we solve it. The best medical situations [are] definitely when I know I was heard and understood."

For Hofley, the New Hampshire physician, the ability and willingness to listen and converse with her patients is a responsibility that comes with the job: "They want you to listen, to empathize and hopefully to collaborate with them, to come up with a plan, to investigate or manage their concerns. Mostly, they want you to make them better."

Michael Curry, a patient from Cleveland, Ohio, discovered that physicians with exceptional interpersonal skills are in high demand but worth the wait to see them. He found a local doctor who is so popular, he says, that she's often double- or triple-booked.

"I've never really had to wait a long time [to see her]," he says, "but if I do have to wait that's fine, because when I am in that appointment with her, I've never left feeling like she had any other patient than me. She's spoken out for more than my physical health; she has an interest in me as a person and has the great ability to listen. Just those personal experiences with her have been incredible."

Still, some physicians might believe they are so skilled or exceptional in their particular field of expertise as to exempt them from acceptable or exemplary bedside manner. In communication, it all comes down to delivery. Patients notice the difference.

Follman, the Missouri patient, says physicians who are "notorious for being difficult or not having a good bedside manner" should not be excused as, "Oh, that's just how he is."

"I find that to be very concerning and frustrating, but how do we fix that?" she asks. "I don't think it's OK for somebody to be gruff and mean and make people cry because 'that's just how they are.' I'm thinking of one physician in particular who's a brilliant doctor, and when you have an issue that [requires] his specialty, that's who you go to. But why do you have to put up with him being a less-than-helpful partner. How do you impact that culturally? It's a challenge, for sure."

WHAT CAN WE DO BETTER?

"The most important thing in communication is hearing what isn't said." This quote from the late Peter Drucker, who sometimes is described as the founder of modern management, aptly applies to communication between patients and physicians.

It isn't always what's said but rather what isn't said — or isn't heard — that matters. Communication is like an obstacle course best navigated if you can see what's getting in the way of the message, and then take steps to move past it.

Those obstacles can include internal or external distractions, fear, tone of voice, accessibility, a willingness to consider and/or accept ideas that aren't yours, and a lack of understanding that noncompliance and defiance are not necessarily the same thing. Identify and overcome these communication barriers, and the experi-ence can be equally rewarding for physicians and patients.

Here are some ways to get there.

MAKE QUESTIONS SAFE

Responsibility for better patient-physician communication falls to both parties. If something is not explained to the patient's satisfaction — if the doctor's explanation or instructions aren't understood — it's up to the patient to request clarification. But a physician must better recognize when their patient isn't "getting it."

Given that some patients might already feel intimidated or hesitant to pose questions, any opportunity to crack open that door of communication will disappear if physicians are dismissive to patients who seek clarification or additional options.

"I want my doctors to be respectful, and I want to feel listened to," says Follman, the Missouri patient. "But I've had examples where I've been made to feel stupid for asking certain questions, and I don't want to be made to feel that my questions are dumb. I'm a very high-information-seeking patient and patient advocate, so I need a lot of information. I ask a lot of questions. I might do a lot of research, so I want the time to talk some of that through with a provider who is able to make the time to do that with me. How can we all work together to get the best outcome?"

Physicians should understand that dismissing questions or ideas without discussion or explanation can invalidate and disrespect patients' efforts to be a partner in their own health. It can also erode trust and effectively mute any forum for discussion.

"The thing that really frustrates me," says Martin, the cancer survivor from Washington, D.C., "is when a physician or a care team disempowers a patient who walks in feeling empowered because they have information they want to discuss with the doctor. They [patients] pull it off Google, and the doctor says, 'Google? No. I don't trust the sources.' Well, that doesn't give the physician the right to just totally discount what was important to that patient."

With access to reliable information readily available from well-established medical sources, such as Mayo Clinic and the National Institutes of Health, patients are capable of research or even preliminary self-diagnosis.

For years, a woman in Tampa, Florida, had experienced deteriorating bone density, and was instructed by her doctor to take calcium supplements and engage in increasingly rigorous daily weight-bearing exercises. Despite strict adherence to this regimen — including 3-mile walks and 40 flights of stairs at work each day — her condition worsened over a decade, bordering on osteoporosis. Frustrated, she researched her symptoms and concluded she had hyperparathyroidism. Her self-diagnosis was confirmed by a specialist, who discovered and removed two tumorous parathyroid glands. Relief from symptoms was expeditious and a full recovery is expected.

Still, sensitivities persist among patients and physicians alike over who's calling the shots about the patient's health. Just as patients can feel disrespected if the information they present isn't considered by their physician, physicians feel disrespected when their expertise takes a back seat to the internet.

"When people feel that 'Dr. Google' is just as good [as a doctor] … it's very hard to take," says Dietrich, the Montana physician, "because we put in a ton of time [in med school and in practice]. We want the best for our patients. We want to be their source of information and help them."

Most health care providers recognize not only that patients should have a say in their own health care decisions but that their participation is a necessary component of the process.

"If there are things that are not clear," affirms Curry, the Ohio patient, "there's an expectation that I bring that up, that I question it, that I follow through, and if there are any issues or problems that I make sure that I communicate those as well. You know, there's always the list of questions that they're going to ask, but some of the things are so nuanced that I just think it should be expected of me to communicate clearly what's going on."

The ideal doctor visit, Follman says, "would leave you feeling satisfied, empowered and educated – unafraid to ask for help because it is hard to ask for help. A lot of times it's intimidating talking to physicians. It would be nice to feel empowered and partnered with in a way that makes you feel comfortable."

BE OPEN-MINDED

As educated health care providers, physicians also assume the role of adviser — sharing what they know and helping to guide patients to what they believe are the best treatment options. Arriving at a consensus can require a certain degree of open-mindedness. That's easier for some than others.

"I once had a dermatologist tell me, 'I will never remove a mole from you unless I believe it's problematic,' " Martin remembers. "And I said, 'Then I'm afraid we're done.' [There needs to be an] understanding that my care is not ultimately the doctor's decision — it's ultimately mine. The doctor is there to advise me. My oncologist for my breast cancer advised me to do chemotherapy, and when I told him, 'No, I'm going to do herbal,' he wasn't offended. He said, 'OK. I don't agree though I also don't think you're being unreasonable.' He respected my values as a patient and even spoke with my herbalist about my care, which was an ideal outcome."

Adds Hofley, the New Hampshire physician: "It has to be a partnership between the provider and the patient, with certain mutual respect and a shared understanding of the patients' goals for their health — not necessarily my goals — and meet them there. My side of it is to provide them with as much education in a way that they can understand it, and help to guide them, but work with them to formulate a health care plan. But it has to be a partnership."

Follman found such a partnership after she was diagnosed with breast cancer in 2016. She saw 10 different doctors and "every physician I met gave me lots of time to have my questions answered. I felt like I got what I needed," she says. "I didn't have a lot of concerns about the providers and getting information and help. And that was a big deal."

Although it was recommended that she have a lumpectomy, followed by radiation and hormone therapy, Follman instead opted for a double mastectomy. "I felt very supported in that decision," she says. "I made a very different choice because I didn't think that's how I wanted to spend the rest of my days. But nobody made me feel bad about it, nobody told me not to, and nobody discounted my feelings, and that was really important."

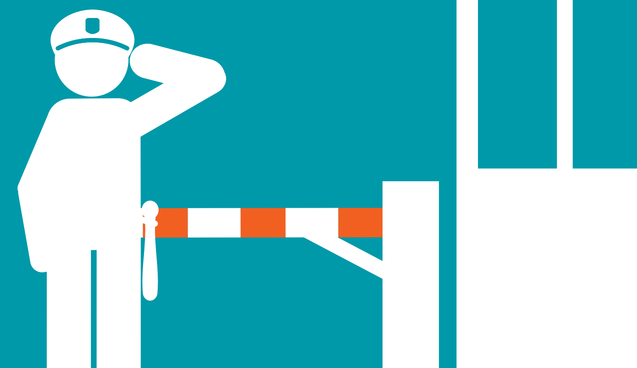
CONSEQUENCES FOR NOT FOLLOWING ADVICE

Most disappointing to physicians is when they present a health plan with a history of success that should extend and improve the patient's quality of life, but the patient doesn't follow through. That's the patient's choice, yet it's "probably my biggest frustration or concern when the patient's expectations and goals are not matched by their willingness to engage in the problem-solving," Hofley says. "It's like:

ADHERENCE BARRIERS

BARRIERS TO MEDICATION AND TREATMENT INCLUDE:

- **Cost of treatment**
- **Scheduling**
- **Religion**
- **Allergic reaction**
- **Physical disabilities**
- **Psychological**
- **Inability to swallow pills**
- **Language barriers/misunderstanding**
- **Mistrust or misconceptions**
- **Fear of addiction**
- **Concern about side effects**
- **Unstable living environment**
- **Difficulty of regimen**
- **Apathy**



HOW TO IMPROVE ADHERENCE

According to Essential Medicines and Health Products Information Portal, recommended solutions include:

- ✔ Increased communication between patient and health professional
- ✔ Provide full treatment instructions, including the pros and cons
- ✔ Reduce the number of medications and the frequency of doses
- ✔ Memory aides such as watch alarms, iPhone alarms, or pill cases

"Physician: 'OK, this is what you want, this is where you want to go, so this is what we need to do.'

"Patient: 'Well, I don't want to do that. Don't you have a pill for this?'

"I mean, some of those decisions are difficult, but probably the toughest thing is when you hit that wall of 'OK, I get where you're going, I get what you want, you understand what I'm telling you — but you're not going to do it.' "

Gilchrist, the Massachusetts physician, notes that when patients don't follow instructions, "there's probably going to be some consequence." Instead, he says, "I want to make sure they ask questions or tell me why they don't think that plan would work for them so that we can negotiate a plan that *would* work for them — then follow through on the agreed-upon plan so we can actually see if that improves their condition."

It's incumbent upon physicians to ensure their patients know compliance can change their lives. Following through can make all the difference — not just taking medication to overcome an illness but changing behaviors.

"I talk to many of my patients about healthy behaviors, but very few of them take me up on it," Gilchrist says. "I do have six to 10 patients who have not only just taken that advice about healthy lifestyle, but ran with it. And those are the patients who have gotten rid of their diabetes, high blood pressure and their medications by changing their lifestyle, but it's very few that are able to take it to that level. It's easier to take pills or to just kind of keep doing what they're doing. And we all struggle with that."

Abbott, the patient from Georgia, understands those struggles — that no matter how beneficial or how strong the desire to follow a physician's advice, "diets are a big thing," she says.

"You can't eat the wrong way for 40 years and then fix it in three months. But you give me a few years, I'm going to figure some of this out and things are going to get better because I have real incentive to try, but I need time and I need a team and I need support."

IDENTIFY AND NEGOTIATE BARRIERS

Noncompliant is a term commonly used by physicians when describing patients who don't follow their instructions. The implication is that patients are intentional and defiant in declining to follow the instructions.

Often, however, there are underlying reasons or barriers that inhibit a patient's ability or desire to follow the physician's advice. In such cases, it isn't noncompliance in the sense of defiance, but inaction or disengagement resulting from obstacles or circumstances beyond the patient's control that prevents them from acting on that advice — all otherwise unknown to the physician.

This is where communication plays such a vital role.

On the one hand, Dietrich says, "I expect that patients follow the instructions that I give them," and on the other hand, "to the best of their abilities, that they identify any barriers for me."

The patient-physician partnership is a collaboration that leads to solutions that meet the goals of the patient. *Health Science Journal* calls the relationship, which includes encouragement and reinforcement, one of the most important factors influencing adherence.[6]

"Sometimes I'm asking them to do this," Hofley says, "and if you can't do it, tell me. It's OK. I have to know it. Better you tell me that you can't do it — or that you didn't do it — before I run off in the wrong direction."

She says there are times when a patient might tell her, "To be honest, my child will never drink that," or "I'll gag on it. I can't do it." At that point, she acknowledges, there's no sense in filling the prescription, or filling it but putting it on the shelf to collect dust, so "let's try something else."

"The biggest thing for both sides is honesty," says Abbott, who once walked her grandmother back into the doctor's office after she'd declared she wasn't get-ting her prescription filled. "I think the physician expects if he's going to lay out a treatment plan that we should follow it. If I have concerns, I think the physician expects me to raise them and say, 'I'm not so sure about this. Are there other

options? Do you really think this is the best thing for me?' Just get a feel for that honest exchange."

MORE ACCESSIBILITY

When asked about their primary expectations of physicians, surveyed patients emphasized that while face-to-face communication is vital, so is the end-of-visit or after-visit experience — the ability to ask questions after an appointment or hospital stay.

The benefits of this continuing access to the physician include a safety net of reassurance that builds trust, respect and appreciation for the physician.

Ying, the patient from Oregon, spoke of making calls to the office of her mother's doctor, and "he would call me back before the day's end. Sometimes, he would call at 9 at night, just to answer my questions. It just showed how much he cared about his patients," she says.

Hala Durrah, a family caregiver from Washington, D.C., admits she doesn't always think of questions when she's with the physician, but often does later.

"If there's a way to circle back, that's really important to me, to be able to have that open line and two-way communication — not just from the point of care, but afterward," she says.

Technology can help. MyChart, for example, is a medical app that provides 24/7 access to personal information such as lab results, appointments, medications and immunization history, and also is a convenient avenue of communication between patients and providers. "I use MyChart a lot," says Curry, the Ohio patient, "and I will often pop a question to [his physician] on MyChart, and it's always within 24 hours that I get a reply. Follow-through is always important for me — and not feeling rushed."

RECOMMENDATIONS

FOR PATIENTS

1. **Ask questions:** Physicians are your partner in achieving your health care goals. They want to educate and answer your health care questions. If you experience appointment anxiety, bring a support person — a friend or family member — who can ask and discuss on your behalf.

2. **Recognize communication obstacles:** Pain, illness, dementia, foreign language, medical jargon and diagnosis shock can detract from your ability to process or understand what a physician is saying. Bring a support person who can take notes and ask questions on your behalf. Also, ask the physician if the conversation can be recorded for reference at a later time.

3. **Prepare for your appointment:** Face-to-face time with physicians is limited, so make the most of it. Bring a list of questions (so you don't forget) and a list of current medications (or bring the medications themselves). Physicians love this. Also, bring a notepad to take notes. Call in advance and ask if you can fill out forms online so you don't have to do so at the office.

4. **Know your medical history:** It's not easy to remember all of it. (When was the last time you had a tetanus shot?) Use technology such as smartphones, laptops or electronic medical records to store personal medical information, or handwritten notes or medical cards that list current medications and can be kept in a wallet or purse.

5. **Be open-minded:** This is important for both the patient and the physician. Listen to and consider what the physician is saying. If there are questions or concerns, express them. Ask if there are other options more in line with your health care goals.

6. **Ask about after-visit communication:** It might be necessary to contact a physician or staff with followup questions or concerns. Request contact information — a telephone number, email address or other contact information — before leaving. Learn how to make contact after office hours.

7. **Ask about bills:** Hospital charges can be confusing and anxiety-inducing. Before checking out, ask for charges to be explained to you or your support person. Also, avoid surprises by asking what additional bills to expect in the mail.

8. **Be honest:** It's the foundation of good communication and outcomes. Know that forthright information is imperative to accurate diagnoses and treatments by physicians.

9. **Be willing to compromise.** This element of the collaborative process is beneficial to both parties in arriving at reasoned decisions. Although you have the final say, consider the informed ideas of physicians who are dedicated to the best outcomes for their patients.

10. **Adhere.** Although following the doctor's orders is advisable, not everyone does. Ask for pros and cons of suggested treatments. Use memory aids, such as pill cases or alarms on your watch or smartphone as medication reminders. But if you find your treatment option unacceptable, ask about alternatives.

FOR PHYSICIANS

1. **Choose your words:** Keep it simple. There's no such thing as being too basic. Remember: The average American speaks at an eighth- or ninth-grade level, meaning many are below that level.

2. **Educate your patient:** Understand the patient's health care goals and explain the pros and cons of select treatment options, including medications, their benefits and side effects. Result: better encounter, better outcome, fewer return visits and less doctor shopping.

3. **Ease fears:** Patients can feel intimidated, educationally inferior, embarrassed about financial concerns or medication conditions, or anxiety from previous experiences. Identify the cause(s) of the fear to help patients overcome that anxiety. For example, if prescription cost is the concern, offer a more affordable alternative. Also, be authoritative, not an authoritarian.

4. **Provide enough options:** Patients appreciate choices of treatments, but be careful not to confuse them with too many. Be selective with proposed medical options.

5. **Prepare for appointments:** Know the purpose of the patient's visit in advance. This can be accomplished by instructing patients to fill out online forms in advance of their appointment. Doing so streamlines the appointment, allows more time for discussion and leads to higher patient satisfaction.

6. **Examine your exit handouts:** Multiple pages of take-home instructions can be daunting. Review your handouts with the patient and answer questions. Also, supplement lengthy material with simplified, one-page checklists — must-do instructions and must-know information.

7. **Be available:** It's inevitable that patients will want to contact physicians after their appointments. Provide (or highlight) telephone numbers, email addresses or other points of contact for the patient, including who or how to make contact after office hours.

8. **Explain the bills:** Patients prefer clarity, not surprises and confusion. Hospital bills can be especially complicated. Your staff members should be able to review a bill with a patient or a support person, answer questions and inform of additional bills they can expect in the mail.

9. **Collaborate:** Patients want their provider to listen, understand, care, show compassion and include them in the decision-making process. Remember to be open-minded, respectful and inclusive in arriving at a decision, strategy or compromise that is satisfactory to both parties.

10. **Help with adherence:** Even when it's in their best interest, patients don't always follow instructions. Reduce number of prescriptions and frequency of doses if possible, and suggest memory aids (alarms, pill cases). For lifestyle changes, set realistic and attainable goals, proper direction, support and accountability (a group with shared goals or a buddy system).

CONCLUSION

WE'RE IN THIS TOGETHER

Although good communication is the linchpin of any successful patient-physician relationship, there's ample evidence that disconnects still exist. They contribute to confusion, lead to decisions based on bad or incomplete information, and result in less-than-optimal experiences for the patient. To the credit of patients and physicians alike, although they assign some of the blame for this disconnect on each other, they also accept responsibility for their respective roles in communication breakdowns.

That's the main finding of this study of the patient-physician relationship as it relates to the optimal patient experience, but it comes with ideas and strategies for patients and physician leaders to share with their staff about how to better navigate communication barriers and obstacles.

Shared responsibility among patients and physicians, coinciding with expressions of mutual respect, give rise to the hope that although a disconnect might always exist on some level, there is strong desire from both sides to work with each other in an effort to narrow the communication gap.

It was the physicians in this study who conceded their use of medical parlance continues to interfere with messages to the patients, that they sometimes inundate patients with too much information — and that sometimes "we don't make it easy for people," as one physician confided. And it was patients who conceded that 30 years into the evolution of a relationship that encourages self-advocacy in personal health care decisions, there remains a sizable segment of that population that fails to contribute to its own health care discussion and decisions.

The question is: What can be done?

In the case of physicians' use of health literacy, the answer is simply this: Keep it simple, and the simpler the better. At the risk of sounding condescending to patients, physician leaders should advise their staffs not to overestimate the patient's ability to understand even seemingly elementary medical terms. This premise is reinforced in one study that implores emergency health care providers to carefully explain even the most commonly used medical terminology to their patients.[7]

Resources available through the federal Agency for Healthcare Research and Quality (ahrq.gov) can help explain health-related matters to patients in ways they can understand. This includes the use of easy-to-understand handouts and charts that might seem simplistic to a physician but actually hit the target with patients.

"Some of these things, when I look at them, I think, boy, that's like treating them like juveniles," says Hofley, the New Hampshire physician. "But sometimes when I do it in clinic, and I draw pictures of a bottle and pills [for my patients], they say, 'Oh, thank you so much!' And I'm thinking, 'Really? You're kidding.' "

But they're not. It works.

"Not everyone who comes into the office is literate," she says, "but you think they are until you've handed them something and they can't read it. Not everyone understands the language that you're using, even if they're English-speaking people. I think the medical community needs to get much, much better at that whole concept of health literacy. And that health literacy expands to understanding the person's access [to what they need]." That includes such matters as:

- Can they drive here?
- Do they have the money to get the medication that you're asking them to buy?
- Do they have the time off from work to come to their follow-up appointment?

"What is [the physician's] understanding of all of that?" Hofley asks. "And what's [the patient's] understanding of these instructions that you're giving? It's not just, do they understand they're supposed to take two pills twice a day [but] can they even get to the pharmacy? Do they have the money to pick it up? And so we're frustrated that someone didn't take their hypertension medication, and then they show up for their follow-up appointment and their blood pressure is still up. But there are all these other factors that are reasons that they didn't do it."

Helping patients and physicians understand each other is one issue. Getting patients to communicate with physicians is another. It's a three-pronged challenge.

1. **The patient's ability or inability to remember and share their medical health history.** Physicians expect patients to know it — and often that of their parents and other family members — in addition to vaccinations, surgeries, allergies and current medications, to name a few. It's a lot to remember, and

not everyone does. Technology can help, with electronic medical records and the archival of personal health information on digital devices — to the extent that memorization might become less necessary, or not necessary at all.

2. **The patient's fear or reluctance to ask questions.** The reasons are many, including perceived or actual intimidation, sense of inadequacy (financially or educationally) and prior bad experiences with other physicians. Whatever the case, it remains the responsibility of physician to educate, inform, spell out options, and, if possible, recognize when a patient has questions they aren't asking. For example: After explaining the pros and cons of treatment options, solicit their preferences or concerns.

3. **The patient's decision not to follow physician instructions.** This remains a big divide. But it isn't just the patient's inaction that frustrates physicians, it's their failure to communicate their intent not to follow through — or to identify the barriers that prevent them from doing so. Without this information, physicians can't offer solutions for getting past those barriers or the best alternatives that could help patients achieve their own goals.

As Dietrich, the Montana physician, says, physicians expect patients to be open-minded, honest, actively engaged, and understand "that we're telling them things that they may not want to hear but it's not for our benefit; it's for their benefit."

In the end, physicians want only to communicate, inform and educate patients in ways they can fully understand so that decisions can be reached that meet their individual health care goals. And the patients who rely on their physicians want the same thing.

It *is* a partnership. It *is* a relationship. And for successes to be realized, it requires working together.

"It's give and take because we're all on the same team," says Durrah, the caregiver from Washington, D.C., whose daughter is a liver and bone marrow patient.

"I think sometimes the way we present this information may give the appearance that it's all about the patient. But it's not. The 'patient-physician experience' is the team experience. It's not just about me. It's not just about what you can do for me, but what else I can do for you, because we're in this together. If we are team players and teammates and equal partners, then that doesn't mean that this is all about me. I want to stress that — that we have to care for one another."

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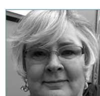
PATIENTS



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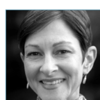

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ABOUT THE AMERICAN ASSOCIATION FOR PHYSICIAN LEADERSHIP

The American Association for Physician Leadership is the only professional organization dedicated to providing education, career support and advocacy to support physician leaders as they create transformative solutions within the rapidly evolving field of health care. Founded in 1975, the nonprofit association has members worldwide and is known for its Certified Physician Executive certification program. It is based in Tampa, Florida.

physicianleaders.org

ABOUT THE BERYL INSTITUTE

The Beryl Institute is the global community of practice dedicated to improving the patient experience through collaboration and shared knowledge. It defines patient experience as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care. It is based in Dallas, Texas.

theberylinstitute.org

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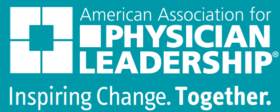

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