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JANUS proposals for the improvement of person's experience in outpatient clinics

Propuestas JANUS para la mejora de la experiencia de la persona atendida en consultas externas

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Introduction

In Roman mythology, JANUS was the name of the god with 2 faces, one that looked back (to the past) and the other that looked forward (to the future). The JANUS group takes its name from this mythological god and is the initiative of a group of healthcare professionals (see full list in the acknowledgements section) who have suffered or are suffering from a serious illness and who, from their perspective as *patients with healthcare training*, reflect together on their experience as patients in order to help improve the experience of other patients in their journey through the healthcare system. The JANUS initiative has been welcomed and supported by the Collegi Oficial de Metges de Barcelona (https://www.comb.cat/es/serveis/salut-metge/janus).

We present the first JANUS document, focussing on the topic of outpatient clinics. The JANUS group decided to choose this topic for this first recommendations document because it is a cross-cutting issue that affects all patients and stakeholders in the health care system (primary/specialised care, medical/surgical, public/private). This consensus document was developed during 2019 and was scheduled for public presentation in early 2020, but the COVID-19 pandemic disrupted the intended schedule. Now, 2 years later, when the pandemic seems to be subsiding, it has been considered timely to present the document incorporating the lessons learned during the pandemic itself. Interestingly, some of the recommendations anticipated in the document in 2020 have been fully confirmed by the pandemic, such as, for example, teleconsultation (or e-consultation or telemedicine), which is already fully implemented in current clinical practice and is most likely here to stay. However, it is considered that many other recommendations may be of interest now that it seems that we are returning to normal clinical activity.

This document has been structured into 5 different sections: 1) Communication in outpatient clinics; 2) New forms of consultation; 3) Empowerment of the outpatient; 4) Structural improvements; and 5) Post-COVID lessons. Specific areas of improvement are identified in each of them, for which specific actions are proposed[1]. It is important to note, however, that this document *is not based on scientific evidence* (and therefore incorporates few literature references), but rather it is based *on the personal experience* of the JANUS group members and does not claim to be an exhaustive list. It is possible, therefore, that some readers may miss the discussion of specific aspects or feel that some of the recommendations are not appropriate or are already part of their routine clinical practice. Recognising these possible limitations, we still believe that the following reflections may be useful to at least initiate a discussion on a relevant topic, namely, the experience of the person who visits an outpatient clinic. We hope that the various stakeholders in the healthcare system (professionals, managers, administrative staff and patients) may find some of the recommendations put forward

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useful and, eventually, may implement them in clinical practice for the benefit of the people (patients and accompanying persons) seen in outpatient clinics.

Communication in outpatient clinics

Communication as a corporate strategy of institutions

It is proposed that all healthcare institutions develop and implement specific recommendations (some already exist) on concepts such as politeness, code of good practice and emotional ecology. Emphasis should be placed on non-verbal communication, including gestures, smiles, body language, tone of voice, politeness, respect, cordiality, dress code; greeting the person with a "good morning", introducing oneself if it is a first visit, looking at the person (not the computer); writing the clinical note at the end of the visit, when the person has already left the office (not during the visit), explaining who are the äccompanying personsïn the clinic, if there are any (e.g. staff in training), and explaining the importance of this experience for their training,[2] as well as asking permission for them to remain there during the visit.

In addition, it is important to train professionals in communication skills, for which there are already proven tools, such as the Objective Structured Clinical Accreditation (ACOES, for its acronym in Spanish)[3], among others. It would be desirable to make the profession more people-oriented by including specific training in the curricula of medical, nursing and other health professions degrees. Bad news is difficult to give and receive. Specific training in this type of communication skills is proposed.

These reflections raise the question of whether the quality of communication with the person who is ill could be assessed[4]. In this sense, there are experiences in other professional fields that could serve as a reference, such as the use of emoticons at the exit of the consultation (like those found at airport security controls or toilets), or the "fake customers" that evaluate Michelin stars in high-end restaurants. Could consideration be given to the use of "sham patients" to assess the nature of their outpatient care?

Empathy

According to the Oxford English Dictionary, empathy is the ability to understand and share the feelings of another[5]. Empathy is not something you are born with, but something that, ideally, you develop throughout your life and that you can learn, exercise and improve if you have the express will to do so. The need for and importance of empathic communication not only affects medical staff, but also nursing[6] and administrative (reception, telephone; the first contact is important) staff. In this sense, the "person" suffering from an illness should be recognised, not the "patient" (the label "patient" should not be used as it has the potential to stigmatise the "person who is ill", who remains a person despite his or her illness). It is important to make the person who is ill feel "comfortable", as they will understand better what we are saying (many of them leave the clinic without really understanding what the doctor has said, partly because they are in a stressful situation and sometimes because the doctor has not been sufficiently empathetic). "Active listening" is also important, i.e., paying attention to the person (not to the computer screen); the person in consultation wants to be listened to!

Language appropriate to the educational and intellectual level of the information recipient

With patients (or those accompanying them) it is recommended not to use expressions that are too technical and difficult to understand. In this regard, it is important to have the cooperation of those accompanying the patient, since people under stress (such as the patient himself) often have difficulties in understanding what is being explained to them.

It is worth noting, however, that effective communication is not only with the person visiting the clinic. It is also between colleagues, of the same or different level of care. In this regard, there is also a need to improve care reporting as a tool for professional coordination and communication. To this end, it is recommended to avoid "copy/paste" as care reports quickly become unreadable (in general, they should be shorter and clearer) and the indiscriminate use of abbreviations (many of them interpretable only by specialists in the field, and sometimes not even). It is also recommended to conclude the reports with a clinical assessment and specific therapeutic recommendations. The shared electronic medical record is a definite element of improved communication between professionals, but it could probably be optimised if these recommendations were heeded.

New ways of medical consultation

Table 1 lists opportunities for improvement in the outpatient clinic from the perspective of the patient and the practitioner. Based on these, the following actions are proposed:

Be considerate of the waiting time of the person being seen (and those accompanying them)

This should be a key objective in any redesign (structural or functional) of outpatient clinics. In addition to trying to minimise or avoid unnecessary waiting times, it is recommended to use digital identifiers on arrival in order to respect the privacy of each person visiting the clinic, avoid queues, provide updated information in real time on the estimated waiting time to see the doctor, apologise if there has been a delay with respect to the scheduled time (this should not usually be the case), and, on leaving the office, schedule new visits and/or complementary tests by administrative staff via telephone, e-mail, SMS, WhatsApp® or other digital platforms (again, this avoids queues and optimises the time of patients and professionals). Of course, alternative appointments (evenings, weekends) should be considered, as is already the case for some complementary diagnostic tests (e.g., imaging techniques) to reduce waiting lists, and to offer alternative appointment times for people who have work or family obligations in the morning.

Table 1
Opportunities for improvement in outpatient care from the perspective of both, the patient and the professional.

Patient's perspective	Improve accessibility (waiting lists). Difficulty of travel for face-to-face visits due to the patient's own circumstances (limited mobility, residence far from the care centre) or, during the pandemic, due to restrictions on social mobility. Need to maintain a safe distance in waiting rooms and other healthcare spaces during the pandemic. Meeting the needs of the younger generation of digital natives who may prefer tele-consultations. Contribute to environmental sustainability by reducing unnecessary travel.
Professional's perspective	Difficulties in making consultations between different levels of care (primary care/specialised care, different specialties). High pressure of potentially inappropriate face-to-face visits. This pressure could be reduced by new forms of remote consultation. The need to control the care activity rather than the hours in which care is provided, especially in some of the new forms of teleworking.

Table 2
Advantages and disadvantages of potential new forms of consultation.

Type of visit	Advantages	Disadvantages
Tele-consultation (telephone, video)	Within the reach of most people (including the elderly).	Does not allow physical examination of the person and therefore, not recommended for the first visits.
	Can solve queries or m̈inorïssues. Allows chronic patient follow-up.	Not all clinical circumstances are suitable for tele-visiting, including patients who have deteriorated, when b̈ad newsb̈as to be given, when the other person is not familiar with technology or not able to process the information received correctly, when there is no electronic access to the results of complementary tests or to the medicines the patient is receiving (electronic prescription).
	Enables effective reporting of complementary test results.	It may be in breach of the GDPR.
	Can have the same quality of content as a face-to-face visit.	They require the allocation of specific time in health professionals' schedules.
	Technologically viable.	
	Well suited to the d̈igital nativesg̈enerations (born in the digital age).	
	More environmentally sustainable.	
	Useful for consultations between professionals.	
e-consultation *(e-mail)*	Useful in the follow-up of chronic patients by advanced nursing. D̈eferredc̈onsultation, does not require the presence of the professional in real time.	Requires specific time allocation in work schedules.
	To be promoted as a communication tool between professionals	Does not apply to all types of consultation.
Chat consultation	There are already some precedents with positive results (e.g., S̈anitat respon̈in Catalonia).	Less useful for individual discussions.
	It can work in real time (synchronous) or deferred (asynchronous).	Requires the allocation of time in the work schedule.
	Within the reach of most people. Useful among groups of professionals.	In real time, it requires the presence of the professional.
	Useful among groups of patients with similar diseases.	Difficult to manage in large groups of patients.
	Useful for group discussions.	Security issues related to the GDPR.

GDPR: general data protection regulation.

Adapting consultation time to actual health care needs

It is considered that a minimum consultation time should be 15 min (face-to-face) plus an additional 5 min after the person visiting has left the office, to write the electronic clinical note, make the necessary requests for complementary tests, and discuss the case with the possible students present at the clinic. A possible strategy for making this time available for complex patients could be to consider the following alternatives, which are not necessarily mutually exclusive: (1) *relieve the doctor of as much administrative/bureaucratic activity as possible* allowing him/her to spend more time on the clinical care of the person concerned; (2) *to reduce the demand for consultations* invest in patient autonomy and education, expert nursing consultations, and harnessing new communication technologies for patient training and tele-consultation [7]; (3) *avoid practice disruptors*. In this regard, it is recommended to consider switching mobile phones and/or pagers off during the appointment or installing a pilot light on the door (do not disturb), and (4) *reduce bureaucracy and improve the efficiency of organisations*. Remember that the health professional himself/herself can also be stressed (they are also human beings), so counselling groups can be considered to assess emotions during visits[8]. It would be important to fight *burnout* among professionals by taking advantage of their improved social image resulting from their exemplary performance during the pandemic.

Personalised consultation

Depending on the needs of patients and professionals, various models of "personalised consultation" can be considered, including *multi-consultation* (involving different specialists dealing with complex diseases (*multi-disciplinarity*)), *telephone/video consultation* (greatly enhanced by the pandemic and possibly "here to stay"), *e-consultation* (consultation by *e-mail*) and *chat consultation* (e.g., MedXat[9]). Table 2 shows the advantages and disadvantages of these different types of consultation. In addition, new ideas can be "imported" from other types of spaces adapted to new ways of working and interacting between people, such as those being implemented by many banks *(fresh banking),* increasingly based on telematic attention (clearly preferred by the younger generations) and longer opening hours.

Empowerment of outpatients

Ensuring respect, confidentiality and privacy

This is a legal imperative[10] which, for the most part, is being adequately complied with, but the right of every person who seeks medical advice to ensure that the *confidentiality* of all their health data is observed, and that no unauthorised person has access to it, must be emphasised. In addition, the person seen in outpatient clinics has the right to *privacy*[10]. In this sense, it is important to convey that, for health staff, during the visit, that person is "unique" and represents a professional, social and personal commitment. For example, as mentioned above, it is recommended to ask for permission if there are trainees in the practice and to avoid/minimise "disruptors" during the visit (e.g., mobile phone).

Sharing clinical decisions

The doctor/patient relationship has traditionally been paternalistic. The physician believed that he knew better than anyone else what was best for the patient and decided according to his own judgement (usually appropriate to the knowledge of the time). Fortunately, this situation is changing. Law 41/2002 of 14 November 2002 regulates patient autonomy and their rights and obligations in relation to information and documentation[11]. This law states that the individual has the right to know all information about his or her own health, that it must be truthful, and that it must be given in a way that is understandable and appropriate to his or her

needs and requirements in order to help him or her make informed decisions autonomously (if possible). It is the responsibility of the healthcare professional to guarantee these rights. However, as discussed above, communication skills are not innate and younger health professionals in training generally learn what they see. Communication skills must be taught and required. In addition, shared decision-making involves the participation of patients in the decision-making process affecting their health, once they have been adequately informed of the advantages, disadvantages, benefits and risks of the necessary diagnostic tests, efficacy and safety (possible side effects) and prognosis of their disease. Written self-care plans can contribute to the empowerment of patients.

Supporting people through their (not always easy) health system journey

The role of the case manager should be strengthened in connection with planning and monitoring of visits and examinations, especially in chronic diseases. The role of patient associations as support for other patients to explain, recommend, understand and empathise with the person who is ill and their relatives who are new to the experience of a serious illness is put forward for consideration.

Access to quality-assured health information

The creation of a directory of websites containing information validated by the administration, professional associations or other academic bodies for people with specific health problems is proposed. Consider the role in the near future of Internet-based voice assistants on validated information websites.

A special situation: the person seeking care is a health professional

They are often seen outside the official circuits (corridors, without appointment), which can undermine the quality of care received. The aspects of communication (in this case the patient does have healthcare training) and confidentiality discussed above must be taken into account, especially when the professional who is ill works in the same healthcare centre as the professional who is caring for him/her.

Structural improvements

General considerations

In this section of structural improvements, it is necessary to clearly differentiate between new architectural projects and possible reforms of existing spaces (in which the introduction of some of the measures proposed here may be more difficult or impossible)[12,13]. In any case, it is recommended to encourage the participation of patient associations in this debate in order to have a more cross-cutting vision.

Waiting room

It is the place where the person seen in outpatient clinics spends the most time, generally under psychological pressure, stress and, often, in a hurry if the appointment is delayed (see previous comments in this regard). It is therefore important to take into account both physical and psychological well-being concerns[14]. Physical well-being includes hygrothermal aspects (ventilation, temperature and air quality), acoustics (minimizing unnecessary noise such as door closings or loudspeakers, reverberation), olfactory aspects (toilets, cleanliness, disinfectants), lighting (level of ambient light, too little creates unease and uncertainty, too much creates a feeling of overexposure, colour of light - white versus warm) and ergonomic aspects (comfortable furniture, especially chairs/armchairs, where the person spends more time in the waiting room). Psychological well-being is related to spaces (their rational use gives a feeling of spaciousness and lowers the level of distress) and the flow of people (entrance/exit of clinics, patient/professional circuits). If possible, outdoor views are recommended; if not, alternatives such as decorative images, TV panels, videos, etc., can be considered.) Consider the colour and shade of the paint and materials used to transmit peace of mind (chromotherapy) and the level of maintenance of the facilities, especially in older ones. Entertainment can be considered to reduce the stress associated with waiting. In paediatric clinics, it is recommended to consider a children's play area or clowns. In all clinics, consider offering free internet access (Wi-Fi) and battery charging for personal devices, TV screens with informative or general videos with subtitles to avoid the soundtrack. It is also recommended to consider piped music and access to food and beverage vending machines.

Fig. 1. "P-shaped" desk in outpatient clinics to facilitate «proximity» with the patient (rounded part) while allowing a section for the computer, keyboard and printer. *Source: courtesy of the Respiratory Institute, Hospital Clínic, Barcelona.*

The outpatient clinic

Recommendations: 1) facilitate accessibility for patients with disabilities; 2) facilitate physical proximity between the health professional and the person. For example, avoid placing a desk between the two (creates distance) or consider new desk designs (P̈shaped desk) that allow for greater proximity while maintaining the location of the computer and material needed for the visit (Fig. 1), and 3) ensure the privacy of the person both physically (if they have to undress to be examined) and acoustically (ensure the privacy of the conversation).

Post-COVID lessons

The COVID-19 pandemic has led to structural changes in the health system in general and in outpatient consultations in particular. The importance of telemedicine[15,16] has been discussed for many years, but for the most part it has been confined to the theoretical sphere. However, in response to the pandemic[17], telemedicine in outpatient clinics has been implemented with unusual speed. The benefits of this new way of working, which we have seen for both professionals and patients (and those accompanying them), should allow the maintenance of a number of telematic activities that facilitate access to the healthcare system, avoid unnecessary travel (thus saving time and reducing its environmental impact)[18] and enable safe and effective clinical practice. It should be noted, however, that not all outpatient visits can be conducted electronically. Face-to-face visits should be maintained

when required, e.g., first visits, follow-up visits requiring physical examination of the patient, and those where tele-communication with the patient (or relatives) is difficult. On the other hand, the danger of dehumanisation that can result from the abuse of telecare must be avoided[19,20].

Conclusions

This article contains a series of reflections on possible opportunities for improvement in the field of outpatient care based on the experience of a large group of health professionals who, in their dual role as patients and professionals, contribute their personal views on the subject. Taken together, these reflections suggest that there is room for improvement in the traditional outpatient model by focusing it more on the individual who seeks care and on the needs of the professionals who provide it. The authors hope that some of these proposals can be taken up by health managers for the benefit of the person receiving outpatient care.

Conflict of interests

None of the authors have any conflict of interest to declare in relation to this article.

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