

**PATIENT RESPONSIBILITY: A COMPARATIVE REVIEW OF ADMINISTRATOR
AND PATIENT PERSPECTIVES**

by

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ABSTRACT:

Healthcare entities across the United States establish responsibilities that competent patients are expected to assume throughout the duration of the physician-patient relationship. While these might vary between organizations, the author suggests that healthcare institutions, nationwide, widely agree on four patient responsibility categories, each of which encompass six specific responsibilities. This essay examines these six responsibilities and the extent to which patients at UPMC are believed to assume them throughout the duration of the physician-patient relationship. The conclusion will establish that the majority of competent patients at UPMC are not fully knowledgeable and do not assume their expected responsibilities. This study suggests that healthcare costs could be reduced and our nation's public health could be improved if more patients were active participants in their healthcare.

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1.0 INTRODUCTION

The question is, “What responsibilities are competent patients expected to assume and which do they assume when interacting with their physician on healthcare matters”? It is important to note that patient responsibility is a broad topic in research discourse. It can vary on the individual patient and between behavioral choices that affect healthcare outcomes or adherence to treatment plans. This analysis is limited in that it is not a comprehensive account of the many areas where patients may take responsibility for their health, and it does not address patient responsibilities for individuals who are not deemed legally competent to make their own healthcare choices. Rather, this analysis examines the responsibilities healthcare entities expect competent adult patient’s to assume and the extent to which patients at UPMC are believed to assume them.

The analysis will begin by defining the area in which patient responsibility will be examined in this discussion: the physician-patient relationship as present in America today. It will also define the type of patients included in the analysis: adult individuals whom are deemed competent patients through the eyes of the legal system. An account of the historical evolution of the physician-patient relationship will help clarify why most responsibility, both in terms of a patient’s health outcomes and experience, is currently placed in the physician’s hands. This discussion will segue into an analysis of the implications of increased patient responsibility including the benefits and disadvantages. Interviews with key stakeholders at UPMC will provide a current account of the extent to which competent patients at UPMC are aware of and assume various responsibilities.

Lastly, recommendations will focus on education and communication of patient responsibilities as well as the need for further discussion and research on the topic.

2.0 LITERATURE REVIEW

In the United States, healthcare spending accounts for about 17% of the country's gross domestic product which is significantly more than the Organisation for Economic Co-operation and Development (OECD) reported country average of about 10% (OECD). Not only do healthcare expenses in the United States largely exceed that of other developed nations, but the U.S. also ranks poorly in regard to health status factors including, yet not limited to, life expectancy at birth (OECD).

In an effort to reduce national healthcare expenses as well as increase the quality of care provided, hospital and physician reimbursement is becoming increasingly tied to quality of care indicators. These indicators reflect the patient's actual and perceived value of care. Thus, the results not only directly effect the physician's reputation as well as their professional reimbursement, but they also place the majority of the responsibility, both in terms of the patients' health outcomes and experience, on the provider. This phenomenon suggests that, in America, greater emphasis is placed on physician responsibility throughout the physician-patient relationship rather than patient responsibility. This unbalanced attribution is rooted in a historical context, the advent of patient rights, as well as in the unbalanced knowledge relationship between the medical professional and the layperson (Kelley 192).

Furthermore, the literature suggests that when patients take an active role in their healthcare the results include better health outcomes and lower costs (James, 2013). Some scholars refer to this notion as "patient activation" or when patients are said to possess the

ability, skills and willingness to manage their healthcare (James, 2013). Furthermore, the literature proposes that various quantitative analyses of patient activation scores indicate that less activated patients incur more healthcare costs and have worse healthcare outcomes in comparison to activated patients (James, 2013). The evolution of the physician-patient relationship allows for increased patient participation and consequently, increased patient responsibility.

The physician-patient relationship, once characterized by a largely paternalistic and authoritarian dynamic, has evolved into one of patient autonomy where the patient is empowered to participate in their healthcare (Will, 669). Thus, the literature suggests that patient autonomy, in the current physician-patient relationship, might lead to increased patient participation, perhaps, improving an individual's healthcare outcomes and lowering costs (James, 2013). While patient autonomy allows for individuals to be more involved in their healthcare, patients may face barriers to doing so such as low socioeconomic status or low health literacy (Kelley, 192).

It is important to consider the extent to which patients should be "activated" or participate in their healthcare as the degree of patient activation might have benefits and disadvantages. The findings in this review propose that informed patients who are active participants in their healthcare also assume various patient responsibilities (Ballard, 2003). When patients assume an active role in their healthcare they can begin to ensure that they receive quality care (Ballard, 2003).

In contrast, other scholars believe that placing greater emphasis on physician responsibility is correct. It is possible that, in practice, increased patient responsibility actually becomes a test of adherence to treatment plans thus, going against a competent

patient's right to refuse treatment if they wish (Kelley, 196). The literature also recommends that the arguments against paternalism validate not increasing patient responsibility (Kelley, 189). Nonetheless, the literature still suggests that increased patient participation and responsibility results in improved healthcare outcomes and lower healthcare costs.

3.0 DEFINITION: PHYSICIAN-PATIENT RELATIONSHIP

Physician-Patient Relationship – A formal or inferred relationship between a physician and a patient, which is established once the physician assumes or undertakes the medical care or treatment of a patient (Segen’s Medical Dictionary).

The exact definition of a physician-patient relationship varies according to state law. However, the general rules of the relationship apply nationally and will be used in this analysis (AMA). According to the American Medical Association’s *Journal of Ethics*, physicians do not have an obligation to treat all patients except in emergency cases or when the refusal to treat is due to discrimination (AMA). A physician-patient relationship is formed when a physician agrees to advise or treat the patient for their healthcare condition (AMA). The AMA states, “Once the physician consensually enters into a relationship with a patient in any of these ways, a legal contract is formed in which the physician owes a duty to that patient to continue to treat or properly terminate the relationship” (AMA). A physician has a legal and ethical duty to continue to treat the patient (AMA). If the relationship is terminated incorrectly such as without proper notice to the patient, then it is deemed abandonment and the physician will be held liable in court (AMA). In contrast, a patient can terminate the patient-physician relationship at any time without legal or ethical implications (AMA). It is important to note that the physician-patient relationship is complex and imposes many legal duties on the physician that are not addressed in this brief overview.

4.0 DEFINITION: COMPETENT PATIENT

Competence – A legal term for the capacity of a person to act on his/her own behalf; the ability to understand information presented, to appreciate the consequences of acting-or not acting-on that information and to make a choice

(McGraw Hill Concise Dictionary of Modern Medicine).

As mentioned previously, patient responsibility is a broad topic where the discussion changes depending on whether the patient is deemed legally competent. A competent patient is viewed as possessing the fundamental abilities to assume responsibility for their healthcare including, but not limited to, accepting medical procedures, following treatment plans and making end-of-life decisions (McGraw Hill). Competent patients are expected to assume various responsibilities when interacting with a healthcare entity (McGraw Hill). In addition, if these patients do not assume responsibilities outlined by healthcare professionals, patients will be held accountable for any and all consequences that may accompany their decision (McGraw Hill). This essay will focus solely on patients who are deemed legally competent.

5.0 HISTORY

A historical account of medical practice, one that looks particularly at physician and patient duties, is crucial to the analysis of patient responsibility in the current healthcare environment. Will explores the physician-patient relationship using the beneficence model, which he describes as, “A paternalistic framework characterized by the authoritative physician being afforded maximum discretion by the trusting, obedient patient” (Will, 1491).

Will begins by discussing the Hippocratic Oath, which outlines the duties physicians were expected to assume about 2,400 years ago. Will states, “While it establishes a core set of physician responsibilities, notably absent is any language speaking to a meaningful role for the patient in the decision-making process” (Will, 670). In fact, the Hippocratic belief was that the physician held the knowledge and decision making power thus, patients were expected to follow their command (Will, 670). It is clear that the Hippocratic Oath was devoid of informed patient decision making and rather, it recommended “...concealing most things from the patient, while you are attending to him . . . turning his attention away from what is being done to him; . . . revealing nothing of the patient’s future or present condition” (Will, 671). Thus, the patient was not expected to assume any responsibilities except that of being submissive to the physician’s orders. This model carried through to the 18th century and the Enlightenment period when the authoritarian practices that characterized the physician-patient relationship were challenged (Will, 671).

Physicians Benjamin Rush and Thomas Percival were notably the two most influential contributors to the discussion of patient and physician responsibility during the Enlightenment period (Will, 671). Although never in opposition of the aforementioned Hippocratic model, Rush believed that, "Increasing patient understanding would lead to improved medical outcomes, and he warned of the dangers attendant to blind adherence to the Hippocratic tradition and its emphasis on physician authority and deception" (Will, 671). Adding to the discussion, in 1803, Percival developed and published what is now known as Medical Ethics (Will, 671). Medical Ethics supported the Hippocratic model while also formally outlining the physician's duty to act in a manner that promotes the patient's best medical interests (Will, 671). While staying in line with Rush in never opposing the beneficence model he added to the discussion the idea of "truth telling" (Will, 671). Now, physicians had a duty to tell the truth to their patients thus, beginning the movement towards patient autonomy and away from the early history, which was characterized by physicians withholding information from their patients (Will, 671). Furthermore, it is important to note that both Rush and Percival only advocated for patient rights to the extent that it facilitated patient cooperation and maintained the physician's reputation in the community (Will, 671). Again, there is no mention of patient responsibilities. Beginning at the turn of the 20th century, the patient autonomy model would supersede the beneficence model with the advent of patient rights and arguably, a degree of patient responsibility (Will, 673).

Will describes the shift towards the autonomy model. Will states that ethics within the practice of medicine became the topic of discussion as American society began to question the authoritarian beneficence model (Will, 1491). The 1914 landmark case of

Schloendorff versus Society of New York Hospitals proposed that patients have a right to self-determination thus, establishing the foundation for what is now known as the informed consent doctrine (Will, 1493). Commenting on the notion of self-determination, Justice Cardozo wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages" (Will, 1493). Furthermore, in 1972 the Canterbury versus Spence case formally established the concept of informed consent where, "true consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available," which can only be accomplished when a patient is able to look to the physician "for enlightenment with which to reach an intelligent decision" (Will, 1495). As patient rights became an integral part of the physician-patient relationship consequently so did patient responsibility. Patients now would be expected to assume the role of a competent and informed patient who was expected to participate in their care thus, assuming a degree of patient responsibility.

The aforementioned cases defied the beneficence model in support of the autonomy model where the patient's right to make informed choices in their healthcare treatment was established. The shift from the beneficence model to the autonomy model not only establishes patient rights but also conjures increased patient responsibility. After a historical review of the physician-patient relationship it is clear that the overarching model was one where the physician was the authoritarian figure and the patient was expected to abide by their orders. While patient rights have balanced out the once authoritarian and paternalistic physician-patient relationship, there is further room for improvement. Many

argue that giving patients more responsibility in their care would challenge this balance.

The paternalistic physician-patient relationship that characterized the first nearly 2000 years of medical practice brought attention to physician's medical practices. With the advent of patient rights, people began to question the paternalistic physician-patient relationship specifically, the extent to which physicians were practicing in the patient's best interests. While the majority of focus has long remained on the physician's behaviors, individuals are beginning to question the extent to which patients should assume responsibility and ensure their best interests are kept in mind.

6.0 IMPLICATIONS OF INCREASED PATIENT RESPONSIBILITY

6.1 BENEFITS

Ballard begins by commenting on the evolution of the physician-patient relationship stating that patients are transitioning from passive to active participants in their care (Ballard, 2003). Healthcare institutions have become patient-centered where ensuring patient rights and improving their experience has become a top priority (Ballard, 2003). Although Ballard does not state why this is happening, recalling the earlier discussion of the patient rights movement provides a valid explanation. A patient-centered focus coupled with the ability of patients to access medical information has begun to mold patients into informed individuals who demand quality care (Ballard, 2003). Ballard writes, "Patients can request that healthcare facilities provide an "institutional report card" that describes such indices as outcomes of patient care for medical conditions and surgical interventions, medical error rates...and incidents of malpractice" (Ballard, 2003). Asking for such reports and questioning an institution's quality of care leads to patients having a stake in the choices that they make and consequently, their healthcare outcomes.

The positive implications of this increased patient responsibility include greater emphasis placed upon safety measures, physician credentials and ultimately healthcare outcomes for the patient (Ballard, 2003). Thus, increased patient responsibility is creating standards of care that hold the healthcare institution, clinicians, staff and patients responsible for the success of their care outcomes (Ballard, 2003).

6.2 DISADVANTAGES

Many opponents of increased patient responsibility argue that doing such would ultimately not only encourage but also require patient compliance to physician orders and treatment plans (Kelley, 197). The argument is that increased patient responsibility would restrict a patient's freedom to make choices in regard to the healthcare they receive thus, resulting in contradiction to the legal doctrine of informed decision making, specifically informed refusals (Kelley, 197). Furthermore, accompanying ethical standards such as informed consent or informed refusal are patient responsibilities in decision-making. Kelley writes, "The burden lies with those in favor of increasing patient responsibility to either empirically demonstrate that informed refusals will continue to be honored within a system of increased patient responsibilities, or offer an argument for overriding the decisions of adult competent patients based on some criteria of irresponsible behavior" (Kelley, 196). Furthermore, Kelley introduces notions to deal with irresponsible patient behavior including repercussions such as asking the patient to switch physicians or firing them (Kelley, 191). She also discusses the possibility of fining or suing the patient for wasting medical resources (Kelley, 191). Furthermore, she discusses the notion of blaming the patient for their poor behavioral choices and consequent health outcomes, which would in turn alleviate physician responsibility in seeing these patients through the continuum of care (Kelley, 197). It is important to note that Kelley does not suggest imposing any of the aforementioned repercussions on the patient for failing to adhere to the physician's orders but rather, she discusses adherence to demonstrate the complexities and consequences

that increased patient responsibility may entail and how difficult they will be to actually execute.

7.0 NATIONWIDE COMPARATIVE REVIEW

Crucial to this analysis is the thorough understanding of the responsibilities competent adult patients are expected to assume throughout the duration of the physician-patient relationship. To establish these responsibilities, the author conducted a review of the top fifteen healthcare institutions in the nation according to the *U.S. News and World Report*. A comparative analysis of each institution’s patient responsibilities, as per their website, suggests that healthcare institutions establish four broad patient responsibility categories which include: communication, financial obligation, rules and respect. Encompassed within these categories are a total of six specific patient responsibilities including the exchange of information, participating in one’s treatment, making payments for services, complying with all rules outlined by a healthcare entity and showing respect in all interactions. The subsequent analysis will define, as per the author’s interpretation, each of the six responsibilities in terms of what it means to the patient during the physician-patient relationship. This analysis also intends to foster questions such as, “Should patient responsibilities be standard across healthcare institutions?” and “How detailed should each patient responsibility be?”

Communication	Financial Obligation	Rules	Respect
1.) Exchange of information 2.) Participate in treatment 3.) Refusal of treatment	4.) Make payments for services	Comply with all rules outlined by healthcare entity	12.) Show respect in all interactions

Figure 1: Widely Accepted Patient Responsibilities According to Top 15 Healthcare Systems in the United States

Communication

Exchange of information:

The exchange of information is defined as providing the physician and accompanying clinicians with one's complete medical history. It is necessary that the physician be informed of the patient's complete medical history as it should then appropriately inform the advice and treatment the physician might recommend. In addition, the patient is responsible for ongoing communication with the physician regarding any changes in their health. The physician relies on the patient to inform them completely of their medical history thus, sharing the responsibility of healthcare outcomes with the patient.

Participate in treatment:

This responsibility can be described as the patient's duty to "speak up". Specifically, patients are expected to ask questions when they do not fully understand their condition, treatment or physician recommendations. While the physician has the duty to comprehensively explain any advice given, the patient must assume the responsibility of ensuring that they understand the physician's advice. Furthermore, if a patient has any concerns during the physician-patient relationship they are expected to voice this to the physician and appropriate clinicians in order to effectively address them.

Refusal of treatment:

The patient is ultimately responsible for complying with the recommended plan of treatment because, when coupled with a complete medical history, the course of treatment should be in the best interests of the patient. However, an important aspect of this element

is the patient's right to the informed refusal of the physician's advice and recommended course of treatment. When a competent patient refuses treatment in defiance of a physician's recommendation, they are therefore expected to assume responsibility for any negative consequences.

Financial Obligation

Make payments for services:

The author suggests that the top fifteen healthcare systems in the United States agree that patients have a financial obligation when receiving medical treatment or advice. Thus, patients have the responsibility to ensure the payment of their medical charges regardless of their ability to pay. The financial obligation can be present before receiving healthcare services in the form of a co-pay or after receiving health services in the form of a medical bill. It is important to note that a physician can terminate the physician-patient relationship if a patient consistently fails to pay their financial dues.

Rules

Comply with all rules outlined by healthcare entity:

Throughout the duration of the physician-patient relationship, patients have a responsibility to comply with any and all ethical rules established by the healthcare entity for which they are receiving care. It is important to note that the responsibilities listed in this category varied the most among the institutions examined in this analysis. However, the expectation for patients to attend scheduled appointments and to notify the healthcare entity, in advance, of late appearances or cancellations, was commonly noted.

Respect

Show respect in all interactions:

Throughout the patient's entire continuum of care they are expected to respect and cooperate during all interactions with individuals at the healthcare institution. The responsibility of respect and consideration encompasses both an individual's emotions as well as an individual's property.

The widely agreed upon patient responsibilities provide a basis for the analysis of patient responsibilities established by the University of Pittsburgh Medical Center. Upon a brief overview of UPMC, the aforementioned responsibilities will be compared to those that UPMC has established.

8.0 ORGANIZATIONAL CONTEXT

The University of Pittsburgh Medical Center (UPMC) is a nonprofit healthcare system primarily located in western Pennsylvania. Furthermore, it is an academic medical center affiliated with the University of Pittsburgh. UPMC is comprised of more than 20 specialty, academic and community hospitals and over 500 outpatient clinics as well as doctors offices (UPMC). The healthcare conglomerate extends it's footprint internationally where they are currently involved in over 20 projects in countries such as China, Japan, Russia and Italy, to name a few (UPMC). UPMC is an integrated care delivery system whereby the services offered range from birth, rehabilitation, long-term care and hospice. The healthcare system is also an integrated delivery and finance network whereby the insurance and provider arms are UPMC owned thus, are incentivized to work collaboratively to achieve quality care at low cost.

Furthermore, UPMC has a three-pronged mission that includes a commitment to bettering the community through clinical and technological innovation, conducting cutting edge research and providing integrated clinical education to prepare future clinicians to do the same (UPMC). UPMC's vision includes a promise to provide patient-centered and state-of-the-art care, partnering with the University of Pittsburgh, serving the disadvantaged population and continuing business development abroad. Lastly, UPMC strives to achieve their mission and vision through championing five main values including quality and safety, dignity and respect, caring and listening, responsibility and integrity as well as excellence and innovation.

9.0 UPMC: ESTABLISHED PATIENT RESPONSIBILITIES

The subsequent discussion will focus on patient responsibilities established by UPMC. These patient responsibilities will be compared to those widely agreed upon by varying healthcare institutions in order to provide an example of the extent to which these responsibilities differ among healthcare entities.

In line with the top fifteen healthcare institutions in the nation, UPMC establishes the four broad areas of patient responsibility. It is important to note that within the communication category UPMC does not establish the “refusal of treatment” unlike the other institutions. Furthermore, UPMC establishes seven additional and unique patient responsibilities encompassed within the communication and rules categories. The red brackets in Figure 1 indicate these unique responsibilities.

Communication	Financial Obligation	Rules	Respect
1.) Provide Complete Medical History 2.) Participate in Treatment 3.) Communicate with Staff	4.) Make Payments for Services	5.) Protect Belongings 6.) Refrain from Drug Use and Other Violations 7.) Comply with Smoke Free Rules 8.) Comply with Visitation Policy 9.) Accept Room Assignments 10.) Arrange for Transportation Home 11.) Appoint a Healthcare Representative	12.) Be Courteous to Patients and Staff

Figure 2: UPMC Patient Responsibilities

The first unique responsibility is the expectation that patients communicate with the staff at UPMC. UPMC states that patients must take the initiative to communicate with staff members if they have any questions or concerns. This responsibility could be encompassed within the “participate in treatment” responsibility as it is in the widely

accepted patient responsibilities noted earlier. In addition, UPMC states, “While you receive care at UPMC, if anything upsets or concerns you, please tell us. Contact your unit director or the Patient Relations department immediately so that we can assist you”(UPMC). However, UPMC’s website does not provide information on how one would go about doing so and contact information is not listed.

The second distinctive responsibility is that patients are expected to refrain from drug use and other violations. UPMC states that a patient should not be consuming any drug except those provided to them by the healthcare entity itself (UPMC). UPMC states, “Do not consume alcoholic beverages or toxic substances. These may complicate and endanger the healing process. UPMC reserves the right to search patient rooms and belongings for illegal substances if illegal activity is suspected” (UPMC).

The third distinctive responsibility is that patients are expected to comply with UPMC’s smoke free rules. UPMC is a smoke free campus meaning that smoking is not allowed on “property, buildings, parking lots, or parking garages” (UPMC). UPMC states that fines may be imposed on patients or their visitors who violate this rule (UPMC).

The fourth responsibility is that patients are expected to comply with the visitation policy. However, it is not the patients who need to comply with the visitation policy but rather, it those who may be visiting the patients. Thus, the responsibility here lies in the notion that patients must communicate visitation hours to their guests.

The fifth unique responsibility is that patients must accept their room assignments. UPMC states that they reserve the right to make room arrangements when necessary (UPMC). UPMC outlines, “We may move you to another room or another unit, or we may restrict your visitors or the number of your visitors. You are responsible to cooperate with

all room assignments” (UPMC). Here, the patient’s responsibility is to simply comply with the room arrangements and to communicate to their visitors that they too must comply. One could argue that this responsibility outlines UPMC’s rights rather than a patient’s responsibility.

The sixth patient responsibility is the expectation that patients arrange for transportation home. This responsibility maintains that the patient must arrange for transportation out of a UPMC facility and that they bear the costs associated with the transportation. Furthermore, UPMC states that they will help facilitate transfer from a UPMC facility to another healthcare entity (UPMC). One may ask, “Why is the emphasis only placed on transportation home when patients may encounter barriers in accessing healthcare services”?

The seventh and final unique patient responsibility includes the duty to appoint a healthcare representative. If a patient becomes too ill to make their own healthcare decisions then an individual must make them for the patient (UPMC). Initially, it is the patient’s responsibility to appoint a healthcare representative. However, UPMC states, “If you do not appoint a decision-maker, UPMC will select one for you in accord with Pennsylvania law. The law provides a priority list to determine who your decision-maker would be” (UPMC). Thus, it is a patient’s responsibility to make this arrangement in advance but UPMC’s right to make the arrangement if they fail to do so.

Upon analysis of the widely accepted patient responsibilities as well as those established by UPMC, it has become evident that these responsibilities are not standardized across healthcare institutions. Furthermore, the patient responsibilities are not clearly defined and in fact, are rather broad. For patients, it may prove challenging to understand

exactly what their responsibilities are throughout the duration of the physician-patient relationship regardless of where they seek their care. If we assume that every patient is aware of these responsibilities, the takeaway in this analysis lies in the notion that patients cannot fully assume their responsibilities if they are not clearly defined. Patients who do not fully assume their responsibilities may encounter issues throughout the physician-patient relationship thus, potentially affecting one's healthcare outcomes. This chance alone warrants further research on the topic of patient responsibility.

It is important to note that the distinctive responsibilities established by UPMC may be outlined by other healthcare entities across the United States. However, they were not consistently found in this review. With that being said, the discussion will now turn to a brief background of the two individuals interviewed for this analysis before examining the responsibilities patients at UPMC are believed to assume.

10.0 UPMC: KEY ACTORS AND ROLES

Dr. Bryk is a primary care physician who works in the General Internal Medicine Division within UPMC's Department of Medicine. She is also the Medical Director of the Enhanced Care Program, which employs a team-based approach to caring for patients with complex medical issues. Dr. Bryk has cared for patients who vary widely in acuity levels, which has allowed her to develop a comprehensive understanding of the responsibilities patients are expected to assume and actually assume throughout the duration of the physician-patient relationship. Furthermore, she also has an understanding of the barriers patients might encounter when attempting to assume their responsibilities.

Megan Quatrini is a senior manager who works within UPMC's Patient Experience Department. The Patient Experience Department focuses on ensuring that patients receive necessary information regarding their care. The Department also focuses largely on improving the interactions patients have with the UPMC healthcare system. Through surveys, focus groups and other feedback mechanisms, the team learns the extent to which patients both understand and assume the responsibilities they are expected to. The following analysis will present Bryk's and Quatrini's perspectives on patient responsibility at UPMC.

11.0 UPMC: ANALYSIS OF PATIENT RESPONSIBILITIES

Interviews were conducted with Dr. Bryk and Ms. Quatrini to ascertain their perspectives on the patient responsibility conundrum. According to Quatrini, patient responsibility is defined as educating and arming oneself with comprehensive and relevant knowledge applicable to a healthcare interaction (Quatrini, 2016). Furthermore, it is the notion that individuals assume personal responsibility for their own health through active participation in healthcare matters (Quatrini, 2016).

Regardless, of where an individual receives care and what they are seeking care for, it is crucial that patients know and understand their responsibilities (Quatrini, 2016). At UPMC, one can find the institutions expected patient responsibilities online, in physician offices and in the admissions handbook, to name a few locations (Quatrini, 2016). While the general consensus is that patients should fully assume these responsibilities throughout the duration of the physician-patient relationship, many fall short of doing so. (Bryk; Quatrini, 2016). In fact, it is agreed upon that most patients are not aware of their responsibilities and do not fully understand or assume them (Bryk; Quatrini, 2016). It is important to note that the degree to which patients assume their responsibilities is contingent on the individual's ability to do so. Even patients who are considered legally competent may encounter barriers to becoming aware of their responsibilities, understanding them and complying with them (Bryk, 2016).

While both Bryk and Quatrini agree that patients need to assume more responsibility, Quatrini states that getting patients to assume the current expected level of

responsibility should be the first step (Quatrini, 2016). Increasing patient responsibility may have positive implications. Dr. Bryk states “If patients make their own appointments and wait on hold, they will be more inclined to come rather than if someone else makes them” (Bryk, 2016). On the other hand, Quatrini comments on a negative implication of increased patient responsibility stating that increasing responsibility may increase questions patients have for their physicians (Quatrini, 2016). While patients may want to spend more time with the physician, the current volume based payment model does not allow for much discussion thus, potentially leaving a patient unhappy with their experience (Quatrini, 2016).

Both agree that the extent to which patients assume responsibilities does in fact affect their healthcare outcomes (Bryk; Quatrini, 2016). At UPMC, patients are expected to follow through on recommendations from their physician, attempt to improve their overall wellness and take initiative in their care (Bryk, 2016). However, the feedback from the patient experience team provides evidence that patients are falling short of meeting these responsibilities, which may directly affect their healthcare outcomes (Quatrini, 2016). Both Bryk and Quatrini discuss that a majority of patients lack full knowledge of their own medical history; many patients are not able to articulate what medications they are currently taking (Bryk; Quatrini, 2016). Quatrini states that when some patients are provided comprehensive care instructions, they still might not take the time to review it (Quatrini, 2016). Quatrini states, “It is evident that many competent patients assume a backseat role in their care whether that is due to apathy or blind trust” (Quatrini, 2016). Quatrini believes that patients who do not assume responsibilities established by UPMC are not doing so out of defiance but rather, a lack of awareness of their duties (Quatrini, 2016).

However, Dr. Bryk believes that the majority of patients are aware that they should take their medications, make their appointments and make necessary behavioral changes (Bryk, 2016). However, she believes that while some patients may encounter barriers, others blatantly choose not to assume their patient responsibilities (Bryk, 2016).

Potential barriers to assuming patient responsibility were also discussed by both individuals. Dr. Bryk brings to the discussion the notion of health literacy. She states that a patient's level of health literacy contributes to whether or not they comply with established responsibilities (Bryk, 2016). In the case that the patient has a low level of health literacy, it becomes the physician's duty to assume more responsibility during the physician-patient relationship (Bryk, 2016). Quatrini comments on barriers to patients assuming responsibilities stating, "Not every patient has the ability socioeconomically or cognitively, so the physician must assume more responsibility" (Quatrini, 2016).

Commenting on how to attain the ideal state of patient responsibility, Dr. Bryk noted that patient advocates could be a catalyst to improving care. Since health concepts can be very complex, patients might benefit from having an advocate who can help them successfully assume more responsibility and navigate the system (Bryk, 2016). Also, both Bryk and Quatrini believe that public health interventions could have positive effects on an individual's healthcare outcomes thus, improving the health of our nation (Bryk; Quatrini, 2016). A public health intervention focused on education and improving health literacy could improve a patient's knowledge of healthcare matters consequently improving the physician-patient relationship (Bryk; Quatrini, 2016). Dr. Bryk stated that she has cared for patients who have learned aspects of nutrition from health initiatives within the community (Bryk, 2016).

Lastly, Quatrini points out that most people aim to avoid interactions with a healthcare system (Quatrini, 2016). She questioned why would the average person who is young and healthy be aware of their responsibilities (Quatrini, 2016)? “We all need to be prepared in certain ways for anything to happen health-wise. This includes knowing one’s personal medical record. If you don’t know in advance, then you need to know where to go” (Quatrini, 2016). Quatrini believes that a logical next step may entail a general awareness campaign where patient responsibilities are communicated and clarified (Quatrini, 2016). This campaign would also include not only giving patients the appropriate resources and tools to educate themselves of their responsibilities but also informing them of where they can find the information (Quatrini, 2016).

12.0 CONCLUSION

The literature review, coupled with an analysis of the patient responsibilities established by the top fifteen healthcare institutions in the nation, provide a perspective of the scope of patient responsibility. A closer look at the patient responsibilities at UPMC shows that while some responsibilities are fairly standard across healthcare institutions, others are unique to the specific organization. In addition, these responsibilities are not clearly defined.

Interviews with UPMC stakeholders reveal that while patients are expected to assume various responsibilities, the majority are not fully aware of their duties nor fully understand or assume them. The literature, as well as the responsibilities established by healthcare institutions nationwide, lacks information regarding the implications of assuming or not assuming one's responsibilities including the benefits and disadvantages of doing so. In addition, while these responsibilities are outlined, healthcare entities largely fail to provide easily accessible contact information for patients who may have questions or concerns.

A national patient responsibility awareness campaign could spearhead progress towards improving patient responsibility and educating the public on how doing so could significantly improve their health. This research suggests that administrators, clinicians and staff must work in collaboration with patients to ensure that they understand and assume their responsibilities. Thus, healthcare institutions must begin fostering a culture where patients are expected to assume responsibility in their healthcare. Lastly, further

research on the topic could potentially establish a link between assuming patient responsibility, healthcare outcomes and the cost of care.

BIBLIOGRAPHY

1. Ballard, Karen. "Patient Safety: A Shared Responsibility". *Online Journal of Issues in Nursing*. Vol. 8 No. 3, September, 2003. Web 6 Feb. 2016.
<www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No3Sept2003/PatientSafety.aspx>.
2. Bryk, Jodi. "Patient Responsibility Interview". Interview by author. March 4, 2016.
3. "Competence." McGraw-Hill Concise Dictionary of Modern Medicine. 2002. The McGraw-Hill Companies, Inc. 1 Apr. 2016
<<http://medical-dictionary.thefreedictionary.com/competence>>.
4. James, Julia. "Health Policy Brief: Patient Engagement," *Health Affairs*. Health Affairs, February 14, 2013. Web. 19 April. 2016.
<http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_86.pdf>.
5. Kelley, Maureen. "Limits on Patient Responsibility." *Taylor & Francis*. Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine, 6 Aug. 2006. Web. 2 Feb. 2016.
<<http://www.tandfonline.com/doi/full/10.1080/03605310590926858>>.
6. "OECD Health Statistics." *OECD*. OECD, 2014. Web. 5 Jan. 2016.
<<http://www.oecd.org/unitedstates/Briefing-Note-UNITED-STATES-2014.pdf>>.
7. "Patient Rights & Responsibilities at UPMC Hospitals." *University of Pittsburgh Medical Center*. University of Pittsburgh Medical Center, 2016. Web. 3 Feb. 2016.
<<http://www.upmc.com/patients-visitors/patient-info/Pages/rights-and-responsibilities.aspx>>.
8. "Physician-patient relationship." *Segen's Medical Dictionary*. 2011. Farlex, Inc. Web. 1 Apr. 2016. <<http://medical-dictionary.thefreedictionary.com/physician-patient+relationship>>.
9. Quatrini, Megan. "Patient Responsibility Interview". Interview by author. March 4, 2016.
10. "UPMC Facts & Stats." *University of Pittsburgh Medical Center*. University of Pittsburgh Medical Center, 2016. Web. 3 Feb. 2016.
<<http://www.upmc.com/about/facts/pages/default.aspx>>.
11. "When Is a Patient-Physician Relationship Established?" *Journal of Ethics*. AMA Journal of Ethics, Web. 02 Apr. 2016. <<http://journalofethics.ama-assn.org/2012/05/hlaw1-1205.html>>.

12. Will, Jonathan F. "A Brief Historical and Theoretical Perspective on Patient Autonomy & Medical Decision Making - Part I: The Beneficence Model". *Social Science Research Center*. CHEST 139 (3), March 2011. Web. 3 Jan. 2016. <<http://ssrn.com/abstract=2138332>>.
13. Will, Jonathan F. "A Brief Historical and Theoretical Perspective on Patient Autonomy & Medical Decision Making - Part II: The Autonomy Model" *Social Science Research Center*. CHEST 139(6), June 2011. Web. 3 Jan. 2016. <<http://ssrn.com/abstract=2138335>>.