Research on Patient-clinician Relationships

Celebrating Success and Identifying the Next Scope of Work

The articles on patient-clinician communication and relationships in this issue of JGIM[1–6] provide an opportunity to reflect on how far this field has come. As a medical student in the mid-1970s, I had no formal instruction in interviewing skills. I was simply given a list of questions constituting a complete Review of Systems and told to come back in 2 hours having gathered all this information, and I was left to my own devices to figure out how to get it. The term "communication skills" was never used. Instead, people spoke of "bedside manner," which was regarded as a personal attribute that you either were born with or not. If you were, so much the better for you (and for your patients) and if you weren't, oh well.... Relationship process was not thought of as something that could be taught, and certainly was not a recognized focus for scholarly work.

Now fast-forward to 2003 and look at what's changed:

- To be accredited, residency programs in all disciplines must demonstrate that they are teaching communication and relationship skills and evaluating each resident for these competencies.
- The Robert Wood Johnson Foundation, National Cancer Institute, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality and other grant-making organizations have had specific funding initiatives in the area of patient-clinician relationships and communication.
- MEDLINE lists more than 34,000 articles on patient-clinician relationships and communication dynamics. JGIM alone has published more than 100 articles on this topic, including recent articles on difficult patient-clinician relationships,[7] the sociophysiology of caring,[8] patient perspectives on talking about spirituality with their doctors,[9] and patients' use of the Internet for medical information.[10]

That's a lot of progress in 25 years. It would be beyond the scope of this editorial (and indeed, beyond the scope of my own knowledge) to present a comprehensive history of how this change came about. Nevertheless, I would like to acknowledge a few landmarks along the way. One of the earliest research studies of patient-physician communication dynamics in a nonpsychiatric setting came out of pediatrics when in 1968, Barbara Korsch published a study describing communication lapses in the care of children in an emergency department.[11] The take-home message of that groundbreaking paper—that communication is an essential factor in the quality of care—is still relevant and has found its most forceful expression yet in the Institute of Medicine's 2001 report Crossing the Quality Chasm.[12]

A string of important contributions were made under the aegis of the Society of General Internal Medicine (SGIM) and its progenitor organization, the Society for Research and Education in Primary Care and Internal Medicine, through its Task Force on Medical Interviewing. Convened in 1978 by Mack Lipkin, Jr. and Sam Putnam, the Task Force sponsored the nation's first course for medical educators on how to teach relationship skills and self-awareness. Not only has this course taught thousands of teachers (and thus affected the educational experience of hundreds of thousands of students), but it has been and continues to be a laboratory for exploring new teaching methods and topics. The Task Force published the first core curriculum on medical interviewing and relationships[13] and the first comprehensive academic textbook in the field.[14] Ten years ago, the Task Force became the American Academy on Physician and Patient, amicably separating from SGIM to become a more truly interdisciplinary organization.

Our colleagues in family medicine have made equally substantive contributions to establishing communication and relationship skills as a core medical discipline, including the definition of core competencies,[15] integrating the family,[16] and striving for a unified theory.[17] They have also produced the first entirely evidence-based textbook on medical interviewing.[18] That such a project could be accomplished attests to the volume and breadth of research in the field.

It's clear to me that the first scope of work in this field—to demonstrate its legitimacy and value and to place relationship process in the mainstream of medicine—has been largely fulfilled. So what now? The articles in this issue of *JGIM* offer some clues. First, there is the continuing study of basic skills (such as empathy[1]) and a myriad of special topics in communication and relationship issues (represented in this issue by confidentiality,[2] the use of interpreters,[3] and communication and relationship dynamics in the care of survivors of intimate partner violence[4]).

I have already alluded to the second major agenda item for future research: the effect of communication on performance with regard to safety, effectiveness, and efficiency. An important new frontier lies in the dynamics of communication within health care organizations and interdisciplinary teams and the nature of workplace relationships that support outcomes monitoring, continuous learning, and process redesign. Organizational culture also pertains to a third important agenda topic: the implications of relationship dynamics for the recruitment, retention, satisfaction, and health of the health care workforce.

Finally, I think the new scope of research on health care communication and relationships should address the changing nature of patienthood. More and more, patients want us to respect and engage them as active, competent

partners in their own care,[19] but we health professionals habitually see them as helpless, dependent, and utterly lacking capacity (a view rooted in an old-fashioned notion of professionalism[20]). Two of the papers in this issue of JGIM get right into the thick of this role transformation, exploring how to support patients' active involvement in self care[5] and the association between the role expectations and behaviors of both patients and clinicians.[6] If there is ever to be such a thing as real health care reform, I believe it will center on this issue—expecting and supporting capacity and active participation on the part of patients. That will have profound implications for the role and education of health professionals, the financing of care, access to and control of personal health information, and a host of other issues.

In summary, we can celebrate the successful completion of the first scope of scholarly work in patient-clinician communication and relationships and now shift our gaze to several new frontiers. I have no doubt that the clinicians and behavioral scientists in general internal medicine, along with colleagues in our sister primary care disciplines of family medicine and pediatrics, will continue to lead the way in this important work.—**ANTHONY L. SUCHMAN, MD, MA,** *American Academy on Physician and Patient, St. Louis, Mo.*

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