Virtual Physicians, Health Systems, and the Healing Relationship

Healing relationships are characterized by several enduring features: the patient is and feels known as a unique sentient being; the patient is provided with good information, prudent judgment, and presence; and the patient is involved actively in his or her own health care.

But healing relationships are complex. First, healing relationships include more than just the physician-patient dyad. Consider the situation of a man recently diagnosed with prostate cancer. His healing relationships might include several physicians, who may or may not constitute a team, and with whom he might communicate in person, over the telephone, or via e-mail; other health professionals, both mainstream and "complementary/alternative"; his close friends and family; someone he happened to meet on an airplane; acquaintances from a web chat room; or an imagined or spiritual being.[1] Second, the nature of information provided is different, depending on which city or country he lives in, and on whether his primary care physician refers him first to a urologist or a radiation oncologist. Third, the patient may welcome or may be overwhelmed by attempts to involve him in his health care, such as providing a menu of treatment options. Fourth is the issue of continuity; when his primary physician is on vacation, or leaves the practice, he entrusts the relationship to someone who otherwise might be a stranger. But the relationship does not start anew; continuity of context and information, and an implicit relationship between the new physician and the prior physician ease the transition.

The set of articles in this issue of the *Journal of General Internal Medicine* may initially seem unrelated. However, they are all linked by the theme of elements extrinsic to the physician-as-person, which may be included, in the patient's view, within the healing relationship. These elements include the culture, the health care system, the office setting, the medium of communication, the patient's hopes, and continuity. Even as blunt an instrument as a governmental mandate can, as Baker et al.[2] show, swiftly and irreversibly change the nature of emotionally charged patient-physician discussions. A statistician might think of these elements as confounders that impinge on what is and should be a dyadic relationship. For example, some internists dread the presence of family members at an office visit and view them as barriers to effective communication and patient care.[3,4] But I doubt that most patients take a similar view (there are exceptions, of course!). Taking the patient's view, these "confounders" constitute part of the web of influences that the patient receives and cannot distinguish from the physical presence of the physician. These may be core elements of the patient-physician relationship.

PATIENT DEMANDS AND PHYSICIAN EXPECTATIONS

Harris et al. raise the question of whether physician, patient or combined interventions are best when trying to change physicians' prescribing habits.[5] But there is a deeper question: why do physicians do what they might theoretically judge to be inappropriate? Anecdotally, many of us *have* provided antibiotics for a patient with an upper respiratory illness. What motivates us to do such a silly thing? Does compliance with a benign-seeming patient demand allow more time to discuss something more substantive? Are we physicians fatigued from having to explain the futility of antibiotics for a cold over and over again? Information usually is not sufficient to change what physicians say to patients. Improving communication might also include financial incentives, public health campaigns directed at patients, and systems changes to provide patients with information at the point of visit. Patients can be effective at changing physician behavior,[6] so perhaps a patient intervention alone might also have produced an effect similar to the physician intervention.

VIRTUAL PRESENCE

E-mail creates a virtual presence of the physician. Unlike telephone calls, e-mail has the potential to allow asynchronous communication that does not interrupt other activities. E-mail can be easily archived and reviewed; it can be an efficient means of transfer of information, and a way of monitoring chronic disease. "Smart homes" are a further extension of e-mail; the patient's home becomes a virtual extension of the physician's office or hospital ward by placing sensors, monitors, and immediate access to information in the home of the patient.[7]

Although words are the "stuff" of communication, they can carry different messages when they are delivered in person, over the telephone, or via e-mail. Although Gaster et al. indicate that physicians and patients who use e-mail seem to be satisfied with it,[8] we know very little about how the medium affects the message, for better and for worse, nor how e-mail transforms healing relationships.

INFORMATION IS POWER

Patients provided with information should, theoretically, have more power over their own destiny. But, why, as Chan[9] et al. report, might a competent, caring, self-respecting urologist want to withhold information about the uncertainty of a procedure (the prostate-specific antigen [PSA] test) from patients? Are urologists so jaded

by the profit motive that they see in every elevated PSA the possibility for financial gain from performing a biopsy? Do they suffer from availability bias? After all, urologists are surrounded, every day, with men suffering from and dying of prostate cancer. Or is there something more fundamental; for example, do urologists choose their specialty (rather than a more generalist field) because they find it more difficult to tolerate uncertainty? And what does this imply for the patient-physician relationship? In primary care, it seems, tolerance of uncertainty may be a marker for the kind of patient-centered openness that might be desirable. But we know from the work of Levinson and others[10,11] that primary care physicians are different in many ways from our specialist colleagues, and that it may be an error to apply the same measures to both.

THE DEPARTED PHYSICIAN

Can one logically talk about sustaining the patient-physician relationship after the physician has left the practice? This may seem like an oxymoron unless one considers that the physician is important to the patient for reasons that both include and transcend the physician-as-person. For patients, the physician may serve as a representative of the practice or the health care system. Our experience in a residency practice is that patients are often more loyal to the practice than to individual residents. Surprisingly few switch to other practices when their residents leave because, I believe, we attend not only to continuity of care but also to continuity of caring.[12] Roy et al.[13] confirm that the effort to humanize the transition results in greater patient satisfaction. They applied qualities of physicians, such as patient-centeredness,[14,15] to a microsystem—the practice setting. Improving the patient-physician relationship, in part, includes improving the larger systems that nurture it.

HOPE

When I become ill, I not only desire help, but also help from a particular person, or kind of person. When the physician who treats me conforms to that image, I am comforted; I am more likely to entrust my life to him or her, and to follow the advice given. This is only human nature, it seems. Taking this view, it seems somewhat short-sighted to consider physicians as interchangeable parts, cogs in a giant machine, that will equally serve each ill person. It is not surprising, then, that Hsu et al. report high patient satisfaction when patients are given an informed choice of physician compared with those not offered such a choice.[16]

Personality is important; it predicts many aspects of human relationships. Although personality is not absolutely immutable, each of us has enduring (and sometimes endearing) qualities that persist over time. Compatibility between the personality of the physician and that of the patient may form the "glue" that allows the relationship to endure the inevitable awkward moments,[17] conflicts, and sadnesses that accompany the lived experience of illness. Given that communication interventions are difficult, costly, and with relatively modest results in practicing physicians, giving patients a choice is both desirable and possible in all heath care settings. But it is important not to confuse the illusion of choice with patient autonomy. True autonomy is based in real choices that make a difference, in the context of an environment that supports the patient's ability to make them.

PATIENT-CENTERED CULTURES

Bensing et al. raise the question of what it means to be patient-centered.[18] Is socioemotional talk always a marker of patient-centered care? Do patients want information or emotional support? Is patient-centeredness a quality of the physician's manner of speech? the patient's personality? the "culture" of the health care system? Is greater frequency of visits—characteristic of European health care systems—more important than length of individual visits, assuming that the same amount of contact time occurs over the course of an average year?

Culture may refer to ethnicity as well as professional identity. In that sense, determinants of cultural practices, such as psychosocial orientation, may be due to differences in training and the prevailing economics of health care in addition to deeply held values based on ethnicity and tradition. General practice and family practice were early adopters of Engel's biopsychosocial model and a family systems approach to health care. Although the values of internal medicine and family medicine may have converged over the years, there are differences, and the results of Bensing et al. may reflect the greater preponderance of general practitioners in their sample. Also, it raises the question of whether the health care system supports patient-centered care better in The Netherlands than in the United States.

Can a measure that observes a single office visit, without access to how the patient feels after the visit, adequately measure the quality of healing relationships? It is not known if less biomedical talk and more psychosocial engagement actually results in better patient outcomes. Studies to date have been mixed in their ability to document these associations.[19–22] In addition to studies of communication behavior, it is essential to study the effect of the communication on the patient as distinct from the observations that can be made from an audiotape, and also the nature of the relationship with the physician over time; only patients can provide us with that perspective.

A NEW MODEL

Engel's biopsychosocial model[23] is a profound description of ideal clinical practice. Engel proposed that

illness and healing involve relationships between individuals, and can be described in terms that extend from the molecular to the societal level. Bringing a biopsychosocial approach to clinical practice requires attention to the particulars of each patient's situation as much as the understanding of universal principles.[24,25] This was as well known to the ancient Greeks as it is to exemplary physicians today.[12,26–28] There is a temptation, though, to regard anything but person-to-person discourse as extrinsic to the patient-physician relationship, and to then set up false dichotomies between "impersonal" and "humane" aspects of care. This was brought home to me when, several years ago, a student asked me whether he should do a "regular" or a "biopsychosocial" interview when we were about to see a patient together.[29] The alternative view is to understand these aspects of clinical care as "not-two-not-one." From one perspective, there are clearly differences between the physician and the setting, between culture and dyadic relationships, between e-mail and in-person communication, and between legislated mandates and spontaneous physician action. However, all of these media can be vehicles for understanding, empathy, and healing. Our task, then, is to keep in mind a qualitative, holistic view of illness and healing, while at the same time making quantitative linear approximations in order to promote effective healing interventions.—**Ronald M. Epstein, MD,** *Rochester Center to Improve Communication in Health Care, Department of Family Medicine, University of Rochester School of Medicine and Dentistry, Rochester, NY.*

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