Articles

Physician-Patient Communication in Managed Care

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The quality of physician-patient communication affects important health care outcomes. Managed care presents a number of challenges to physician-patient communication, including shorter visits, decreased continuity, and lower levels of trust. Good communication skills can help physicians create and maintain healthy relationships with patients in the face of these challenges. We describe 5 communication dilemmas that are common in managed care and review possible solutions suggested by recent literature on physician-patient communication. We also describe ways that managed care plans can promote more effective communication between physicians and patients.

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The physician-patient relationship, characterized by mutual respect and understanding, is the cornerstone of medical care.[1] Good physician-patient communication, using skills that best express these characteristics, improves biologic and psychosocial health care outcomes and enhances patient satisfaction.[2-4] A breakdown in communication is frequently cited by patients as a reason to change physicians, disenroll from health care plans, or initiate malpractice litigation.[5-8]

Managed care presents a number of new challenges to physician-patient communication.[9-11] First, longstanding relationships may be restricted or nullified as patient and physician groups "change hands" in the managed care market. Second, productivity requirements may reduce the amount of time physicians spend with patients, eliminating or curtailing effective communication. Third, patients may join managed care plans with unrealistic expectations and a sense of entitlement. If patients expect their "money's worth" while the plan encourages physicians to limit costs and use, both parties may lose trust in each other, feel "trapped" by the plan, and seek administrative rather than clinical solutions to problems. Finally, some managed care physicians are less satisfied than those in fee-for-service settings, in part because of frustrations with physician-patient communication.[12-14]

The following are brief statements made by patients to their physicians. Each statement portrays a common dilemma in communication between physicians and patients that is especially problematic in managed care. Following each statement is a brief description of techniques and procedures suggested by recent literature on physician-patient communication. The goal of these techniques and procedures is to preserve the essential features of the physician-patient relationship in the face of challenging managed care environments.

Too Many Problems, Too Little Time

"Oh, by the way, Doctor, I still have a few other things bothering me. You're not going to rush out the door again, are you? Can't we talk for more than 10 minutes?"

This patient expects to talk with the physician for more than ten minutes, the usual time allotted for a return visit in many managed care settings. The physician's goal in this situation is to help the patient feel "heard" without sacrificing efficiency. Sitting down, making eye contact, and removing physical barriers to communication simply but powerfully facilitate rapport.[15] Allowing patients to finish their opening statements without interruption rarely takes more than several minutes and establishes the importance of their concerns and subsequent participation in care.[16,17] Many patients tell brief stories about their illnesses; allowing them to proceed without interruption helps them to feel understood and respected, an important first step in care.[18,19]

Because some patients save the most serious or difficult problems for last, inviting patients to "put all their cards on the table" early in the visit can improve patient satisfaction and reduce the chance of new symptoms being introduced at closure.[20,21] Once all of a patient's concerns and requests are aired, a realistic agenda for the visit can usually be consensually negotiated. One way to help patients prioritize is to ask them which concerns are most important to address before they leave the office that day.

For patients with emotionally distressing problems, physicians' empathic skills can be therapeutic without sacrificing efficiency. Five elements of empathic communication have been described[22]:

- Reflection: "You're really feeling overwhelmed by all these symptoms";

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- Legitimation: "I can imagine how upsetting it must be";
- Respect: "You've been doing your best to cope";
- Support: "I'd like to help"; and
- Partnership: "Maybe we can work on these one at a time."

Contrary to some physicians' fears, patients' expressions of emotion are often brief, self-limited, and responsive to direction by their physician.[23] Physicians' use of empathic skills does not prolong the visit substantially and is associated with greater patient satisfaction.[24,25]

Finally, some patients who expect more time need an initial orientation and subsequent redirection to the process of the visit. The following illustrates this approach: "When our time together is limited, it's even more important that we work as a team. Right now we need to decide early on what to work on today and what can wait. I'll make sure you have time to tell me your concerns and also to hear what I think we should do."

Interruptions, repetitions, and stereotyping—"So you're *that* kind of doctor [or patient] . . ."—by either party are early warning signs of communication breakdown. If they occur, consider acknowledging that a problem exists and inviting the patient's input: "I think we both want to understand each other, but we're having trouble doing it. How can we get back on track?"

Misguided Requests

"I always need antibiotics to get over these colds. I can't miss any more time at work, and the wife says, 'Don't come home without the pills.' That's why we signed up for this health plan."

This patient has specific ideas about what is wrong and what needs to be done about it. His wife acts as an informal health advisor. Finally, he feels entitled to request services as a subscriber to his health plan.

Most patients have beliefs or concerns about the meaning of their symptoms, based on folk knowledge, lay literature, or experiences with friends and family.[26] Asking about these is important because patients will be unable to listen to new information until they feel that they have been heard and understood. Ask patients what they think is wrong: "Most patients already have some ideas about what could be wrong. What thoughts or concerns have you had?" Patients may respond with new information: "They told my brother it was just a cold, but it was really pneumonia. He wound up on a breathing machine." Before examining patients, ask "What would you like me to pay particular attention to?" Ask patients what they think should be done for them: "What have you already tried? What else do you need?" Asking patients what others have said about the problem can also help reveal hidden concerns.[27] Most patients have an informal health advisor—often a family member, friend, or neighbor—who has suggested possible diagnoses or treatments. Finally, patients who change from fee-for-service to managed care may find that tests and treatments that were provided without question are now viewed as misguided requests.

A next step is to find ways to work with patients when their assessments and plans conflict with your own.[28,29] Acknowledge that a disagreement exists: "We seem to be disagreeing about whether you need antibiotics to get over this cold," but remain open to caring for the patient within your limits: "If you feel that you can work with me despite this disagreement, I'd still like to be your doctor and help you manage your health." Empathize with the patient's dilemma: "I can see this hasn't worked out at all like you wanted. No wonder you're frustrated." Provide a rationale for your decision: "The group of doctors I work with have reviewed the medical literature on this topic, and we all agree that there is no proven benefit of antibiotics for this condition." Consider sharing decision-making responsibility with the patient: "The chance that this is bacterial is about the same chance of your getting a side effect from an antibiotic. How do you think we should proceed?" Reaffirm the goals of the visit, which can sometimes be met more appropriately through other means (for example, in the case above, with a note to the employer or a phone call to the spouse). Physicians may reasonably choose to prescribe antibiotics in this case and save negotiations for larger issues: "I have a terrible sinus headache with this cold. I brought in this clipping about CT scans of the sinuses in people with colds. I'm covered for that, aren't I?" At times a mutually agreeable solution cannot be found, leaving both parties dissatisfied.

You Fix It Now

"You're not going to be happy with me today. This darn diabetes is just going crazy. The sugar is always up no matter what I eat or do. I wish you doctors could find some way to control it."

This patient seems puzzled by her diabetes mellitus, as though it has a life of its own. Although the condition is chronic, incurable, and best managed by the patient herself, she seems to want a "quick fix" by her physician. Because of the extra time and energy involved in communicating with her, she represents a financial risk in a capitated health care plan, where the primary physician receives a fixed amount for her care. Rather than become angry and frustrated with such patients, consider using empathy: "I can see that this diabetes is really a struggle for you. You'd really like us to take care of it for you, like a broken bone. But you're finding that diabetes isn't like that. It requires a lot of work on your part. I'll bet that's really disappointing." This statement goes beyond empathy by making clear to the patient that she has responsibilities as well as rights in receiving safe and effective health care.

The next step is to find out what keeps her coming to the physician. What goals or gains does she hope for—to feel better? to avoid heart attacks? or to appease her family? Exploring these goals takes some time but demonstrates to her that her ideas and participation are

important. Clarifying her goals can lead to a discussion of what she already knows about her diabetes, what she is ready to do differently, and what she needs next to change her behavior.[30] Once goals are established, strategies to reach them become clearer: "If our goal is to reduce your risk of blindness, your job is to keep a blood sugar diary, and my job is to advise you on how much food, exercise, and insulin to take." A patient's noncompliance can be put into the context of a normal response: "Many of my diabetic patients have trouble keeping track of food and blood sugars. What trouble have you had?" and then explored: "What else could you do to remember to take your blood sugar when you first get up?" Noncompliance can be presented as a choice that rests with the patient: "You've told me that you really enjoy smoking and don't want to stop. But you also worry that smoking increases your risk for another heart attack. How is this a problem for you?"[31] For patients with many problems—for example, obesity, diabetes, hypertension, and hyperlipidemia—small, incremental changes toward one goal at a time are most likely to be successful.[32]

Seeing the Specialist

"I know how my insurance works. If you don't send me to the gynecologist, then you get to keep the money. But the one who took out my cancer said I should see him every 3 months. He really understood my care."

This patient's previous gynecologist is not a member of her new managed care plan. In her new plan, the primary physician receives a fixed amount for her care, from which expert consultant expenses are deducted. The continuity relationship she enjoyed with her previous gynecologist is gone, her new physician is cost-conscious, and she feels cheated and abandoned.

An early goal for the physician in this visit is to keep the focus on the provision of quality health care rather than on the managed care plan. Address the patient's feelings of loss and frustration, but explain her current plan in realistic, unbiased terms: "I can understand how upsetting it must be to have your previous care interrupted. On the other hand, you've got a good plan. It allows you good medical care, but it restricts the use of specialists. It requires that I do things for you that we normally do in the office, such as pelvic exams and Pap smears. If something comes up that you and I decide needs the input of a specialist, I'll help you get it."

The patient's ability to trust her new physician can also be dealt with explicitly: "It sounds as though you're not sure I'll have the knowledge or skills to take care of you properly, or worse, that I wouldn't act in your best interests. I want you to know that my goal, like yours, is to provide the very best care we can. If at some point you feel that we're not meeting that goal, I hope we can talk about it and reach a solution together." Then do a thorough and careful examination as evidence of your competence and concern.

As managed care plans expand, referral patterns between primary care and specialist physicians can change rapidly. Primary care physicians help specialists by formulating specific questions and defining roles and tasks for follow-up. Specialists can help by being brief and specific, anticipating problems, and identifying contingency plans.[33] Specialists may also wish to identify the primary physician as the patient's "point of contact" for follow-up. This approach is challenging in highly technical specialties—for example, cardiac electrophysiology—where standards of care are constantly being revised.[34]

Bending the Rules

"Doc, I haven't seen a dentist in years, and I can't afford to now. Could you make a referral saying that I need it because of my diabetes? Then the plan will pay for it."

In some managed care plans, coverage for certain types of care, such as dental, optometric, preventive, or mental health, is minimal or absent depending on the level of coverage purchased. Physicians working in such plans should be familiar with the types of care that are covered and denied, what specialists are available and their qualifications, and the physician's role if specialty treatment is denied by the plan.

This physician has a number of options, reflecting his or her various roles. Administratively, he or she can refer the patient to an eligibility office, write in support of the patient's request, or ensure that the eligibility committee has appropriate input from both patient and physician. Clinically, the physician can request specialty consultation to evaluate the effect of the dental condition on diabetes—for example, "rule out dental infection." Investigators found that physicians are willing to use deception in recording the reason for ordering a mammogram in a setting where mammograms ordered for "screening" are denied but those ordered to "rule out breast cancer" are approved.[35] Ethically, a physician's duty to advocate for the individual patient conflicts with his or her duty to work within the guidelines of the plan, which provides cost-effective care of a population of patients. Current ethical guidelines clearly support the physician's role as an advocate for individual patients.[36,37] Legally, if a plan denies care that a physician strongly feels is indicated, he or she may have an obligation to contest or appeal the decision on the patient's behalf and to discuss all options with the patient, including getting care outside the plan at the patient's expense. Although managed care plans may be held liable for a physician's actions, courts may also hold physicians responsible for upholding community standards of treatment, even when denied by a patient's plan.[38,39]

In responding to patients' requests to bend the rules, physicians' actions—and related communications with patients—can be impulsive, depending on their feelings about the individual patient, the ease of dealing with the managed care plan, and the time available to think about it. Such requests rarely require immediate action. Physicians should take time to consider the issues just outlined, their personal responses to them, and what messages they want to convey to their patients. Then

they should communicate the message clearly: "I'd like to help you, but I don't think your teeth are aggravating your diabetes, and I'm not comfortable bending the rules that way."

How Managed Care Organizations Can Facilitate Physician-Patient Communication

Managed care plans can help physicians and patients communicate more effectively. For patients, the plan can describe what to expect regarding time with a physician, use of the telephone and emergency room, and the roles of other health care professionals in enhancing physician-patient communication. The plan can also describe policies regarding referrals to specialists, handling of grievances, and physicians' role as patient advocates if financial conflicts of interest arise. For physicians, the plan can provide opportunities to review how its promises and limitations are marketed to possible subscribers and its development of resource allocation guidelines to avoid "bedside rationing" by physicians.[36] Programs should be available to educate and coach patients in the management of common health problems and to educate providers in population-based and traditional dyadic medical care.[40]

Second, there should be a well-defined, physician-generated, prospective internal policy for dealing with difficult physician-patient relationships, including a means for terminating a patient's relationship with an individual provider or with the entire plan.

There should also be a strong, sensitive central administrative physician to deal directly with patients who have insistent demands and contentious behaviors. This frees up primary care professionals to be advocates for good medical care and to negotiate about medical rather than administrative issues.[9] Some administrators and risk managers unwittingly undermine physicians' efforts to provide safe, effective health care when it involves setting limits on patient demands, by tracking patient complaints as the only relevant outcomes, or by administratively reversing physicians' decisions regarding patients' requests. Managed care plans may reasonably decide that for some patients unable to cooperate with their physicians in obtaining safe, effective care, disenrollment is administratively preferable to providing substandard care.[9,41]

Finally, managed care plans should provide training in physician-patient communication. Plan administrators and risk managers should work collaboratively with physicians to identify mutual goals for such training and to ensure that the plan's policies and measures of quality of care support those goals. Goals for administrators and risk managers could include greater patient satisfaction and retention and fewer complaints or lawsuits. Goals for physicians could include fewer frustrating patient encounters, improved treatment adherence, and improved job satisfaction. All of these outcomes are demonstrably related to physicians' communication skills. Skills training is best conducted in workshop format, with opportunities to review recent research findings in physician-patient communication, practice new skills in relevant and realistic situations, and work in small groups with a free exchange of ideas and feedback. Such training is increasingly part of medical school, residency, and continuing education curricula.[42-44]

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