EDITORIALS

Let's "Face" It: Time to Introduce Yourself to Patients

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At the core of a good physician is mastery of critical communication skills. Good communication establishes rapport and can also heal patients. As communication is an essential ingredient of good physicianship, the recipe starts with a fundamental staple—the physician introduction. The physician introduction is step 2 of Kahn's "etiquette-based medicine" checklist to promote good doctoring.[1] Although such rudimentary communication skills are cemented in kindergarten, sadly, more training is needed for doctors. In a recent *Journal of Hospital Medicine* study, interns failed to introduce themselves in 3 out of 5 inpatient encounters.[2]

Despite waning introductions, increasing importance is being placed on hospitalized patient's knowledge of their treating physician's name and role for patient safety. The Transitions of Care Consensus Policy Statement endorsed by 6 medical societies, including the Society of Hospital Medicine, recommend patients know who their treating physician is while caring for them at every step across the continuum, including hospitalization.[3] The Accreditation Council for Graduate Medical Education requires that patients be informed of who the supervising physician is and understand the roles of any trainees in their care.[4] Last, the death of young Lewis Blackman in South Carolina resulted in state legislation requiring clear identification of physicians and their roles for patients.[5] Given these recommendations, tools to remind physicians to introduce themselves and explain their role to patients are worth consideration. In this issue of the *Journal of Hospital Medicine*, the effectiveness of 2 interventions using physician photo tools is described.[6,7]

Even though both studies advance our knowledge on the effectiveness of such interventions, nonrandom variable uptake by physicians represents a major common hurdle. Physician workload, competing priorities, and time pressures prevent physicians from distributing such tools. Consistent adopters of the cards likely already introduce themselves regularly. Interestingly,

physicians likely withhold the cards from patients they perceive as unsatisfied, who ironically have the most to gain. System changes, such as increasing handoffs and transient coverage with resident duty hours, can also hamper tool effectiveness through the introduction of more physicians to remember, inherently decreasing the ability of patients to identify their treating physicians.[8]

Patient factors also affect the success of such interventions. Interestingly, patients' baseline ability to identify their physician ranged from 11% to 51% in these studies. Such differences can be readily attributed to previous disparities noted by age, race, gender, and education level in patient recall of their physician.[8] Future work should target interventions for these subgroups, while also accounting for the high prevalence of low health literacy, memory impairment, sleep loss, and poor vision among inpatients, all of which can hamper such interventions.[9,10]

Although neither intervention improved overall patient satisfaction, patient satisfaction is influenced by a variety of factors unrelated to physician care, such as nursing or the environment. Given the inherent ceiling effect in patient satisfaction metrics, both studies were underpowered to show minor differences. It is also worth noting that complex social interventions depend on their context. Although some patients may enjoy receiving the cards, others may feel that it is not critical to their patient satisfaction. Using a "realist evaluation" would ask patients what they thought of the cards and why.[11] Like one of the authors, we noted that patients do like the cards, suggesting the problem is not the cards but the metrics of evaluation.[12]

In addition to robust evaluation metrics, future interventions should incorporate patient-centered approaches to empower patients to ask their doctors about their name and role. With the request coming from patients, doctors are much more likely to comply. Using lessons from marketing and advertising, the hospital is full of "artifacts," such as white boards, wristbands, remote controls, and monitors, that can be repurposed to advertise the doctor's name to the patient. Future advances can exploit new mobile technologies and repurpose old ones, such as the hospital television, to remind patients of their care team and other critical information. Regardless of what the future may bring, let's face it…introducing yourself properly to your patients is always good medicine.

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