

From Our Lips To Whose Ears? Consumer Reaction to Our Current Health Care Dialect

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Introduction

Every profession spawns a dialect, a language that facilitates efficient communication among insiders. In written communication, that dialect often becomes even more compact, as acronyms and code words are substituted for “plain text.” This tendency has received some attention in the government sector (where efforts to translate bureaucratic jargon into English periodically gain media attention) but much less so in health care. Yet we may well have reached the point in health care at which the dialects spoken by practitioners and health policy experts are not just confusing to outsiders, but actually prevent us insiders from achieving our goals. The findings presented here emerged from what began as a qualitative marketing study, but which revealed a tremendous gap between what health care professionals say and what health care consumers hear.

That the unfettered use of our professional dialect may be counterproductive is highlighted as two recent health care trends collide: the ever-increasing complexity in the language of health care occurring at the same time that we are asking lay people—as patients, consumers, and voters—to take a more active role in their health and health care choices.

The language of health care and health policy has grown more com-

plex over time as new diseases and conditions have been identified, new treatments discovered, and new ways of reimbursing providers implemented. Physicians who once could do little about heart attacks now treat “acute myocardial infarctions” with “beta blockers, angiotensin-converting enzyme inhibitors, and drug-eluting stents.” The Medicare program that once paid whatever numbers physicians wrote on their bills, now bases payments on “resource-based relative values” that are multiplied by a “geographic practice cost index” and a “conversion factor” and whose growth over time is determined by a “sustainable growth rate mechanism.”

Twenty, perhaps even ten years ago, the discrepancy between professional and lay dialects did not particularly matter. Just as one need not be an engineer to drive a car, patients did not need to understand medical jargon or health care policy. But that has changed. Increasingly, we want consumers to be “empowered” and to take an active role in maintaining their health, not to be passive recipients of medical care. Consumer “choice” forces health care organizations to differentiate themselves, which they try to do by packaging and selling their new and improved services. We want voters to understand policy alternatives and assess options for change. Perhaps most importantly, we want to enlist

patients and consumers to advocate for change in the way that health care is delivered and force the system to improve quality and efficiency.

American health care consumers do not speak our dialect, and they perceive and understand our health care system in a very different way. Patients have strong opinions about health care based on their individual health conditions and their experience with that part of the largely fragmented delivery system in which they receive care. The problem is that in trying to enlist these patients and consumers, the provider and policy communities have gone full speed ahead in developing new ideas without bothering to investigate whether those new ideas and the words used to describe them resonate with the audience. Professional journals, trade publications, and policy blogs are replete with terms such as evidence-based medicine, care coordination, health information technology, medical home, and comparative effectiveness. From an insider perspective, these terms all describe ideas intended to make our health care system better. But do they mean anything to consumers?

Before true health care reform can take place, we must convince patients that their needs will be fulfilled through whatever changes are made: at the national level to heal the ailing health care system,



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and locally, in individual physicians' offices to heal ailing patients themselves. But how do we convince them that any new model of health care delivery will benefit them? What words will work?

Study Purpose

The Council of Accountable Physician Practices (CAPP), an affiliate of the American Medical Group Association, is a coalition of multispecialty medical groups and integrated health systems united in their commitment to coordinated, integrated health care. As part of its ongoing work to promote the benefits of this health care delivery model to consumers and media, CAPP created a marketing campaign that used a number of words and messages to describe care coordination. Before launching the campaign, CAPP realized that it needed to test key words and the messages that used these words to see if they would resonate with the average consumer.

CAPP hired a professional health care market research firm to assist in this effort. The firm recommended that the message testing take place through a series of focus groups, which, unlike survey research or other quantitative methods, allow for in-depth probing of respondents' attitudes and experiences. This qualitative research method would provide the flexibility CAPP needed to explore unanticipated issues and better understand consumer attitudes, which would not be possible within the more structured, and often inadvertently biased, questioning typical of survey questionnaires. The objective was not to find out how the majority of Americans understand a particular word or phrase, but to understand what associations and connotations the term could have, and whether

they were generally positive or negative.

The focus groups were charged with exploring three questions:

1. How do consumers think about quality health care? (In other words, what is it they think they *need*?)
2. How is the provider/policy health care lexicon understood?
3. What words and phrases can health care professionals use to reach consumers to promote the benefits and attributes of coordinated care and organized delivery systems?

Methodology

The study was composed of ten focus groups conducted between November 2007 and February 2008 in Boston, MA; Edina, (St Paul) MN; Billings, MT; San Diego, CA; and New York, NY. The focus groups were conducted during the week with English-speaking women. Women were targeted because it is generally accepted in health care marketing that they make the majority of health care purchasing decisions. Participants were segmented by age: 1) women, ages 35 to 54 years, often responsible for making health care choices for their families; and 2) older women, ages 55 to 70 years, who also make health care decisions for their families and who have an increased need for medical services. Except for New York City (which does not have a comparable organized delivery system from which to recruit patients), both CAPP patients and nonpatients were included in the study to account for varying levels of familiarity with coordinated care. Participants were screened to represent a mix of income levels around the median for their region of the country. All participants had made at least four medical appointments for themselves or for a family member in the past year. All participants had, at a minimum,

a high school education. The education and income levels were chosen because the final CAPP marketing campaigns would target this group as being most engaged in making health care decisions within the private or employer-sponsored health insurance system. (Not surprisingly, the New York participants were more highly educated and had a much higher median income than the other groups across the country.)

Twelve participants were randomly recruited for each group by a professional focus group firm in each city using databases from the research facility and from the participating local CAPP medical group. The first group was held at 6:00 in the evening and the second group was held at 8:00 in the evening. All groups were held at a focus group facility, equipped with a two-way mirror for viewing. The recruitment process resulted in 8 to 11 participants in 9 out of the 10 groups. Due to weather conditions on the night of the focus groups, only four participants attended the later group in Edina, MN. The number of participants in this group, although smaller than the standard focus group size, is sufficient for qualitative analysis from a market research perspective.

Participants received an incentive between \$60 and \$100, depending on the target market and expected show rates, and were served a light meal. Each focus group was audiotaped and videotaped to provide an accurate account of the discussion. Each group lasted approximately two hours.

In each group, a professional facilitator led the participants through the following agenda:

1. A discussion about the participants' general attitudes about health care.
2. A rating of individual key words,

The objective was ... to understand what associations and connotations the term could have, and whether they were generally positive or negative.

with a subsequent discussion of each, which included the participants trying to use the words in a health care context.

3. A review of marketing materials: During this section, the focus group was asked to react to specific taglines, descriptions, and marketing materials developed for CAPP that used some of the terminology that was rated. Since these marketing materials are proprietary, the results of that part of the focus group are not presented in this report.

The sponsor of the study (CAPP) was identified at the start of each group to engender trust and foster open, honest communication among the participants. There was little awareness of CAPP among the participants because CAPP had not yet marketed to or communicated directly with consumers, so there was no bias to consider in the evaluation of the results. The names of the participants' individual physicians or medical groups, however, were not revealed by the focus group facilitator.

Results: General Consumer Attitudes About Health Care

To provide a framework for participants' views on specific aspects of health care, the focus groups began with open-ended discussion around three questions:

- What factors did you consider in selecting your current physician or medical group?
- How do you feel about the quality of medical care you and your family are currently receiving?
- How do you define quality health care?

Not surprisingly, patients select their personal physician on the basis of recommendations from friends and family. Perhaps in part because

participants lack information, they pay less attention to the medical group itself, usually selecting one from among the limited options offered through their employer-sponsored health plan. The most frequently cited factors in choosing a group were cost and location.

Participants' views of quality varied. Only a few participants talked about technical expertise, medical training, or familiarity with current research and treatment options when discussing the quality of medical care they receive from their physician. And whereas some in each group remarked on the importance of convenience—including location, hours, wait time, after-hours care, and care coordination—it was clear that the primary driver of satisfaction is the physician/patient relationship. Patients seek physicians who “listen,” “care,” and provide “personalized” services; they attributed poor medical care—such as misdiagnosis or incorrect treatment—to physicians who are “rushed” or fail to listen.

“The doctor rushed us in and rushed us out. The diagnosis was wrong because he didn’t listen.”
—Boston participant.

“[Quality health care] is when you leave the doctor’s office and your questions have been answered ... when I leave I feel satisfied that we made the right decision [regarding care]. They explain everything.”
—Edina participant.

Attitudes toward care were similar across geographic regions, but there were significant differences by patient status, age, and health. For example:

- Participants currently receiving coordinated health care services, and those experiencing health problems, were more likely than other participants to give

examples of care coordination when asked how they selected their medical group and how they defined quality care.

- Younger women, age 35 to 54 years, particularly working mothers, placed greater importance on convenience than did older women.
- Older women, age 55 to 70 years, placed the greatest emphasis on the physician’s bedside manner and the level of personalized care.
- Older women were least likely to embrace the use of e-mail and electronic medical records. Such technology, they felt, was impersonal and interfered with direct communication between physician and patient. (Those whose physician had explained the importance of computerized records were more supportive of technology.)

One significant regional difference we did find was that New Yorkers were more willing than lower- and middle-income consumers in the CAPP markets to question their physician’s expertise and were more willing to switch physicians if their expectations were not met. As one New York participant explained, “I think that basically you have to take care of yourself. If it doesn’t smell right, get out.” New Yorkers did value their personal relationship with their physician, but they also placed more emphasis on their physician’s training and familiarity with the range of treatment options than did other consumers. *“The things that matter to me are: the expertise that the doctor has had and the frequency with which the doctor has performed a procedure,”* said one participant.

Regardless of age, health, or type of medical group/delivery system

through which they received care, the majority of participants evaluate the quality of their medical care primarily in terms of their personal relationship with their physician. What patients primarily believe they *need* is not better quality care (or a delivery system that can deliver it), but a physician they can trust. The challenge for proponents of delivery system reform is to find language and messages that do not force patients to question their beloved physician’s expertise, but do make them more aware of what quality care should be and how it should be delivered.

Results: Word Associations

Focus group participants were then asked to score key words on a scale of one to four, where one is negative and four is positive. After they rated the terms, the facilitator asked the respondents to comment on their ratings. During this time, the participants were encouraged to talk about the words and try to use the terms in context. Participants often assisted each other to try to better understand what the words meant. These rating procedures were designed to enrich the discussion and do not represent a statistical sample of consumers; therefore, the rating scores are not presented in this report as percentages or counts. Instead, the score results have been combined with the researchers’ qualitative analysis of the participants’ subsequent discussions to draw conclusions.

The following terms were tested:

- Value
- Treatment
- Communication
- Teamwork
- Guidelines
- Treatment guidelines

- Integrated care
- Coordinated care
- Medical home
- Multispecialty medical group
- Integrated health care delivery system
- Medical decision support
- Evidence-based medicine
- Best practices
- Accountable

Going into the focus groups, the belief was that most of these terms would be viewed favorably or neutrally. The researchers were quite taken aback to find that several terms provoked negative reactions among participants. We describe their reactions by grouping terms according to participants’ views (Table 1). The results for New York are presented separately (Table 2) because the participants’ demographics were different and because none of the CAPP groups operate in Manhattan.

**Negative Terms
Medical Home**

“Medical home,” coined by the American Academy of Pediatrics¹ and recently further defined by the American Academy of Family Physicians,² is a term that has quickly been adopted by health plans, policymakers, and politicians (including the 2008 presidential candidates). Our findings suggest it is unlikely that the term was tested with consumers, however, because it consistently received the lowest scores among all the terms tested. Participants associated “medical home” with nursing homes and end-of-life care, with only a few thinking it described coordination of medical services through a primary care physician or group.

“It just sounds like a nursing home.” —Boston participant.

“First you go to the medical home and then you go to the funeral home

Word	Negative association
Medical home	Nursing home, home health, end of life
Medical decision support	End-of-life decisions
Guidelines or treatment guidelines	Restrictive, rigid, limited, driven by cost
Integrated health care delivery system	Bureaucratic, industry language, meaning unclear
Integrated care	Bureaucratic, industry language, meaning unclear
Multispecialty medical group	Bureaucratic, industry language, meaning unclear, trying to do too much, low quality, limited choice of specialists to choose from
Best practices	Bureaucratic, meaning unclear, insincere, cookie-cutter care, not tailored to the individual
Evidence-based medicine	Impersonal, one size fits all
Accountable	Something will go wrong, minimal care, buzz word

Word	Negative association
Medical home	Nursing home, home health, end of life
Medical decision support	End-of-life decisions
Care protocols	Restrictive, one size fits all
Multispecialty medical group	Limited choice of specialists to choose from, forced to choose within group instead of getting the “best”
Best practices	Bureaucratic, insincere, cookie-cutter care, not tailored to individual, legal disclaimer

(laughter).”—Edina participant.

“It [medical home] just gives me the creeps.”—Edina participant.

Medical Decision Support

Whereas health care administrators view “medical decision support” as using evidence and care protocols to benefit both physicians and patients, participants had a strong negative reaction to the term. Older women in particular associated the term with end-of-life decisions. Only a minority of participants reported that “medical-decision support” to them meant increased communication regarding the best treatment options, and even then the association was not always positive:

“I don’t want my doctor to support my medical decision. I want my doctor to make the medical decision.”—New York participant.

“I never got past ‘medical decision.’ I took it as a directive—do not resuscitate.”—New York participant.

Guidelines

Participants disliked the term “guidelines,” associating it primarily with restrictions set by insurance companies to limit medical treatment. Participants described guidelines as “restrictive,” “limiting,” “inflexible,” and “bureaucratic.” A few participants found the term positive, explaining that they like the structure imposed by guidelines. Very few participants, however, associated guidelines with quality control or medical standards.

“Guidelines are restrictive. It means you put parameters around what you are going to do.”—Boston participant.

Integrated Care/Integrated Health Care Delivery System

“Integrated care” received mixed feedback. Patients of coordinated health care systems had better associations with the term than did

others, but most participants agreed the term was “unclear” and “bureaucratic.” The term “integrated health care delivery system” received even lower ratings, with participants describing it as “having more words and less meaning.” Participants from two groups commented that the word “delivery” sounded impersonal—like delivering the mail.

“I think it’s important that one hand knows what the other hand is doing.”—Boston participant.

“When you come to a term that you don’t understand, to me that’s a turn off. Just give me the meat and potatoes.”—Boston participant.

“I didn’t like it [integrated care] because it sounded like a sales pitch in a cheap brochure.”—New York participant.

“Integration means the integration of mind, body, and spirit.”—New York participant.

Multispecialty Medical Group

Consumers had mixed reactions to “multispecialty medical group” depending on their familiarity with the term. Most participants found the term confusing and wordy. Participants in New York had a more positive reaction to the term than did nonpatients in the CAPP markets and did not find the term confusing or wordy, but did feel it implied limits on the specialists a patient could see. These participants associated the term with lower-quality care.

“[It means] you just go around and around because every doctor of every kind is in their system and you can’t ever get out.”—San Diego participant.

Best Practices

Participants who had heard the term used in their own professions found it positive, associating it with quality care or, as one participant

described it, “... *the latest and greatest techniques.*” However, the majority either was not familiar with the term or found it to be a catch phrase: “overused,” “bureaucratic,” and “insincere.” Some associated “best practices” with limitations on what care a patient could receive.

“It’s just such a phony expression to me. It doesn’t bring forth any quality to me.”—San Diego participant.

“What is best for one is not best for another. I gave it a three, but that is how I feel about it ... to me, that word means one shoe fits all.”—Billings participant.

Evidence-Based Medicine

Except for New Yorkers, participants were very skeptical of this term. They believed it to be a “one-size-fits-all” approach that would undermine personalized medical care. Only a few in each group found the word positive and reassuring. By contrast, New Yorkers gave “evidence-based medicine” mixed results. Some found the term reassuring, associating it with rigorous and responsible medical treatment, while others viewed it as redundant and anxiety provoking because they assume that all medicine is anchored by research.

“Evidence based on what? The pharmaceutical company that ran the test so their medicine would be favored?”—New York participant.

“I thought [evidence-based medicine] was silly. If medicine isn’t based on evidence what is it based on?”—New York participant.

“You hope that the research has been done.”—New York participant.

Accountable

Many were unfamiliar with this term, which gave it little resonance and resulted in a low score. Others who were familiar with it thought

Evidence-Based Medicine ... Except for New Yorkers, participants were very skeptical of this term. They believed it to be a “one-size-fits-all” approach that would undermine personalized medical care.

of accountability as a defensive position used to prove that a physician or organization has not violated professional standards, an indicator of minimal care. Consumers expect their physicians and medical groups to be “accountable;” seeing the term raises their concerns. Some liked the term, interpreting it to mean that they will get good, responsible care. *“They are communicating a standard.”* Several reported that they thought the term was overused.

“I get a middle-of-the-road feeling. I hear it so much in politics. ‘He has to be held accountable for this or else.’” —San Diego participant.

“I think it is kind of scary. It is telling me ... I am going to go there and something bad is going to happen and someone has to be held accountable for it.” —San Diego participant.

“I would think that this would be a totally unnecessary word.” —San Diego participant.

Positive Terms

Of the top three most positive terms from both sets of focus groups, only two were ranked unambiguously positive by both the general focus group participants (Table 3) and the more highly educated New Yorkers (Table 4): communication and coordinate/coordinated care.

Communication

The term “communication” received the highest rating of any words tested across all groups. Participants interpreted communication to mean communication between physicians and patients, but also between physicians and their medical staff. Communication was associated with physicians who listen and answer patients’ questions.

“Communication means getting answers to your questions.” —Edina participant.

Treatment

“Treatment” was a positive term for both patients who interpreted it as a reference to medical practice and those who interpreted it as a reference to customer service. A few people negatively associated treatment with serious illness, although this was a minority opinion.

“You are going to get better.” —Edina participant.

“It’s the emotional treatment.” —Boston participant.

Coordinate/Coordinated Care

Participants associated the verb “coordinate” with efficiency and communication; they viewed “coordinated care” as less sincere, more bureaucratic, and less clear. This was particularly true for patients of less organized delivery systems, who were probably less familiar with the term.

“Sounds like people taking care of everything for you.” —Boston participant.

“Putting all of the pieces together to make the whole.” —Billings participant.

Integrated care

This term tested more positively among New York participants than among other consumers. Most New Yorkers understood the term to mean commitment, teamwork, and coordinated care. A few associated the term with industry language that was deliberately ambiguous.

“[Integrated care] is working together ... and coming up with a solution.” —New York participant.

“[Integrated care] is five different types of doctors working together ... if the person has five different problems.” —New York participant.

Terms with Mixed Results

A number of terms were not ranked particularly high or low, but the participants’ interpretations are intriguing (Tables 5 and 6).

Value

The term “value” received mixed results. Rating it highly were those who interpreted it to mean that they (as patients) were valuable. Participants who heard “value” to mean cost effectiveness or low cost gave the term low scores. To avoid misinterpretation, discussions of value in health care should combine

Word	Positive association
Communication	Physician listens to patient, followed by physician talks with other physicians/medical staff. Physician listens, explains, and answers questions
Treatment	“Red carpet” treatment, caring medical staff, welcoming, medical needs taken care of
Coordinate	Efficient care, good communication, needs met

Word	Positive association
Communication	Physician listens to patient, followed by physician talks with other physicians/medical staff. Physician listens, explains, and answers questions
Coordinated care	Efficient care, good communication, needs met
Integrated care	All needs taken care of, medically comprehensive

Word	Association
Value	Individual is “valued,” but also low cost and low quality
Teamwork	Communication, coordination but also no individual in charge, overused in business
Convenient care	Convenience is desired, but marketing convenience implies low cost, low quality

Word	Association
Evidence-based medicine	Quality care based on research; however, patients assume they are already receiving this level of care, therefore implies minimal care
Treatment guidelines	Protective but also restrictive, rigid, limited, driven by cost
Teamwork	Communication, coordination but also no individual in charge, overused in business
Value	Individual is “valued,” but also implies low cost and low quality

messages about quality.

“I was thinking that I was of value and worth the time the doctor’s going to spend.” —Boston participant.

“It reminded me of buying a shirt ... I don’t rate a doctor in terms of whether she’s a good value for my dollar.” —Boston participant.

“It means things are cost effective. They are going to keep the value down. You aren’t getting the best care.” —Edina participant.

Teamwork

“Teamwork” did not resonate with participants, many of whom commented that the word reminded them of business terminology and sports. Participants liked the idea of people working together and associated the concept with increased communication, but ultimately found the term to be “fluffy” and overused. Interestingly, a few participants expressed concern that teamwork implied that there was no “captain,” someone taking responsibility for coordinating services.

“It’s nice, but I don’t have strong feelings.” —Edina participant.

“I don’t have any bad connota-

tions of the word. It just didn’t tell me anything.” —Edina participant.

Convenient Care

The mixed results given “convenient care” illustrate the subtleties at play. Although participants—particularly younger women with children—desire convenience, they associate *the promotion* of convenience with poor medical care. Convenience was associated with urgent care, “sloppy services,” and convenience stores or fast food eateries. People who liked the term, however, associated it with minimal waiting times, multiple locations, and extended hours. As with “value,” the term “convenient care” should be coupled with messages about the delivery of quality care.

“Convenient care does not always seem like the best.” —Boston participant.

Treatment Guidelines

Some participants liked the term, associating guidelines with quality control and medical standards, while others felt it implied restrictions to medical treatment. *“If you*

have a heart problem this is how we are probably going to treat it ... this is the correct way of going about it,” said one participant. However, other participants felt differently, as expressed by one woman, “[Treatment guidelines means] I can only give you six injections. If you need eight, too bad.”

“You don’t want to be put into a slot—‘According to our guidelines, this is all we can offer you.’” —San Diego participant.

Discussion

The limitations of a qualitative study involving only a hundred or so participants in a few select markets notwithstanding, three key findings emerged that have some profound implications for health care practitioners and policy makers.

First, consumers think differently about quality than do health care professionals. For them, quality care is entirely about the relationship with their physician. Even when asked to define quality specifically, not one participant referenced clinical quality; they referenced only their comfort and trust in their physician. From these discussions, we could not tell whether participants were unaware of the extensive literature on health care quality (most likely) or knew of the literature but did not value it highly. What is clear is that the slide on quality and errors that appears in every presentation on health care reform is asserting the need to fix a problem that these consumers were not aware existed.

Second, our professional language is not well understood by patients, an unsurprising result. More surprising was the variability in reactions. In some cases, participants’ views of particular terms may be dominated by their experi-

ence in contexts other than health care. The consumer is bombarded by messages about all kinds of services and products through multiple channels on a daily basis. Consumer interpretations of words like “teamwork,” “value,” “convenience,” etc, are informed by *life* experiences, not just health care experiences (so that “value” connotes 99 cent hamburgers). In other cases, professional buzz-words do not resonate because consumers’ expectations are so different. For example, participants had no clue what evidence-based medicine meant and when told, asked “What else would physicians use?” Whereas Washington, DC is abuzz with efforts to put science back in medicine, these consumers did not

know it had ever left.

The different reactions of participants in New York City are a reminder that national discussions of policy must proceed mindful that health care is a very local concept, both in terms of its delivery and its context. For example, living in a city famous for both its academic medical centers and its “anything you want, 24/7” consumer culture gives New Yorkers a different way of thinking about and talking about health care. We must understand that not only will the health care “solution” vary geographically, but so must the way we talk about it.

Finally, how should we think about reaching consumers? First, be aware that even seemingly neutral or positive words may have very

different connotations. The term “medical home,” for example, a favored concept among experts for promoting care coordination, conjured up images of nursing homes and “places where you go to die.” Participants associated “treatment guidelines” not with helping physicians navigate a complex world to make better care decisions, but with limiting what physicians can do. Even the word “delivery” was viewed negatively, making medicine sound like a package or letter!

As we try to convey the benefits of our system, we need to remember that any new process, tool, innovation, service or feature that is being rolled out to patients should be positioned as being a *support*—and not a hindrance—to

Implications for the Practicing Physician

These focus group results highlight yet again the primacy and importance of the physician-patient relationship. The physician holds the unique position of being the major influence on a patient’s understanding of health care and their decision making, a fact that pharmaceutical and other companies selling health care products understand very well. Our own organizations fail to take full advantage of the physician “sweet spot” in communicating with patients, and many physicians themselves don’t understand the strong effect that their language and communication skills have on their patients.

Organized delivery systems and medical groups that invest significant time and money on developing new care processes and support services for patients should be aware of the consumer reaction to the health care terminology we tested in this study. Practicing physicians can also do much to support their organizations and promote aspects of quality care by paying more attention to their own language use. Here are a few tips that emerged from this study:

- When talking to patients about a new service or feature (such as after-hours care, specialist referrals, in-house medical services), emphasize quality care over convenience or cost. Although consumers want and need convenient and cost-effective medical care, they associate these terms with low-quality, minimal, and impersonal care. If your organization has put a process or service in place to make care delivery more “convenient” for patients, promote that feature as a component of “top drawer” service.
- When talking about the benefits of a new feature—such as an electronic medical record or new physician-patient e-mail capability—

emphasize the improved communication that will take place between the clinician, the patient, and the medical staff. Each patient likes to know that his/her clinicians are conferring together and communicating on his/her behalf.

- Although clinicians understand the benefit of evidence-based medicine and treatment guidelines, consumers can associate these terms with cookie-cutter treatment and an attempt to override their physician’s best judgment. If you feel the need to explain evidence-based treatments and guidelines (using these terms), do so by telling your patient how these protocols assist you in making better judgments, and that you would not advise such treatment if you had not already considered their very particular case. In other words, *personalize*.
- The benefits of care coordination and system integration are not well understood by the consumer. Physicians can do much to educate their patients about what they should look for in quality care and medical services by speaking positively about the support services you and your patients have. If, for example, your patient has a chronic condition that requires education, follow-up, and oversight by several care providers, describe how this team approach will benefit the patient with you, the physician, at the helm, following the patient’s case and monitoring their progress.
- Speak to your patients simply and straightforwardly. Complex medical terms can be anxiety provoking and industry terms can feel bureaucratic and impersonal. Consumers seek a strong personal relationship with their physician, which comes from trust. Trust is engendered through clear communication—understanding and being understood.

the physician-patient relationship. In other words, our language should describe how the new feature will help address the patient's core need—to continue to trust the personal, caring relationship that exists between physician and patient. (See sidebar: Implications for the Practicing Physician.)

Taken together, these findings suggest that, at a minimum, engaging consumers requires thinking more carefully about the language we use and, perhaps, behaving a little more like marketers and doing some pretesting. How can we ever hope to influence our most important constituents if they do not understand one word we say?

There is a more profound issue here as well, namely that all of us have a difficult time conceiving of a world significantly different than the one in which we live. Our New York City participants, for example, discussed the need to bring all their

medical files to every appointment. The notion that an integrated delivery system with an electronic medical record—much less a Web-based system that aggregated information across independent providers—might routinely have all of the relevant information was not in their imagination. Solutions to problems people don't know they have won't be easy to sell.

Finally, this investigation not only provided the CAPP team with valuable feedback on our specific marketing messages, but highlighted the fact that wide communication gaps exist in our industry that beg for further detailed investigation and study. ❖

Disclosure Statement

This study was commissioned by the Council of Accountable Physician Practices, an affiliate of the American Medical Group Association and partially funded by the Kaiser Permanente Institute on Health Policy, which also provided input into the questionnaire design. Dr Ross is

a Vice President of the Kaiser Foundation Health Plan, Inc and the Director of Kaiser Permanente Institute for Health Policy, and Ms Igus and Ms Gomez are both consultants to the Council of Accountable Physician Practices.

References

1. What is a medical home? [monograph on the Internet]. Elk Grove Village (IL): American Academy of Pediatrics: 2007, updated 2008 Aug [cited 2008 Nov 17]. Available from: www.medicalhomeinfo.org/Medical%20Home%20Talking%20Points%20Final%20Version-%20Word.doc.
2. Joint Principles of the Patient-Centered Medical Home [monograph on the Internet]. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Leawood (KS): American Academy of Family Physicians: 2007 Feb [cited 2008 Nov 17]. Available from: www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf.

The Same Language

Ever since I told a crowded room I had a Bavarian cyst and not only did no one laugh, but two others had the same thing, I've been convinced that doctor and patient do not speak the same language. They speak Latin. We speak *Reader's Digest*.

—Erma Bombeck, 1927-1996, American humorist and newspaper columnist