REPORT 09 OF THE BOARD OF TRUSTEES (June-2021)
Preservation of the Patient-Physician Relationship
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting Resolution 703-A-19, "Preservation of the Patient-Physician Relationship," was introduced by the Organized Medical Staff Section and referred by the House of Delegates (HOD) for report back at the 2020 Interim Meeting. The 2020 Interim Meeting was replaced with a Special Meeting of the HOD due to restrictions resulting from the COVID-19 pandemic. This report was not presented during the Special Meeting so is now presented to the HOD at the June 2021 Special Meeting. The resolution asks the American Medical Association (AMA) to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, and to identify health care work environment factors that impact a physician's ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter.

Many factors contribute to the patient-physician relationship, including the use of electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician's ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-JUN-21

Subject: Preservation of the Patient-Physician Relationship

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee G

INTRODUCTION

At the 2019 Annual Meeting Resolution 703-A-19, "Preservation of the Patient-Physician Relationship," was introduced by the Organized Medical Staff Section and referred by the House of Delegates (HOD) for report back. The resolution asks our American Medical Association (AMA) to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, and to identify health care work environment factors that impact a physician's ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter.

This report discusses factors that contribute to patient-physician relationships and when those factors can detract from the physician's ability to provide high quality care or result in barriers to communication that can threaten the patient-physician relationship. The AMA has dedicated significant resources and effort to identifying and addressing the barriers to patient care and effective patient-physician relationships, including the use of technology, documentation requirements, prior authorization, and other work environment factors. This report will in part describe those efforts and relevant outcomes.

BACKGROUND

The relationship between a patient and their physician is sacred. It requires trust, honesty, and communication. As the healthcare industry has changed in recent decades, so have external factors and internal dynamics that influence the patient-physician relationship. Both the patient's and physician's roles and experiences have evolved, as well as their perceptions and expectations of the communication and relationship with each other. Many factors contribute to the patient-physician relationship, including electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician's ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients.

AMA POLICY

The AMA *Code of Medical Ethics* provides a definition of the patient-physician relationship that exemplifies the spirit of this resolution. "The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare" (*Code of Medical Ethics* 1.1.1, "Patient-Physician Relationships").

Health care technology has become integral to the practice of medicine and has improved many aspects of patient care and the patient-physician relationship. The AMA recognizes the important role technology has in modern health care and has established multiple policies to reflect this. For example, the AMA supports the establishment of coverage, payment, and financial incentive mechanisms to support the use of mobile health applications and associated devices, trackers, and sensors by patients, physicians and other providers that support the establishment or continuation of a valid patient-physician relationship (Policy H-480.943, "Integration of Mobile Health Applications and Devices into Practice"). AMA policies support telemedicine as a mechanism to deliver patient care and advocates for the widespread adoption of telehealth services in the practice of medicine (Policy D-480.965, "Reimbursement for Telehealth" and Policy D-480.963, "COVID-19 Emergency and Expanded Telemedicine Regulations"). The AMA *Code of Medical Ethics* also make it clear that these technologies should not compromise or interfere with the patient-physician relationship (AMA Code of Medical Ethics 1.2.12, "Ethical Practice in Telemedicine). It is AMA policy that new communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. The AMA provides detailed guidelines for the appropriate and optimal use of email and text messages for communicating with patients (Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail and Text Messaging"). The AMA *Code of Medical Ethics* also provides guidance for the ethical and professional use of email and text message communications (Opinion 2.3.1, "Electronic Communication with Patients").

The AMA supports protecting the patient-physician relationship by advocating for the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements (Policy H-165.837, "Protecting the Patient-Physician Relationship"). The AMA also supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization, or specialty consultation (Policy H-160.901, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care").

Recognizing that government has a large influence on the practice of medicine, the AMA continuously works to reduce the burden of government and third-party regulation on medical practice and its intrusion into the patient-physician relationship and doctor-patient time (Policy

H-180.973, "The "Hassle Factor"). The AMA will continue these efforts, with additional focus on the prescription of medication (Policy H-100.971, "Preserving the Doctor-Patient Relationship"). Furthermore, the AMA endorses principles concerning the roles of federal and state governments in the patient-physician relationship:

> A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
> B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
> C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
> D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter (Policy H-270.959, "AMA Stance on the Interference of the Government in the Practice of Medicine").

It is AMA policy that the relationship between physicians and their patients should not be disrupted by direct communications from health plans to patients regarding individual clinical matters (Policy H-140.919, "Doctor/Patient/Health Plan Communications").

DISCUSSION

To appropriately respond to the resolution referred by the HOD, this report will focus on describing the factors that contribute to patient-physician relationships, including:

- Shared decision-making
- Online health/medical information
- Health literacy
- Trust
- Implicit bias
- Adequate time
- Physical clinic setting
- Communication
- External influences

Barriers to communication and an effective patient-physician relationship can be encountered at many points during the interactions between a patient and physician. Barriers can also manifest from inherent attitudes or outward behaviors, of the patient and/or physician. Finally, barriers that affect the quality of patient-physician interactions are often external environmental elements, such as technology or the availability of support staff.

Shared decision making

Sharing in the decision-making process can help patients feel their voice is heard and their physician cares what they think and feel about their condition and the options for treatment. Patients value having the opportunity to explain their illnesses, receive information, and be involved in their treatment plans.[1, 2] This requires deliberate attention and thoughtful consideration on the part of the physician. Barriers can arise if patients are simply presented with results and standard check-box choices without discussion. This approach can leave them feeling less than cared for. In addition, the use of decision support tools, while mostly beneficial when used appropriately, can get in the way of quality conversation in which patients and physicians decide together the best course of action.[3] A study of physicians with a "participatory decision-making style" showed this approach resulted in better health outcomes and more satisfied physicians. This research also found that physicians with a more participatory decision-making style were 30 percent less likely to have patients leave their care.

Online health/medical information

An important part of the patient-physician relationship is ensuring patients have the right amount of appropriate and accurate information about their health and medical conditions. In today's internet-driven and information-loaded environment, physicians are often not the initial source of information about medical conditions or potential treatments. Patients are increasingly arriving at a clinic visit after reading information on medical information websites, sometimes even with a specific diagnosis in mind. This can be either problematic or beneficial for the patient-physician relationship, depending on whether and how the patient discusses what they have learned with their physician.[4] For example, 80 percent of physicians report that access to online information has increased the likelihood that patients question their diagnosis or treatment plans.[5] Confirming this observation, a study of patient perspectives revealed that when patients valued information found on the internet above their physician's, that information led them to ignore their physician's expertise.[4, 6] On the other hand, if patients openly discuss their findings with their physician and the physician is receptive to that discussion, this open communication can benefit the patient-physician relationship.[4] Some patients believe that information seeking and discussion about that information with their physician enhances their relationship with their physician and supports their physician's advice.[4] While it can sometimes create barriers, online health and medical information accessed and used appropriately can benefit patients and physicians, and enhance their communication and overall relationship.

Health literacy

Although many patients are increasingly discussing self-searched health information with their physicians, and physicians are more often sharing information with patients throughout decision-making, it does not mean that patients always understand or can accurately interpret the information they are learning. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.[7] Low health literacy, primarily affecting older adults, minority populations, medically underserved people, and those with low socioeconomic status, can create barriers between the patient and their physician. Reasons for low health literacy include language limitations, limited education, use of medical vernacular by health care staff and clinicians, hearing impairment and cultural differences. These patients may have trouble communicating their complaints and health history to the physician or they may not understand the risks their behaviors pose on their health. They may not understand insurance and how to use their benefits, and they may have difficulty understanding medications and their effects.[7] For some, the increase in access to information has

improved understanding and knowledge of their health.[8] Although there is more online health care content than ever, and mobile health applications give patients more access and control over their health information, medical information websites or mobile applications are not always available to everyone. Patients with low health literacy are less likely to use computers and web applications (e.g., email, search engines, and online patient portals), limiting the benefits these sources of information have for certain populations.[9]

Trust

Trust between patients and their physicians is crucial. Patients may have a general distrust of the medical profession due to a bad experience. They may need time to build trust with their physician, or they may not feel their physician has their best interest in mind. Physicians, on the other hand, may lack trust in their patient if the patient ignores treatment or medication plans, cancels or doesn't show up for appointments, or neglects to provide complete information about health history. Shared decision making and open, non-judgmental dialogue about health and medical information as previously discussed, can help foster trust between patients and physicians. In addition, physicians and patients alike may harbor distrust as a result of implicit bias against the other party.[10]

Implicit bias

Implicit bias, on the part of the physician or the patient, negatively affects the patient-physician relationship for many reasons. For patients, biases about providers can have implications for access to care. For example, 29 percent of patients in one survey said they would avoid a certain provider based on personal characteristics such as race, gender, or age.[11] Getting in the way of a caring and respectful relationship are biased remarks made toward clinicians based on characteristics like weight, gender, or ethnicity. Fifty-nine percent of clinicians have experienced bias due to their physical appearances and 70 percent of Black and Asian clinicians report hearing biased remarks.[11] Some biases can exist based on accents or attire such as certain types of headwear. Physicians can also bring biases to their practice. Implicit attitudes about personal characteristics such as weight or race can affect the way they interact with and treat patients.[12, 13] Predisposed notions about patients based on these outward-facing characteristics can unfairly influence a physician's judgment about the individual's condition or the best course of treatment. This inhibits the quality of patient care and damages the patient's trust that the physician has their best interest in mind.

Adequate time

Sufficient time to focus on the patient during a clinic visit is important for both the patient and physician to develop and maintain a healthy and productive relationship. The patient needs time to ask questions and discuss their symptoms, concerns, and history. If they feel rushed by the physician, even if the physician does not intend to send that signal, the patient may feel unimportant and not cared for. The effective use of the patient visit by the physician gives the patient the sense they have been heard and they can comfortably express their concerns and feelings.[14] Feeling that they are the focus of the physician's attention and that they have been heard is more important to patients than the actual amount of time spent together.[1]

Likewise, physicians want to have sufficient time with their patients to gather important information, look their patients in the eyes, and really listen to their concerns. Research has shown that one of the primary sources of physician satisfaction is patient relationships and one of the primary sources of dissatisfaction is "time pressure."[15] Productivity requirements and pressure to keep appointments to short durations can put pressure on physicians to limit their visit lengths to

only a few minutes. In addition, documentation requirements force the physician to spend an inordinate amount of time focused on their electronic health record (EHR) rather than their patient.[16]

Recent data show that 33 percent of physicians in the U.S. spend 17 to 24 minutes with each patient. Twenty-nine percent spend 13 to 16 minutes, and just 11 percent spend 25 or more minutes with each patient.[17] Research shows that longer visits allow for more attention to several aspects of care, including increased patient participation, patient education, preventive care, and performance of immunizations. In addition, patients are more likely to feel they had inadequate time with their physician in visits scheduled to last five minutes compared with visits scheduled to last 10 and 15 minutes.[18, 19] In the U.S., visit rates above three to four per hour are associated with suboptimal visit content. Because patient satisfaction is increased by increased patient participation and activities to educate the patient, it is suggested that more than three to four visits per hour would be associated with decreased patient satisfaction.[20]

Despite the efforts to identify the "optimal" amount of time for patient visits, it remains an elusive goal, owing much to variability in patient visit lengths across specialties and countries.[20] In addition, because every patient is different and every patient-physician encounter is unique, it is difficult and not preferable, to designate a universal minimum time for patient visits. To improve the patient-physician relationship, the focus of physicians' energy should be on quality interactions and value-added tasks, rather than monitoring how many minutes they spend with the patient for billing purposes.

Physical clinic settings

The way in which a physician's office or patient room is designed and organized can create barriers to optimal communication with patients. Patient rooms in which a desk is placed so that the physician cannot look at the patient do not allow for valuable eye contact and hands-on interaction. A similar effect may occur if the physician places the computer screen between themself and the patient or looks at the computer screen while exchanging conversation. Research has shown that patient-physician communication can improve when the computer is placed alongside the patient and physician, rather than between.[21] Patients often perceive higher quality care and have less anxiety when visiting their physician when they find the practice environment attractive.[22, 23] Other design elements such as lighting can improve communication skills, mood, alertness, and performance for the entire care team.[23, 24]

Communication

Communication between physicians and their patients is critical to the success of their relationship. Communication can be verbal and non-verbal, and both types have an impact on the patient's outcomes and the effectiveness of the relationship. Verbal communication includes expression through words of empathy, assurance, explanations, humor, friendliness, summarization of the visit, and others. Non-verbal communication is seen in behaviors such as head nodding, direction of gaze, leaning, arm and leg crossing, and others. Clear and open communication between patients and physicians can enable better decisions about care[25] and better communication between patients and physicians is linked to both better patient outcomes[26, 27] and lower rates of physician burnout.[28] Factors that inhibit effective communication include all of the previously mentioned elements. In addition, general withholding of information by either the physician or patient diminishes the quality and appropriateness of care, reduces trust, and can put the patient at risk. Doctors tend to overestimate their abilities in communication. Tongue et al. reported that 75 percent of orthopedic surgeons surveyed believed they communicated satisfactorily with their patients, but only 21

percent of the patients reported satisfactory communication with their doctors.[29] Patient surveys have consistently shown that they want better communication with their doctors.[30]

External influences

Regulatory requirements and technological interference are also known to create barriers between patients and their physicians. The EHR and other technologies like mobile devices or health applications accessed through mobile devices can sometimes enhance, but often interfere with, the communication and quality of visits between patients and physicians. External factors can detract from the quality of care physicians feel they can provide; nearly 40 percent of physicians report patient care is adversely impacted to a great degree by external factors such as third-party authorizations, treatment protocols, and EHR design.[31]

Some of the external factors identified are significant inhibitors to the patient-physician relationship. EHRs, documentation requirements, and prior authorization each present specific challenges and outcomes that, from both the patient and physician perspective, are barriers to high-quality health care and communication. In addition, telemedicine has proven to be a valuable tool for delivering remote patient care, especially during the COVID-19 pandemic, but it presents its own challenges and barriers to the patient-physician relationship. A lack of access to technology or comfort with the use of technology can also hinder the patient-physician relationship and delay information exchange.

<u>Electronic Health Records</u>

In 2014 the AMA partnered with RAND to identify and describe obstacles to professional satisfaction and the ability to provide high-quality care. EHRs, when they interfere with face-to-face patient care, were found to detract from physician professional satisfaction.[32] The amount of time physicians spend doing administrative work includes more than half their day on completing tasks in the EHR and almost 90 minutes of EHR work at home after clinic hours.[33] Physicians also report that their EHRs have reduced or detracted from the quality of care, efficiency of practice, and interaction with patients.[31, 34]

While the EHR is a documented source of physician frustration and dissatisfaction, the design and function of the EHR system are only one part of the problems physician users experience while using their EHR. Decisions made by regulators, administrators, and policymakers influence the end use of EHRs, adding to the ways EHR use can interfere with patient care. For example, documentation requirements mandated by federal policy and payers result in physicians spending much of the patient visit looking at their computer screen instead of the patient. The quality of the implementation and training can make a difference in the effective use of the EHR during patient interactions. If users are not trained effectively, or the rollout of upgrades impedes daily work, efficient use of the EHR is undermined. Poor or no interoperability with other patient information systems can detract from the physician's access to current and relevant patient data.[35] All of these factors have the potential to contribute to unsatisfactory patient-physician communication.

Despite this, evidence shows the use of an EHR has no impact on the patient's satisfaction or perception of patient-physician communication, suggesting that EHRs may be more of an issue for physicians than patients.[36] Similarly, the RAND research showed EHRs facilitated enhanced communication with patients, contributing to improved satisfaction for some physicians. This was particularly true for communication outside the patient room. Fifty-four percent of physicians surveyed indicated using an EHR enhances patient-doctor communication that is not face-to-face. An excerpt from the report describes this experience:

> I think, if used correctly, [the EHR] definitely improves communication and helps in terms of patient care overall, with tracking what's going on with the patient. I think it's helped with patient-to-physician communication.

Documentation requirements

Increasing documentation requirements from Medicare and commercial payers have also added to physicians' administrative workload. A 2013 survey indicated 92 percent of medical residents and fellows reported that documentation requirements were excessive.[37] Clinical documentation requirements have increased over time with the mandated use of EHRs, increased quality reporting, and increased demand for data. Much of the U.S. medical coding system is time-based,[38, 39] which has led to overemphasis on the amount of time spent with each patient and excessive focus on "checking the boxes" to ensure documentation requirements are met. The Centers for Medicare and Medicaid Services (CMS) recently enacted changes to the documentation requirements for evaluation and management (E/M) services developed by the AMA's CPT Editorial Panel. These changes will allow physicians to bill based on case complexity with less emphasis on the number of minutes spent. Physicians will only be required to enter medically necessary information, enabling them to spend more time connecting with their patient to collect high-value, relevant information instead of redundant information. Further discussion on the Medicare E/M coding changes and their anticipated benefits to the patient-physician relationship is presented in another section of this report.

To reduce the burden of documentation during patient visits, many physicians employ the use of documentation assistance tools or staff, such as speech recognition technology or medical scribes. It has been found that access to documentation support, such as that of a medical scribe, can increase the amount of direct face time with patients during a visit.[16] Medical scribes work in a variety of practice settings, including hospitals, emergency departments, physician practices, long-term care facilities, ambulatory care centers, and others. In a 2015 retrospective comparative study, physicians with medical scribes saw 9.6 percent more patients per hour than physicians without a medical scribe.[40] Physicians who use medical scribes say they "feel liberated from the constant note-taking that modern [EHRs] demand" and they can "think medically instead of clerically."[41]

When face-to-face time with the patient increases, physicians can listen and respond more thoroughly without the distraction of entering data into the EHR, giving patients a better experience. Physicians are in turn able to provide the level of care they find the most satisfying.[16] There is evidence the use of speech recognition technology and medical scribes improves physician satisfaction, including clinic, face time with patients, time spent charting, and accuracy and quality of their charts.[42] Patients also experience increased satisfaction with their physician visits when a scribe is present to document for the physician. In one study of patients surveyed about their physician's use of documentation assistance, 85 percent felt that having a scribe type notes for the doctor improved the overall quality of their visit. Seventy-four percent also said that they would like their other doctors to have scribes to type the exam notes.[43]

The evidence available suggests that documentation assistance, whether through the use of speech recognition technology or a medical scribe, can improve the communication and quality of visit between patients and their physicians. Board of Trustees Report 20-A-17, "Study of Minimum Competencies and Scope of Medical Scribe Utilization," provides additional information about the use of medical scribes in the practice of medicine.

Prior authorization

It has been well-documented, by the AMA and others, that prior authorizations required by payers are another source of dissatisfaction and burden for physicians.[44, 45] In addition to being a source of burden, a 2019 AMA survey showed 90 percent of physicians reported prior authorization has a negative impact on patient clinical outcomes. Seventy-four percent said prior authorization can lead to treatment abandonment, and 24 percent said prior authorization led to a serious adverse event for a patient in their care.[45] The financial toll, emotional distress, and psychological effects on patients of treatment delays and confusing prior authorization procedures can be substantial.[46] These effects could also lead to patients avoiding treatment or seeking care in the future, ultimately undermining the patient-physician relationship and the physician's ability to provide the best care for their patients. Reducing the prior authorization burden would return some of the physician's autonomy and help ensure the patient receives the appropriate care, helping to strengthen the relationship between patient and physician.

Telehealth

Telehealth has been a tool for delivering remote patient care for many years but was not widely adopted. The onset of the COVID-19 pandemic in early 2020 drastically expanded the use of telemedicine services for patient care delivery.[47] Connectivity issues or general technological challenges may create barriers for effective telemedicine visits, and access to the technology may not be available for all patients, leading to the potential risk of jeopardizing the patient-physician relationship. Telehealth has proven its value to the practice of medicine, and there are many benefits to both the patient and physician,[48] yet some concerns about telehealth contributing to the erosion of the patient-physician relationship remain. Although AMA policy supports establishing patient-physician relationships via telehealth when clinically appropriate, it is still recommended that the establishment of a new patient-physician relationship take place during an in-person visit.[49] This in-person connection, a bond-forming element based on human awareness of personal space and the healing effects of human touch and face-to-face interactions, is integral to successful patient-physician relationships.[50]

AMA advocacy, research, and resources

Our AMA has historically advocated on physicians' behalf for changes in policy and practice that would improve and enhance the patient-physician relationship. AMA's ongoing advocacy aims to reduce documentation burden, reform prior authorization requirements, increase transparency, and improve EHR technology so physicians can spend more time with their patients.

In addition to its tireless advocacy efforts, our AMA has worked on many levels to develop resources and education for physicians to help enhance their communication and relationship with their patients. In addition, the AMA has dedicated significant resources to researching the factors that detract from physicians' ability to provide high-quality patient care, including but not limited to the studies previously referenced in this report. AMA supports and carries out research efforts aimed at understanding and identifying solutions to the issues that create barriers between physicians and their patients. The AMA has studied how physicians spend their time to quantify the administrative burdens during and after a physician's work day.[16] The AMA published a report on bullying in the practice of medicine and the effects it can have on physician well-being and their ability to provide high-quality patient care.[51] The AMA has also published research on the burdens of EHRs, including the time to complete tasks, the usability of products, and the process of EHR development.[33, 52] The AMA's research includes a time-motion study to determine how much and in what ways physicians spend time completing tasks in their EHRs. The AMA has also published

eight EHR usability priorities, which outline and support the need for better usability, interoperability, and access to data for both physicians and patients.[53] If followed, these priorities will enable the development of higher-functioning, more efficient EHRs, contributing to a reduction in the burden that EHR use places on patient care.

In 2019 the AMA established the Center for Health Equity to embed health equity into the processes, practices, innovations, and performance of our AMA. This unit works to help the AMA address issues that contribute to health disparities and inequity, including bias, stereotyping, and prejudice, which can all inhibit a successful patient-physician relationship. By helping to reduce these implicit influences, AMA enhances its ongoing work to preserve the integrity of physicians' relationships with their patients.

Multiple collaborations are in place to help foster better EHR design and innovative health information technology (HIT) solutions to help make the EHR user experience better and more efficient. The AMA has established collaborations and partnerships with the organizations such as SMART Initiative, AmericanEHR Partners, Carequality, Sequoia Project and Medstar Health's National Center for Human Factors in Healthcare to help foster innovative HIT design interoperability and transparent testing solutions which will to help ensure EHRs are designed and implemented with physicians and patients in mind. The AMA Physician Innovation Network also connects physician experts with industry innovators to facilitate the integration of the clinical voice and the patient experience into HIT innovation. Finally, the AMA recently worked with various industry stakeholders, including five EHR vendors, to develop a Voluntary EHR Certification framework which will help catalyze an industry-wide shift to higher-quality EHR systems that enable better, more efficient use.

The AMA, as part of its prior authorization reform initiatives, convened a workgroup of 17 state and specialty medical societies, national provider associations, and patient representatives to develop a set of Prior Authorization and Utilization Management Reform Principles.[54] These principles spurred conversations between health care professionals and insurers on the need for prior authorization reform, which culminated in the release of the Consensus Statement on Improving the Prior Authorization Process.[55] The consensus document reflects an agreement between national associations representing both providers and health plans on the need to reform prior authorization programs in multiple ways, including reducing the overall volume of prior authorizations and advancing automation to improve transparency and efficiency. The AMA, in addition to providing an evidence base demonstrating the need for prior authorization reform, offers multiple resources to help physicians understand prior authorization laws and improve processes within their practices.

The AMA and CMS in 2019 worked together to achieve the first overhaul of E/M office visit documentation and coding in more than 25 years. Specifically, Medicare began to allow physicians to document review and verification of history entered into the medical record in lieu of re-entering the same information. For established patients, history and examination already contained in the medical record no longer needs to be re-entered and physicians can document only what has changed and relevant items that have not changed since the patient's last visit. The changes implemented are a significant step in reducing administrative burdens that get in the way of patient care and will allow physicians to spend more time with their patients, one of the key elements to a meaningful patient-physician relationship. Considering the variation in patients, case complexity, and specialty-specific needs, the AMA is not in favor of imposing a universal minimum time for patient visits and supports these changes that enable physicians more flexibility determining the appropriate amount of time to dedicate to their patients. The AMA is collaborating with the University of California San Francisco to investigate changes in documentation and coding time,

perceived burden and physician burnout throughout the phases of the E/M coding changes. The outcomes of this research will help institutional leaders and physicians identify additional opportunities to reduce physician administrative burden and increase time spent with patients. This research will also prioritize and inform advocacy efforts with federal (e.g., CMS) and state regulators, commercial plans and EHR vendors to further address issues such as coding, documentation. and burden reduction on behalf of physicians, their practices and patients.

The AMA during the COVID-19 pandemic has advocated for the expansion of and reimbursement for telehealth so that patients can experience continuity of care and so physicians are adequately compensated for their time providing remote patient care. The AMA's Digital Health Implementation Playbook series offers comprehensive step-by-step guides to implementing telehealth in practice.[56] Each Playbook offers key steps, best practices, and resources to support implementation. The AMA continues to publish new guidelines and resources, as well information about the latest updates on telehealth expansion amid COVID-19.

The AMA offers and continues to develop education modules that teach strategies and tactics to help physicians save time on clerical and basic clinical tasks so that they have more time for relationship-building and medical decision making with patients. Many of AMA's STEPS Forward™ modules address some aspect of organizational culture or practice efficiency to help physicians optimize their patient relationships, including several that aim to help practices save time, communicate more effectively, and improve patient and provider satisfaction.

The AMA's ongoing work to reduce physician burnout strives to remove the obstacles and burdens that interfere with patient care or hinder communication with patients. This work includes the AMA Practice Transformation Initiative (PTI), which supports researchers in building evidence on effective interventions to reduce burnout and increase physician satisfaction within their health systems. Interventions implemented through the PTI include measures to enhance the roles of non-provider care team members to reduce administrative burden for physicians, and to gain efficiencies in physician time. Other interventions aim to help clinicians maximize their practice efficiency, promote self-care, and address sources of burnout and stressful workplace situations. The AMA also offers institutional assessments to help organizations measure burnout among their physician staff, implement improvements, and develop evidence-based support systems within their practices, reducing burnout and improving physicians' ability to provide high-quality patient care. In addition, the AMA offers a guideline, "Collaborative communication strategies: Partner with patients," to help clinicians communicate clearly and effectively with patients, particularly about treatment adherence which is one of the key elements of a successful patient-physician relationship.[57]

CONCLUSION

Many factors contribute to the dynamics of a relationship between a patient and physician, including shared decision-making, online health and medical information, health literacy, trust, implicit bias, physical settings, communication, and external influences. These factors have been studied and written about at length. The evidence shows that patients and physicians both have better experiences when they feel they have adequate time for talking and making decisions about treatment together. Physicians have better experiences when they have assistance with documentation so they can spend more of their visit face-to-face with their patients rather than looking at the computer. Physicians are more satisfied with their patient relationships when patients trust them. Patients are more satisfied with their clinic visits and their physicians when they feel they have been listened to and allowed to talk about their concerns. Improving communication and

preventing implicit biases from influencing care decisions are ways both physicians and patients can ensure their relationships with one another are healthy, trusting, and productive.

Considering the volume and range of published literature about the barriers to patient-physician relationships identified in Resolution 703-A-19 and discussed in this report, it is not recommended that additional formal research be undertaken by the AMA. The AMA will continue to dedicate significant resources to helping physicians overcome these barriers to enhance and preserve their relationships with their patients.

RECOMMENDATION

The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that this report be filed.

Fiscal note: None

REFERENCES

1. Dorr Goold S, Lipkin M, Jr. The doctor-patient relationship: challenges, opportunities, and strategies. J Gen Intern Med. 1999;14 Suppl 1(Suppl 1):S26-S33.
2. Zanini C, Sarzi-Puttini P, Atzeni F, Di Franco M, Rubinelli S. Doctors' Insights into the Patient Perspective: A Qualitative Study in the Field of Chronic Pain. Biomed Res Int. 2014;2014.
3. Kunneman M, Montori VM, Castaneda-Guarderas A, Hess EP. What Is Shared Decision Making? (and What It Is Not). Acad Emerg Med. 2016;23(12):1320-4.
4. Tan SS-L, Goonawardene N. Internet Health Information Seeking and the Patient-Physician Relationship: A Systematic Review. Journal of medical Internet research. 2017;19(1):e9-e.
5. Heath S. How Online Medical Info Impacts Patient-Provider Relationships2018 April 2, 2020. Available from: https://patientengagementhit.com/news/how-online-medical-info-impacts-patient-provider-relationships.
6. Sommerhalder K, Abraham A, Zufferey MC, Barth J, Abel T. Internet information and medical consultations: experiences from patients' and physicians' perspectives. Patient Educ Couns. 2009;77(2):266-71.
7. Health Resources & Services Administration. Health Literacy 2019 [Available from: https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html.
8. Laugesen J, Hassanein K, Yuan Y. The Impact of Internet Health Information on Patient Compliance: A Research Model and an Empirical Study. J Med Internet Res. 2015;17(6):e143-e.
9. Kim H, Xie B. Health literacy and internet- and mobile app-based health services: A systematic review of the literature. Proc Assoc Inf Sci Technol. 2015;52(1):1-4.
10. Borondy-Kitts A. Clinician and Patient Partnership: Barriers and Enablers. Lahey Hospital & Medical Center; 2018.
11. Heath S. How Healthcare Bias Affects Patient-Provider Relationships. Patient Engagement HIT. 2017.
12. Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK, et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Am J Public Health. 2015;105(12):e60-e76.
13. Zestcott CA, Blair IV, Stone J. Examining the Presence, Consequences, and Reduction of Implicit Bias in Health Care: A Narrative Review. Group Process Intergroup Relat. 2016;19(4):528-42.
14. Rabin R. 15-Minute Visits Take A Toll On The Doctor-Patient Relationship. Kaiser Health News [Internet]. 2014 April 2, 2020. Available from: https://khn.org/news/15-minute-doctor-visits/.
15. Mawardi BH. Satisfactions, dissatisfactions, and causes of stress in medical practice. JAMA. 1979;241(14):1483-6.
16. Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med. 2016;165(11):753-60.
17. Elflein J. Amount of time U.S. primary care physicians spent with each patient as of 2018: Statista; 2019 [Available from: https://www.statista.com/statistics/250219/us-physicians-opinion-about-their-compensation/.
18. Morrell DC, Evans ME, Morris RW, Roland MO. The "five minute" consultation: effect of time constraint on clinical content and patient satisfaction. Br Med J (Clin Res Ed). 1986;292(6524):870-3.
19. Ridsdale L, Carruthers M, Morris R, Ridsdale J. Study of the effect of time availability on the consultation. J R Coll Gen Pract. 1989;39(329):488-91.
20. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. J Gen Intern Med. 1999;14 Suppl 1(Suppl 1):S34-S40.

21. Ajiboye F, Dong F, Moore J, Kallail KJ, Baughman A. Effects of revised consultation room design on patient-physician communication. Herd. 2015;8(2):8-17.
22. Becker F, Douglass S. The ecology of the patient visit: physical attractiveness, waiting times, and perceived quality of care. J Ambul Care Manage. 2008;31(2):128-41.
23. American Medical Association. Optimizing Space. Improve Efficiency, Engagement, and Satisfaction for Patients and Providers2015.
24. Zadeh RS, Shepley MM, Williams G, Chung SS. The impact of windows and daylight on acute-care nurses' physiological, psychological, and behavioral health. Herd. 2014;7(4):35-61.
25. National Institutes of Health. Talking to Your Doctor 2018 [updated December 10, 2018. Available from: https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/talking-your-doctor.
26. Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995;152(9):1423-33.
27. Beck RS, Daughtridge R, Sloane PD. Physician-patient communication in the primary care office: a systematic review. J Am Board Fam Pract. 2002;15(1):25-38.
28. Berg S. Better communication with patients linked to less burnout2017. Available from: https://www.ama-assn.org/practice-management/physician-health/better-communication-patients-linked-less-burnout.
29. Tongue J, Epps H, Forese L. Communication skills for patient-centred care: Research-based, easily learned techniques for medical interviews that benefit orthopaedic surgeons and their patients. J Bone Joint Surg Am. 2005;87A:652-8.
30. Ha JF, Longnecker N. Doctor-patient communication: a review. Ochsner J. 2010;10(1):38-43.
31. The Physicians Foundation 2016 Physician Survey [press release]. Boston, September 21 2016.
32. Friedberg MW, Chen PG, Van Busum KR, Aunon F, Pham C, Caloyeras J, et al. Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. Rand Health Q. 2014;3(4):1-.
33. Arndt BG, Beasley JW, Watkinson MD, Temte JL, Tuan WJ, Sinsky CA, et al. Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. Ann Fam Med. 2017;15(5):419-26.
34. Downing NL, Bates DW, Longhurst CA. Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause? Ann Intern Med. 2018;169(1):50-1.
35. Tutty MA, Carlasare LE, Lloyd S, Sinsky CA. The complex case of EHRs: examining the factors impacting the EHR user experience. J Am Med Inform Assoc. 2019;26(7):673-7.
36. Alkureishi MA, Lee WW, Lyons M, Press VG, Imam S, Nkansah-Amankra A, et al. Impact of Electronic Medical Record Use on the Patient–Doctor Relationship and Communication: A Systematic Review. J Gen Intern Med. 2016;31(5):548-60.
37. Christino MA, Matson AP, Fischer SA, Reinert SE, Digiovanni CW, Fadale PD. Paperwork versus patient care: a nationwide survey of residents' perceptions of clinical documentation requirements and patient care. J Grad Med Educ. 2013;5(4):600-4.
38. Sophocles A. Time is of the essence: coding on the basis of time for physician services. Fam Pract Manag. 2003;10(6):27-31.
39. American Academy of Pediatrics. Using Time As the Key Factor for Evaluation and Management Visits [Available from: https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Using-Time-to-Report-Outpatient-EM-Services.aspx.
40. Bank AJ, Gage RM. Annual impact of scribes on physician productivity and revenue in a cardiology clinic. Clinicoecon Outcomes Res. 2015;7:489-95.
41. Hafner K. A Busy Doctor's Right Hand, Ever Ready to Type. The New York Times. 2014.
42. Gidwani R, Nguyen C, Kofoed A, Carragee C, Rydel T, Nelligan I, et al. Impact of Scribes on Physician Satisfaction, Patient Satisfaction, and Charting Efficiency: A Randomized Controlled Trial. Ann Fam Med. 2017;15(5):427-33.

43. Leahey A, Bethel S, Summey J, Heavner S. Patients' Perceptions of Clinical Scribe Use in Outpatient Physician Practices. Greenville Health System Proceedings. 2017;2(2):131-6.
44. Colligan L, Sinsky CA, Goeders L, Schmidt-Bowman M, Tutty M. Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitativeanalysis of physician and staff interviews. 2016.
45. American Medical Association. 2019 AMA Prior Authorization Physician Survey. 2019.
46. Gaines ME, Auleta AD, Berwick DM. Changing the Game of Prior Authorization: The Patient Perspective. JAMA. 2020;323(8):705-6.
47. Koonin L, Hoots B, Tsang C, Leroy Z, Farris K, Jolly B, et al. Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. Centers for Disease Control and Prevention; 2020 October 30.
48. Villines Z. Telemedicine benefits: For patients and professionals. Medical News Today [Internet]. 2020. Available from: https://www.medicalnewstoday.com/articles/telemedicine-benefits.
49. American Medical Association. Policy H-480.946 Coverage of and Payment for Telemedicine 2019.
50. Romanick-Schmiedl S, Raghu G. Telemedicine — maintaining quality during times of transition. Nature Reviews Disease Primers. 2020;6(1):45.
51. American Medical Association. Board of Trustees Report 9 – Bullying in the Practice of Medicine. 2020 November 2020.
52. Ratwani RM, Savage E, Will A, Arnold R, Khairat S, Miller K, et al. A usability and safety analysis of electronic health records: a multi-center study. J Am Med Inform Assoc. 2018;25(9):1197-201.
53. American Medical Association. Improving Care: Priorities to Improve Electronic Health Record Usability. 2014.
54. American Medical Association et al. Prior Authorization and Utilization Management Reform Principles. 2019.
55. American Medical Asssociation et al. Consensus Statement on Improving the Prior Authorization Process.
56. American Medical Association. Digital Health Implementation Playbook 2021 [Available from: https://www.ama-assn.org/amaone/ama-digital-health-implementation-playbook.
57. American Medical Association. Collaborative communication strategies: Partner with patients. 2020.