**By Kipum Lee**

# Designing for Doctor-Patient Interactions During Leave-taking

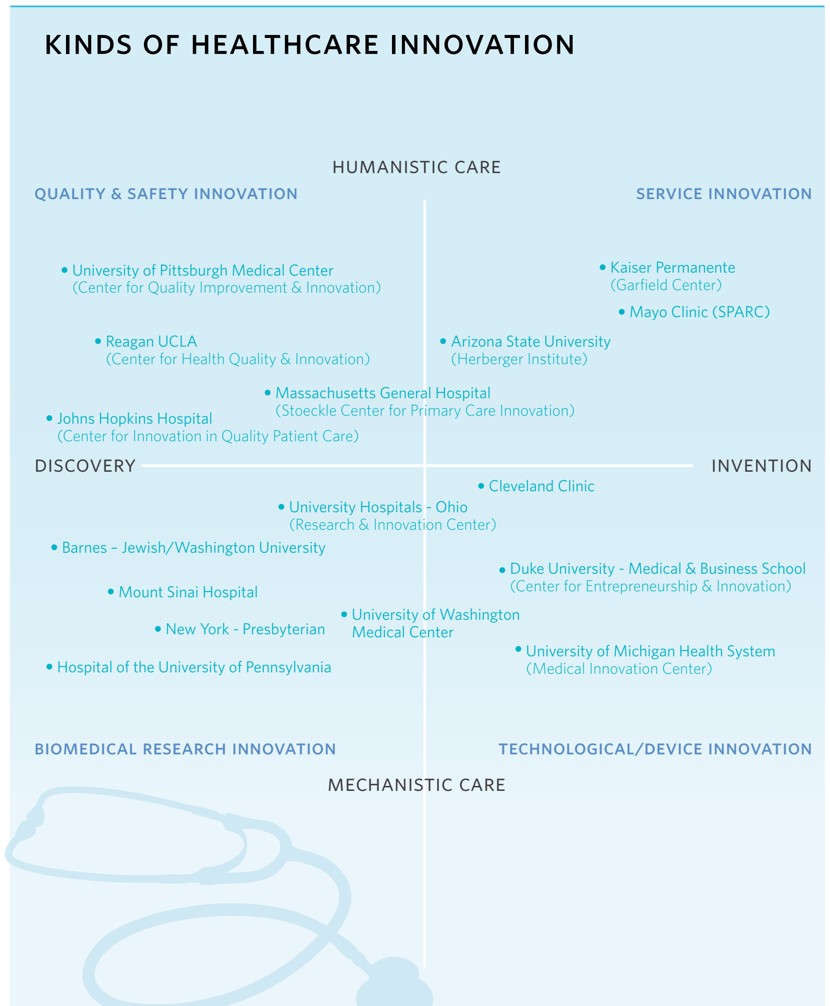
## A Case Study: Impacting a Physician-led Organisation

**Kipum Lee,**
Doctoral candidate at Case Western Reserve University's Weatherhead School of Management and senior interaction designer at Marriott International.

The following academic research project captures the work of a five-member team for a capstone class at the Weatherhead School of Management. While conforming to accepted notions of service design, the project also had a strategic dimension aimed at making an argument to the leadership at Cleveland Clinic. The structure of the inquiry consisted of problem finding, developing a hypothesis and making a product to address the problem. The final deliverables took the shape of a project report and a process book and were presented to and before the Office of Patient Experience, the CXO, and CEO of Cleveland Clinic. What follows is a narrative of our design process that seeks to contribute to the service design discourse.

In 2007, the CEO of Cleveland Clinic was invited to Harvard Business School to discuss a case study on work being done by his organisation. At the end of a session, a student raised her hand and said, "Dr. Cosgrove, my father needed mitral valve surgery. We knew about Cleveland Clinic and the excellent results you had. But we decided not to go because we heard you had no empathy there. We went to another hospital instead." The student then asked, "Do you teach empathy at Cleveland Clinic?" This left the CEO speechless.[2]

Immediately following this penetrating and sobering question, Cleveland Clinic was quick to set up the first Chief Experience Officer (CXO) position in a healthcare organisation and an accompanying support department called the Office of Patient Experience (OPE). Since its establishment, the OPE has played an important role in raising the level of awareness around patient experience at the clinic, starting various programmes and, most importantly, facilitating discussions around the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.




The HCAHPS is an in-patient survey mandated by the Center for Medicare & Medicaid Services (CMS) in the United States that was recently created to increase transparency around patient experience and to aid consumers in their health provider and hospital decisions. While there are a lot of details around this survey, the takeaway is that Cleveland Clinic continues to perform below the national average for several of the questionnaire domains. This impacts the reimbursement that the Clinic gets back annually from the government and has implications for the Cleveland Clinic brand.

It was in the context of these government standards for patient experience, competition from other organisations and the realisation that the art of caring for others had been lost that Weatherhead began a one-year engagement with Cleveland Clinic.

It was important to point out to the leadership at Cleveland Clinic that innovation in the United States is not just about quality and safety improvements, biomedical research and technology/device inventions. There is a strategic imperative for the Clinic's 'engineering culture' to invest in service innovation.

**A Problem**

It was critical that the exploration of possible paths for the project not become too narrow and singular too soon. To accomplish this, the team dedicated a full three months to the contesting of issues (framed as paradoxes within the organisation) before settling on one pressing problem. We wanted to get an intimate understanding of what Cleveland Clinic was as an organisation prior to setting

By Kipum Lee

a course of action. These initial months became our time of problem finding as opposed to problem solving.

Out of a set of a half-dozen interesting issues that were identified, we were perplexed by the paradox of the leadership structure at Cleveland Clinic. In all of the marketing materials, as well as the overall communication that the organisation as a whole publishes, it is very clear that Cleveland Clinic takes great pride in its physician-led culture. This form of leadership goes back to 1921, when four physicians founded the clinic. This 'officer core' remains one of the organisation's greatest strengths[1]: the doctors lead the programs, institutes and innovation.

*"While physicians at Cleveland Clinic are great formal leaders, they face the enormous challenge of being 'servant-leaders'."*

Yet, the paradox lies in the realities that patients and families experience when their encounters with these world-class doctors are marked by frustrations and loss of dignity. While physicians at Cleveland Clinic are great formal leaders, they face the enormous challenge of being 'servant-leaders'. For example, during contextual inquiry, we witnessed a patient at the Clinic who received great clinical care but complained about her doctor's arrogance and poor communication skills. When we asked a caregiver in private about the patient's concerns, he responded that this was a "touchy issue" and that the doctor who provided treatment for this patient is a seasoned and senior physician who is at the Clinic because he is good at what he does.

This exchange illustrates a problem at the Clinic: It is difficult for Cleveland Clinic caregivers – nurses, administrative staff, patients, families, and even other doctors – to change the behaviours of physicians with patients and their families.

**Hypothesis**

While it would have been ideal to explore doctor-patient interactions across the entire patient journey, it was not possible given the time frame and resources. Therefore, to make it manageable as a one-year project, our team chose one part of the patient journey: the discharge experience. To humanise and contextualise this moment in the greater context of understanding what an experience is, we also called this the 'leave-taking' experience – the final sub-unit of a face-to-face engagement that contributes to the overall structure of an interpersonal encounter between people – after Erving Goffman's classic study of human interaction.[3]

Why focus on leave-taking? The last few days of a patient's stay are very important. For patients, this time is a critical moment to understand their condition, to deal with emotional distress and incoherence if they're on medications and to find a way to manage the complexity of information and instructions. For families, this is when key decisions are made about the patient's transition to another place (e.g. facility, another hospital, home) and may be a turning point in the lifestyle of the care-taking family members, especially if the patient requires constant attention. For caregivers, this is the last moment at the hospital before patients are sent the HCAHPS and the last opportunity for service recovery if things have gone wrong in earlier phases of the patient journey. It is also a critical time to mitigate the chances of a patient's readmission due to mishandling of information.

Our hypothesis: Focusing on building quality encounters between doctors and patients during the discharge phase

Design research consisted of observations in the field, co-creating / generative activities, shadowing, and interviews.

By Kipum Lee

A project report booklet detailing the entire design process with some of the recommended doctor-to-patient interaction concepts.

makes a memorable impression and will benefit an important part of the patient journey.

**Design Research: Not Just Outcomes but Process**

Our team had a particular interest in providing alternative ways of gathering insights to inform service innovation. With its long history of thinking about the world through the lens of scientific inquiry, Cleveland Clinic's method of research has always relied heavily on quantitative analysis and statistics.

We found common ground with the clinic by focusing our attention on the theme of innovation. The clinic has a legacy of innovation in the way they manage quality and safety improvements, biomedical research and technical and device inventions. Our team made the case early in the process that service innovation is a legitimate area of innovation that demands exploration and aligns well with the strategic establishment of the OPE.

However, instead of providing a unique voice in the clinic and advocating a holistic perspective of patient experience, the OPE was using the same quantitative methods used by the greater organisation for its day-to-day work. In fact, publication materials from the clinic were explicitly lauding the decidedly data-driven, metrics-make-sense methodology of the OPE.[4] While scientific and quasi-scientific (i.e. social sciences) measurement methods are powerful means to understanding clinical outcomes and making decisions, they are not the only ways research can be done.

We carefully formulated and positioned, as a complementary mode of research, the argument that there is value in patient and family stories as well as insights from ethnographic-type research. We highlighted design research as one product of the project and demonstrated that the architecture of the leave-taking experience, as well as patient stories with accompanying emotions, are just as relevant as quantitative data.

It was at this point that the range of customary service design methodologies was used. Our team developed a toolkit for participatory design activities (we engaged with patients, families, caregivers and senior leadership at the clinic, as well as members

of the OPE), created a detailed service blueprint of the discharge experience with sub-layers of emotional elements, and synthesised various themes for concept development based on the research process.

**The Product**

The themes were then used to propose an interaction guide to help physicians and their teams say goodbye to patients and families during the leave-taking experience of a hospital stay. The interactions are depicted in the form of short sketches with ten scenarios that support the conditions for conversation and connection between doctors and patients. Each scenario highlights the themes that informed the concept, along with where in the discharge experience the idea might have the most impact.

To illustrate this, one concept – the 'dignity blanket' – begins with a Cleveland Clinic caregiver covering the naked body of a patient about to undergo surgery and who is lying on the operating table. After the surgery and during the beginning moments of discharge, a physician presents the patient with the blanket that was used to cover them when they were at their most vulnerable. This service acts as a gift and, more importantly, a vehicle for conversation. Research revealed that patients lose a sense of dignity when they enter a hospital environment, especially when physically exposed. To address this, the clinic redesigned the patient gown several years ago. The dignity blanket elaborates on this notion of preserving or restoring dignity by asking, 'Can we embed the idea of dignity not just in an artefact (e.g. gown) but also in a service?'

There was also a more subtle insight from research that motivated this concept. Some doctors provide preferential treatment by personally making sure that the bodies of those they know are covered. One interviewee also confided that it is easy to be indifferent and to not cover the bodies of individuals whom they do not know, especially if those working think that families and other patients are not looking or aware. Yet, families and patients have a keen sense of awareness: surprisingly, this is true for things that may even happen during the backstage moments of the patient journey.

This concept provides a way for the clinic to exercise transparency, eliminate a potential moment of preferential treatment and guarantee some protection and respect for all patients. It encourages physicians to show an explicit concern for patients' dignity during their most vulnerable moments by providing evidence. Envisioned as a service concept at the beginning of leave-taking, the 'dignity blanket' is one way to set the tone for a time of dynamic transitions.

**Conclusion**

The space of service innovation in healthcare is ripe, with much room for exploration and development. It is our hope that the thoughts and recommended actions in this case study can be a reference, a way to initiate dialogue around doctor-to-patient communication and a point of departure for caregivers at Cleveland Clinic and other healthcare institutions.

*Download full project report at: kipworks.com/clevelandclinic/projectreport.pdf.*

***References***

[1] *Clough, J. D., ed. (2004). 'To Act As A Unit: The Story of the Cleveland Clinic' (4th ed.). Cleveland, OH: Cleveland Clinic Press.*

[2] *Cosgrove, D. M. (2007). 'A Better Patient Experience'. Cleveland Clinic Magazine, Summer 2007, 3.*

[3] *Goffman, E. (1963). 'Behavior in Public Places'. New York, NY: The Free Press.*

[4] *Szilagyi, S. (2011). 'The Patient Experience'. Cleveland Clinic Magazine, Winter 2011, 20-27.*