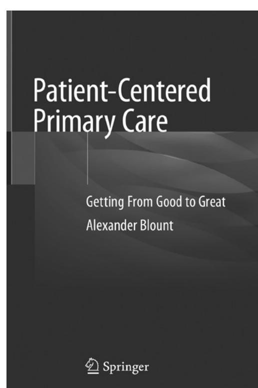
Patient-Centered Primary Care: Getting From Good to Great

Alexander Blount

Cham, Switzerland, Springer Nature Switzerland AG, 2019, 243 pp., $99.99, hardcover



Asking Alexander "Sandy" Blount to write a book about patient-centered primary is akin to asking Michael Jordan to reflect on basketball. There is perhaps no one better to reflect on their experience and history on the ground. But it may also be true that we then look ahead, we desire something more of a critique and meta-analysis, and in our system of health care there is certainly plenty of room to critique everything, starting with the book subtitle "Getting From Good to Great." In our system, I am neither sure that we are in fact currently good, nor that we are in a position to be great, but Blount (and Jose Bayona) who coined the term "integrated primary care" in 1994 certainly has the depth and breadth to at least comment on this, as well as to assert and challenge readers.

Blount is a psychologist, a pioneer, and a leader of behavioral science integration in primary care behavioral health. His pedagogic ways have promoted reducing barriers and improving behavioral medicine responsiveness and usefulness in the primary care setting. His primary care behavioral medicine (PCBM) course developed at UMass Medical School helped highlight the use of standardized tools and assessments, and taking a practical approach to what behavioral medicine can offer primary care. I still have his attitudinal PCBM doorknob-hanging message of "Yes, please interrupt, I'm here for PCBM." Being open to interruption seems a job requirement in all of medicine, but in primary care especially, where the ability to have fractured attention and recovery is a job requirement. During his online courses Blount famously demonstrated this value in action, often interrupting his copresenters to interject something from his experience.

Heath Myers, LCSW: As a new professional in what I have perceived to be a shockingly dysfunctional health care system, I am ambivalent about this text. Without a doubt, I found the repository of theories, interventions, empirical evidence, and professional lexicon highly educational, especially in terms of deepening my working knowledge of how behavioral health functions with a patient-centered model. Yet for a model so focused on the patient experience, the patient experience somehow felt like the most distant aspect of the book. Terminology like "multiply-disadvantaged patients" brought to mind George Carlin's critique of how relabeling "shell shock" as posttraumatic stress disorder drained the color and meaning from content the label held. The more I read on the more the disconnected I felt from the patient(s), and particularly their emotional experience.

I find framing the efforts to establish the patient-center primary care model as moving "from good to great" highly problematic. In Blount's book, I hear the voice of a spirited, passionate, technocratic reformer where I deeply desire a broader, more revolutionary voice. Blount appears to accept, almost without questioning, the supposition that revenue generation and cost savings should be one of the primary, if not *the* primary factor that shapes who gets what care and when. Questions of policy as it pertains to questions such as access or the impact hedge funds shaping care are arguably beyond the scope of a clinical textbook, but I fail to see how. To me, these questions are central to the provision of clinical care. Without more fundamentally confronting current presuppositions about how care is provided, why, and to what end, the suggestion these reforms can move the state of primary care from "good to great" seems to overemphasize how much humanity a patient-centered medical home can bring into the revenue-driven health care system.

Patrick McFarlane, LCSW, MSW, MA: My overall impression, as someone who has been around for a long time, is that the book

isn't stinging enough. It doesn't challenge the field enough, but maybe that's what happens when you're a psychologist in medicine; you may question your standing to really be an effective critic. I'd recommend the book to anyone starting in primary care as it offers a primer on the thinking about primary care, the history of primary care, and models for team-based care. And it's a *tour de force* delineating the difference between care delivery and partnership with the patient that empowers. Blount's mnemonic TEAM stands for Transparent, Empowering, Activating, and Mutuality, and is the center of his argument of how to get "from good to great." These are important concepts, but leave me thinking that concepts and incrementalism are unsatisfying in the face of a difficult system of care that is only becoming more corporatized with the advent of minute clinics, Amazon Health, etc.

This is meant as a textbook, and its strengths are its history and context of these efforts in primary care, and its concepts for incremental improvement. The chapter on growing and retaining an expert team is a great discussion of the factors that organizational leadership should consider. However, in a nation that ranks middling to low in measures of health, health equity, health outcomes, and cost, and where we fail many people (both clinicians and patients), this kind of book can seem like an apology where radical change is necessary, and disruption is replaced with efforts at online care, public health initiatives, and large corporate challenges to a system that is not good, and thus may not be great.

Overall, the text provides an overview of efforts at patient-centered primary care, which is a valuable read for administrators and clinicians who regularly think about such things. However, it may leave some readers wondering if it provides anything close to the radical reforms necessary to achieve significant gains in health, health outcomes, and patient centeredness in primary care.

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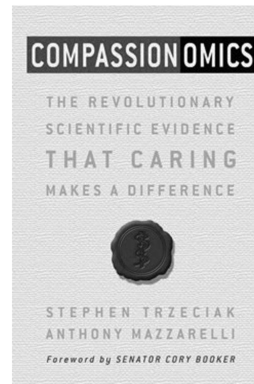
Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference

Stephen Trzeciak, Anthony Mazzarelli

Pensacola, FL, Studer Group, 2019, 375 pp., $18, paperback



I'll admit I wasn't excited when a colleague first told me about *Compassionomics*. Sure, we need to relate well to our patients; what's new about that? I reluctantly picked up the book because I respect the colleague, but I didn't have high hopes for it.

Despite my lukewarm start, reading *Compassionomics* was a great pleasure, and now I'm the one recommending it to colleagues. What Stephen Trzeciak, MD, MPH, and Anthony Mazzarelli, MD, JD, MBE, have accomplished is to make the topic of compassion in medicine engaging, show how it relates to patient and financial outcomes, and dispel fears that engaging compassionately with patients will take a lot of time and energy.

Trzeciak is a practicing intensivist and an NIH-funded researcher who has published widely in the area of resuscitation science. He is a professor and chair of medicine at Cooper Medical School in Camden, New Jersey. Mazzarelli continues to practice emergency medicine, and he also earned a law degree, and a master's degree in bioethics. He is currently copresident and CEO at Cooper University Health Care.

The book is organized in three main sections, the first of which is "The Case for Compassion." Starting with a story about a bus crash on a snowy road in Sweden, the authors describe how researchers learned, 5 years after the accident, that the survivors' primary memories of the incident were not only of the physical pain they endured, but also the lack of compassion they felt from the caregivers once they arrived at the hospital.[1]

The authors then build a compelling case that our current health care system is plagued by a lack of compassion, citing studies from across medical disciplines. For instance, they describe research from a University of Chicago study that found primary care physicians missed 79% of emotional cues from patients

that indicated a need for a compassionate response.[2] They also describe a Johns Hopkins ICU study that found 74% of health care providers showed no evidence of compassion for patients or families.[3]

The second section, "Compassion Improves Outcomes for Patients," examines research showing that medical outcomes, parasympathetic responses, psychological well-being of patients, self-care by patients, and even patients' sense of purpose, are all affected by physician compassion. A striking example studied 370 patients in a primary care setting. The researchers found that the strength of the doctor-patient relationship was associated with a 34% increased likelihood of the patient adhering to prescribed medications.[4]

The third section, "Beyond Patients," examines how compassionate care increases hospital revenue, cuts costs, and how even physicians who are not naturally warm and intuitive can learn to demonstrate compassion. They cite a study showing that compassionate care needn't take long; 40 seconds can make a huge difference in patient care. This number comes from a Johns Hopkins study of breast cancer patients that found reduced anxiety in patients when the oncologist simply said a few reassuring words, including "I know this has been a tough experience to go through and I want you to know that I am here with you. We are here together, and we will go through this together. I will be with you each step along the way."[5]

Strengths of *Compassionomics* are, first and foremost, its focus on the science of compassion in health care. The authors have done a masterful job of interweaving material that appeals to the head with stories that speak to the heart. The style is engaging and conversational, and the patient stories are compelling. Personal experiences of the authors, and stories about physicians in crisis will also resonate with readers. The intended audience is health care providers and administrators, but educated lay people will also appreciate its accessibility.

There are a few areas for improvement, most notably the need for an index. Also, the authors coined the term "compassionomics." It's catchy, but does not represent a revolutionary new field, as research on the impact of the provider's relationship with the patient is not new. At times, the reader may begin to feel that the case has been made, and one might dispense with yet another example of the crucial role of compassion in health care.

However, the examples create a logical flow as the authors build their case, and the book is excellent and very readable. I can easily see why *The Scientist Magazine* listed *Compassionomics* as one of its "Best Neuroscience Books of 2019."[6] I recommend it for everyone from residents to seasoned physicians interested in learning how to be the most effective and engaged clinicians they can be.

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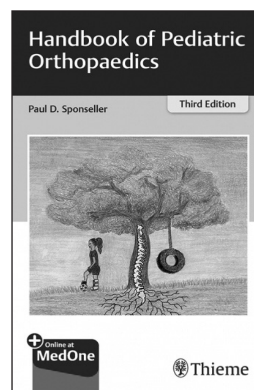
Handbook of Pediatric Orthopaedics, Third Edition

Paul D. Sponseller

New York, Thieme, 2019, 269 pp., $69.99, paperback



An invaluable reference tool for family physicians demonstrates its worth by being comprehensive and convenient to the clinician. The *Handbook of Pediatric Orthopaedics* by Paul Sponseller, MD, MBA, meets this measure in spades. The *Handbook*, now in its third edition in a paperback format fits into the pockets of most white coats.

However, acknowledging that this trend has largely ceased with the rise of technology, the

publisher provides access to a well constructed online version, optimized for both desktop and mobile devices.

The book is full of details helpful to assessing and developing plans for the treatment of common pediatric musculoskeletal issues. There are an abundance of charts, graphs, and figures to help explain topics visually. While the subject material does occasionally venture into areas that seem more specialized than both the level of a family physician's general fund of knowledge and what would be needed to guide referrals, it is this level of detail that makes the book a particularly good reference source—it's there if you need it! The sections on trauma are particularly helpful for those who work in an urgent care setting, including algorithms to assist in clinical decision-making processes.

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Pediatrics: A Case-Based Review

Michaela Kreckmann (Translator: Gertrude Champe)

Stuttgart, Germany,Thieme Publishers, 2019, 297 pp., $64.99, paperback*

** This is a 2019 English translation of the 2008 German second edition.*

With family physicians seeing fewer kids, we need interesting, quick ways to maintain our knowledge of not-to-miss diagnoses. Unfortunately, quality pediatric case-based reviews are hard to find.

In this book, we finally have a case-based review of general pediatrics worthy of purchase by family medicine residents and academic family physicians teaching or overseeing pediatric aspects of curriculum. Highlights include densely informative educational pages with quality photos, focused on high-yield topics for family doctors. Drawbacks are that the English translation does not consistently include American evidence-based standards of care, and the book is a 2019 translation of a 2008 German publication, so some data is outdated. Regardless, this book and its accompanying eBook concisely present in-depth information on timeless pathophysiology for important presentations.

Michaela Kreckmann, MD, a private practice pediatrician in Saarbrucken, Germany, wrote this book for her medical students. In it, she catalogs 85 clinical cases from prematurity through adolescent mental health issues, using a well-structured, educational format. She selected pediatric cases representing the most relevant, essential learning for students and family physicians, with an emphasis on dangerous diagnoses primary care physicians shouldn't miss. Cases span 17 systems, many with educational aspects in more than one system, realistically reflecting primary care practice. The book includes free access to the English eBook, via Thieme's MedOne online portal.

The table of contents is searchable by presentation, system, or diagnosis. The "Cases" section includes each case and related questions with space to write answers. This is followed by an "Answers and Comments" section with several educational pages on each case. This presents a nuisance for readers who do not enjoy flipping from one section to another, but the identical eBook resolves that; with each case, the related questions, and then answers and comments for that case, follow one another. The eBook also includes photos formatted for easy transfer to PowerPoint for lecture purposes.

The greatest strength of this book is the quality of the "Answers and Comments" section. Each is practical with refreshingly informative data organized into concise illustrations, charts, and bullet points. Pathophysiology, rationale for clinical decisions, expected symptoms and potential complications with each diagnosis, next steps in care, and anticipated course are major strengths. Kreckmann expands on some cases to broaden learning on related topics. For example, comments on the newborn with brachial plexus paralysis after shoulder dystocia include practical descriptions of other common birth injuries.

The biggest limitation of this book is that, while many cases do mention important adaptations to US care and geography, there are several cases in which important differences are not mentioned. This is problematic because the US audience most likely to benefit from this book (providers with less pediatric experience) will also be less aware of which practice

tips are not consistent with the American standards of care. Examples include a recommendation to use chloral hydrate for sedation (no longer available in the United States due to safety concerns) or a benzodiazepine and a bronchodilator in infants with bronchiolitis. Other differences include a recommendation to obtain an EEG for children with febrile seizures (not considered necessary in the United States), and lack of mention of American standards for preventive care. Cases where important geographic differences are appropriately described include CDC data references for cases on tuberculosis and tick-borne illness, and information on regions in the United States where various tick-borne infections are found. Additionally, some terminology differs from US practice. For example, the young child with abdominal pain due to intussusception has "invagination." While initially the terminology differences are disorienting, they also add an element of international character.

In summary, this book is an excellent option for pediatric case review, but it does have limitations for US audiences that need to be taken into consideration. While perfect for German medical students, with excellent cases and detailed pathophysiology illustrations that make learning easy , the book's utility for US students is diminished due to incomplete data on US standards of care. Perhaps the population that will find this work most valuable are educators with a solid pediatric knowledge base looking for interesting teaching cases. Family medicine faculty and residents will find it helpful in preparing didactics and stimulating small group discussion, and should have the awareness of local practice standards, or at least the informatics skills to verify local recommendations. Administrative faculty overseeing family medicine residency curriculum would also be wise to use this book to ensure their curriculum includes the most important not-to-miss diagnoses pertinent to family medicine.

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