Toward a Conceptual Reexamination of the Patient–Physician Relationship in the Healthcare Institution for the New Millennium

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There is a crisis in the patient–physician relationship. Mass media, managed care and malpractice are just a few factors that contribute to a lack of trust, understanding and loyalty in the patient–physician relationship. We have experienced some select concepts within the Society, Culture and Personality (SCP) model. In it, we explore how social class, age, race, ethnicity and family background of the patient impact upon the patient–physician relationships. The analysis of the sick role is most prominent, and in this interactive process empathy must be given to each person who seeks medical help.

Key words: patient–physician relationship ■ sociology ■ healthcare ■ Society, Culture and Personality model ■ culture ■ personality ■ empathy ■ mistrust ■ physician satisfaction

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There is a crisis in the patient–physician relationship. The changing times introduce multiple stressors. Managed care, mass media and malpractice affect doctors, who may become closed and defensive, and patients, who lose trust and loyalty. Consumer advertising, availability of online health information on the Internet, access to pharmaceuticals online and across U.S. borders, as well as the use of complementary alternative medicine (CAM), may all pull at the relationship if the physician does not openly and honestly communicate these issues with their patients. Provider dissatisfaction, in part from discontent with compensation, reimbursement, malpractice insurance, reform and work overload, may further pull at the patient–physician relationship.

Previous research has demonstrated that sociodemographic, cultural and attitudinal characteristics play important roles in the patient–physician relationship.[1]

These factors include income,[1] the physician–elderly patient–companion triad in the medical encounter,[2] the physician–patient encounter: a process of reality negotiation,[3] dimensions of patient control,[4] patients' perceptions in medical encounters in Great Britain,[5] the mystification of meaning: doctor–patient encounters,[6] do attitudes predict communication behavior[1] of patients. Further information and decision-making preferences of hospitalized cancer patients,[2] the informative process in private medical concentrations,[7] clinical uncertainty,[8] informed consent and provider–patient relationships,[9] are well documented of the patient–physician relationship. Additionally, Danziger[10] discussed how role perceptions might vary among patients and between the patient and physician.

A crucial need within the area of the behavioral sciences in healthcare is to place the diverse body of descriptive and empirical findings of the patient–physician relationship within some type of thematic framework. This process should incorporate some essential concepts and themes in such a way as to show the interconnectedness and meaning of the central issues sur-

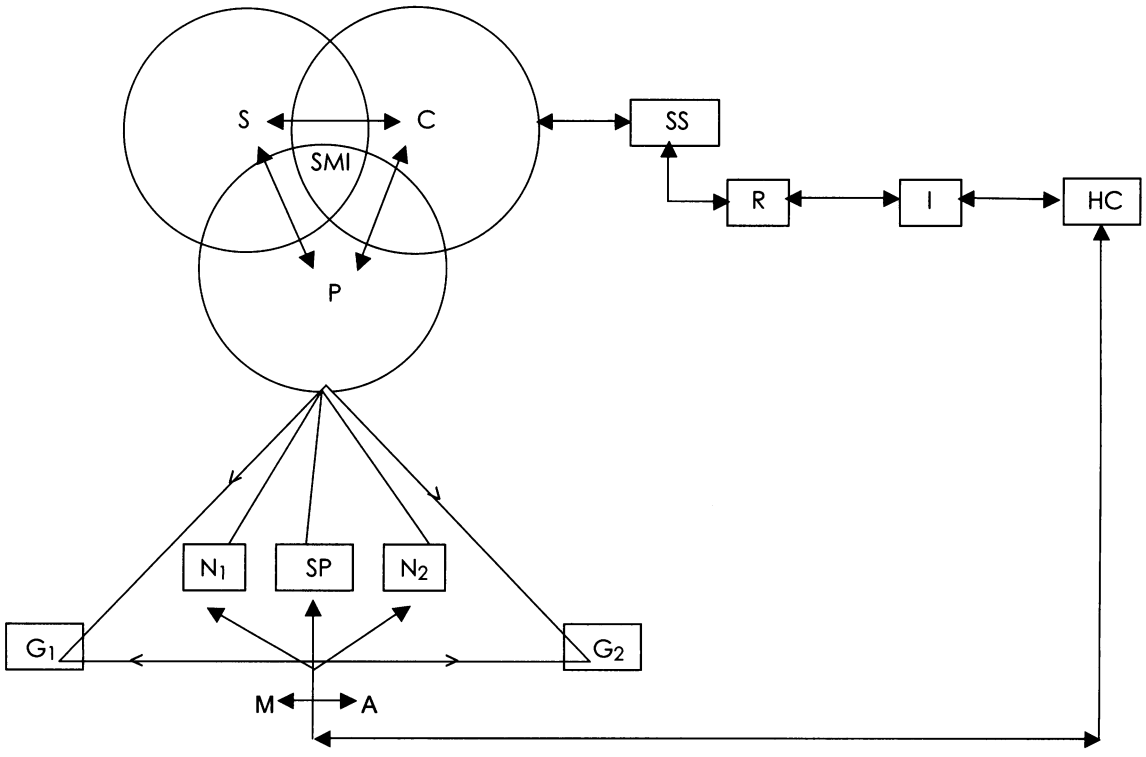
rounding healthcare as an institution. The Society, Culture and Personality (SCP) model (Figure 1) can be used as an organizational device for aiding physicians in developing a greater comprehension and appreciation of the patient–physician relationship as they practice their future roles as physicians and behavioral healthcare practitioners in diverse communities within a Gemeinschaft (G_1) (rural) and/or a Gesellschaft (G_2) (urban) society (Figure 1). The purpose of this research paper, therefore, is to isolate, operationalize, interpret and relate some select major concepts of the patient–physician relationship that bear upon the educational practice and decision-making of physicians in the new millennium. Moreover, these select concepts will be linked to the overall core dimension of the SCP model as an interlocking system.

Fundamental Core: Society-Culture-Personality Model and the Patient–Physician Relationship

It is essential that physicians understand the impact and implications of society, culture and personality in the patient–physician relationship (Figure 1). Society (S) may be defined as "an ordered and dynamic system of all the social interactions involving the members (personalities) of a total population, which can be identified as sharing a culture distinct from that shared by other populations."[11] Culture (C) refers, in a general sense, to a way of life. It is a system of conventionalized understandings of a group manifested in act and artifact. Culture includes knowledge, beliefs, customs, laws and habits—besides the artifacts of a people. As the culture of a society is incorporated by the individual, a personality unique and distinctive to the individual, but more or less adjusted to the demands of a society, is developed. Personality (P), then, is the dynamic system of ideas, attitudes, habits and values, which is unique to each individual. While the genetic basis (N_1) of personality represents only potentiality, the "finished product" is acquired through social meaningful interaction (SMI) in various social processes; a learning process in a social environment (N_2) wherein the value attitude system (VAS) of a culture is internalized (Figure 1).[12] These concepts are important for physicians to grasp, especially to understand the impact of social class, age, racial, ethnic, family and religious background of a patient in the therapeutic relationship.

There are numerous changes within our society

Figure 1. Society-culture-personality (SCP) and the healthcare institution



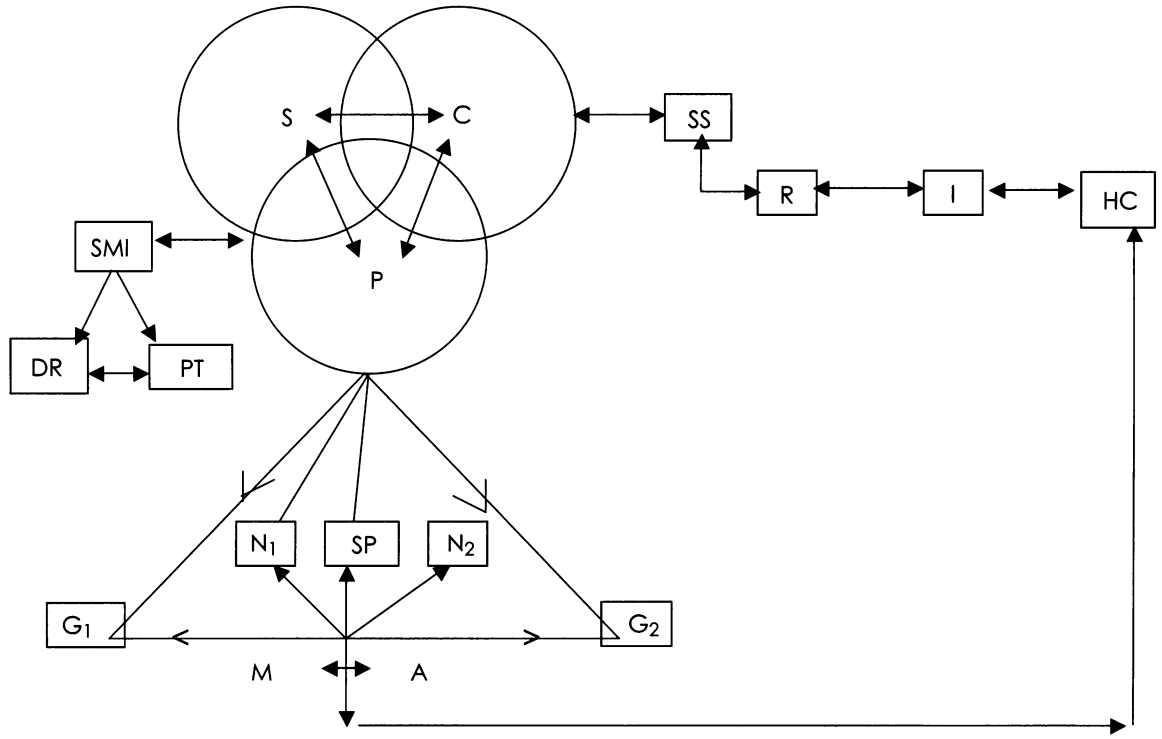
SCP: global village, S: society, C: culture, P: personality, N_1: nature or heredity, N_2: nurture or environment, G_1: Gemeinschaft, SP: socialization process, G_2: Gesellschaft, M: marginality, A: anomie, SS: social systems, R: role, I: institution, HC: healthcare, SMI: social meaningful interaction

that impact the patient–physician relationship. Managed care emerged, in part, as a proposed solution to rising healthcare costs and to improving the provision of healthcare. However, much has been written regarding patient and physician discontent. When physicians occupy the position of gatekeeper, they often experience a loss of autonomy and flexibility, as well as conflict between patient autonomy and third-party interests. Physician satisfaction is associated with quality of care and patient satisfaction. A recent physician survey found that many physicians believe managed care has "significant negative effects on the patient–physician relationship, the ability to carry out ethical obligations, and on the quality of patient care."[13] London found the most consistent and predictive factors of physician satisfaction is their ability to provide high-quality care, obtain needed outpatient and inpatient services, have adequate time with patients and the freedom to make clinical decisions.[14]

Perhaps the hospitalist movement and the creation of concierge medicine are two proposed solutions, though on opposite ends of the spectrum, to increasing physician discontent with the changing practice environment. Hospitalists and VIP doctors both tout their ability to spend more time with their patients. While critics of the hospitalists state this model of care fragments the patient–physician relationship, and critics of the VIP doctors oppose increasing the already present gap between the "haves" and the "have nots" in access to healthcare.

From a physician's perspective, raising healthcare costs often place physicians "between the ethic of individual loyalty to patients and pressure to use clinical methods and judgment for social purposes and on behalf of third parties."[15] From a patient's perspective, raising healthcare costs can stress the patient–physician relationship. One example is the increasing costs of medications. A recent study revealed that 35% of those patients who avoided medications owing to cost never discussed it with their physicians. Of those, 66% of the physicians did not ask about their patient's ability to pay for prescriptions. When patients and physicians talked about medication costs, 72% of the patients found those conversations helpful (e.g., change to generic drugs, referral to assistance programs, free samples, etc).[16] Federman concludes, "when doctors don't ask and patients don't tell, opportunities to help are missed and patients remain at risk for understanding

Figure 2. Social-Meaningful-Interaction (SMI) and the patient–physician relationship in the Healthcare institution



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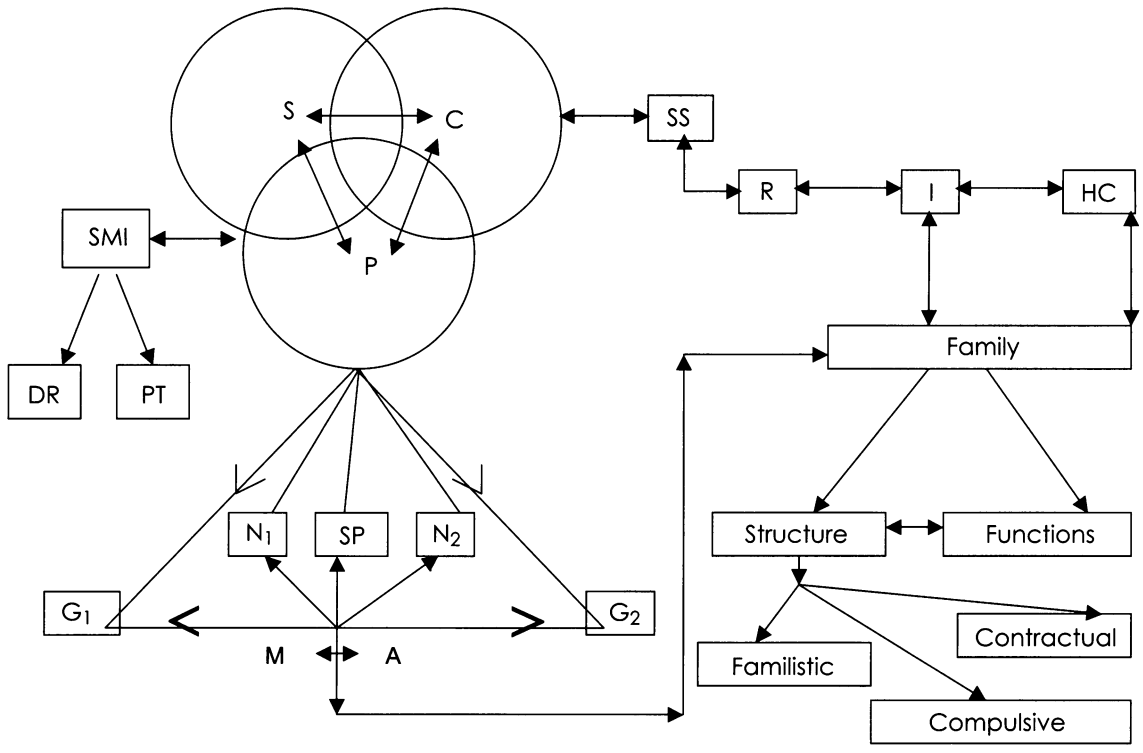
medications and services."[17]

The expansion of consumerism in areas of direct-to-consumer advertising (DTCA), health information on the Internet and e-mail, and use of CAM are further societal changes that may impact the patient–physician relationship. Not surprisingly, many physicians have negative views towards DTCA, but only 29% of patients felt it had a positive effect on their healthcare.[18,19] On the other hand, use of health information on the Internet is widespread (30–40% of surveyed adults) and viewed by patients to have a more positive than negative effect on the patient–physician relationship.[20,21] When patients brought healthcare information to their physicians (almost 1/4 patients who obtained such information and sought physician advice), a worsened relationship ensued if physicians were perceived as having poor communication skills and feeling that their authority was challenged.[20] Increasingly, e-mail is an additional forum for communication between patients and physicians. Though with many attributes (e.g., time efficiency, improved physician accessibility and enhanced patient narratives), it is fraught with legal and ethical implications (e.g., patient confidentiality, informed consent, legal documentation and licensing/regulatory oversight).[22] The growth of consumerism and frustration with the traditional western approach to medicine is perhaps best exemplified by the use of CAM. Many individuals seek CAM therapy (≥25% of those surveyed), but few physicians feel comfortable discussing CAM with their patients and most (84%) thought they needed more education to address patient concerns.[23]

Finally, a disturbing trend that threatens the patient–physician relationship is litigation. Unfortunately, rising malpractice insurance costs and the urgent need for tort reform is pushing many physicians out of their current specialty and practice area, leaving many communities without access to healthcare. In fact, this crisis is the American Medical Association's major focus right now. Medical errors are commonplace and, when they do occur, how physicians communicate with their patients is the number-one predictor of a malpractice claim. Rather than practicing defensively, physicians need to be more open, honest and empathic when errors occur. Patients desire information regarding an error's cause, consequences and future prevention. Physicians have the opportunity to maintain the trust and integrity of the relationship by stating that an error

Figure 3. The family and the patient–physician relationship in the healthcare institution



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occurred, by explaining why the error occurred and, most importantly, an apology for the error with emotional support.[24-26]

Culture (Figure 1) "is a process by which ordinary activities acquire emotional and moral meaning for participants ... (that) is inextricably caught up with economic, political, psychological and biologic conditions."[27] From a historical perspective, several landmark cultural studies observed relationships between age of patient and size of family to the number of symptom complaints;[28] level of social class directly related to seeking physician advice for complaints;[29] Caucasian Americans preferred modern science and hospitalization, while Spanish-speaking Americans relied heavily on family care and support as well as folk medicine;[30] and Zborowski observed differences toward pain among Italian, Jewish and "old American" patients.[31]

Physicians must become "culturally competent" to deliver high-quality care to all patients.[32] Within the American culture, class and race are important predictors of health, although it is often difficult to separate the individual effects of each factor.[33] Specifically, level of education and wealth are determinants of socioeconomic status and related to mortality and morbidity.[33] Within the African-American population, age, gender, poverty and rural residence correlate to healthcare utilization, but the strongest modifiable predictor of utilization is health insurance and/or a usual source of care.[34] Specific to the patient–physician relationship, African Americans are less trusting of their physicians than white Americans.[35] When there is racial and gender concordance in the patient–physician relationship, patients perceive the interaction as more participatory in decision-making (PDM) and with greater satisfaction.[36-39] When PDM was assessed by three questions towards the propensity of physicians to involve patients in treatment decisions, the data suggest "that all patients prefer participatory visits, as patient satisfaction was highly associated with PDM score for all patients in all ethnic groups."[36] An additional, and often forgotten, aspect of the patient–physician relationship is the importance of addressing the patient's spiritual and religious beliefs especially at the end of life. A recent study revealed that 90% of patients believe in the power of prayer, 45% said their religious beliefs would influence medical decisions and 95% of those individuals want to discuss it with their physician.[40]

In short, within the patient–physician relationship, personal definitions of and responses to health, disease and pain are molded by the sociocultural context of the patients in which they occur (Figure 1). We shall now reexamine the patient–physician relationship in terms of social meaningful interactions, roles and communication of the patient (Figure 2).

Social Meaningful Interaction Model and the Patient–Physician Relationship

Any reexamination of the patient–physician relationship must come to grips with the ramifications of Social Meaningful Interaction (SMI) and its intended and unintended consequences (Figure 2). Human interaction occurs whenever human beings respond to the actions of other human beings. Any communication of meaning by speech, writing, gesture or other medium is human interaction. Before SCP can become functional as an interlocking system, a catalyst or agent is necessary. That catalyst is socially meaningful interaction (SMI). Prerequisites for SMI are social contact and communication, Figure 2.[12] Thus, the quality of socially meaningful interaction will determine to a great extent the effectiveness of healthcare delivery since it has significant impact on diagnosis, treatment and outcome of patient care.

Within the patient–physician relationship, physicians must be aware that within the SMI process certain features surround the role of the sick person. From a historical perspective, Parsons outlined four aspects to the sick role of patients.[41] First, sick persons are exempted from their normal responsibilities, depending upon the seriousness of their illness. Second, sick persons cannot help themselves and must be cared for by others. Third, the sick role is viewed as a misfortune; hence, it is assumed that the sick person will want to get well, and is under an actual obligation to do so. Finally, there is an obligation of the sick person to seek competent help, usually from a physician, and to cooperate with the professional in getting well.

The current framework for the patient–physician relationship within the SMI process is the PDM model. The goal of this model is to improve patient understanding, involvement in decisions and outcomes. Within this model, SMI is best described as "the physician's 'bedside manner' (as) a truthful, expression of caring, kindness, understanding and encouragement. The good doctor cares about the well-being and feelings of the patient, and the patient knows. Doctors' words and actions leads their patients to see them as trustworthy, reliable, caring, communicative, a listener and available."[42] Branch asks, "Is the therapeutic nature of the patient–physician relationship being undermined?" To summarize his response, the ideals of empathy, trustworthiness and supportiveness are crucial to protect key elements of this relationship.[43] Further, physicians need to detect and address the patient's unvoiced desires. Half of all visits in primary care included one or more clues (direct or indirect comments about personal aspects of their lives or their emotions) during conversations with their physicians.[44] Nearly 10% of all patients had "something they wanted to ask of their physicians but did not."[45]

Specific steps in a PDM model have been proposed: 1) understand the patient's experience and expectations, 2) build the partnership by empathy and trustworthiness, 3) educate on the evidence and uncertainties, 4) present the recommendations, and 5) check for understanding and agreement.[46] Since the average physician visit is between 15–20 minutes, physicians have a difficult task. However, when medical students are taught the human dimensions of care and motivational/communication techniques, research shows that patient care and satisfaction is improved.[47-49] The PDM model is "an attitude essential for all physicians (and all other health professionals) is respect for each person who seeks our help and each colleague with whom we work: a recognition that each patient is the moral and ethical equal to me."[50]

In short, the analysis of SMI (Figure 2) in the patient–physician relationship is the concept of empathy. Empathy requires the medical student to enter imaginatively into the mind of the patient in order to feel as he or she feels—to understand as he or she understands. The "understanding" concept comes from the Weberian analysis of Verstehen. It has been asserted that "empathy implies understanding the patient's responses to his or her illness...and three responses most important are anger, fear or anxiety, and hope. It is important that the physician comprehend the full depth and breadth of these responses, and weigh every word and action with this understanding in caring for the patient."[51]

Finally, it is important for physicians to put into practice the words of Lesley B. Heafitz, who noted, "empathy is the key to a good patient–physician relationship. Empathy, for the physician, means the ability to experience the illness with the patient, from the inside out, so to speak, feeling and seeing it through the patient's eyes. Empathy is a gift. For some, it is inborn; for others, it is learned from the best teachers; and for still others, it is acquired by actually being a patient. This was my case."[51]

Family and the Patient–Physician Relationship

There is no human society in which some form of family does not exist.[12] The family is the most permanent of all social institutions and fundamental to the socialization process of the individual (N_2). The family is related to health by the fact of biological inheritance (N_1) (Figure 3). It has been asserted, "the family is the unit of medical care because it is the unit of living."[52] The sick role, health behavior and illness behavior are all developed in the socialization process in which the family is the most basic socializing agency in any society. In the patient–physician relationship, the physician should be cognizant of the fact that it makes a difference whether the patient's family is dependent (seeks societal resources for survival) or nondependent (does not seek resources for survival) (Figure 3).

An important role of the family in the patient–physician relationship is in the care at the end of life. Though many physicians are often uncomfortable discussing death and dying with their patients and families and feel such discussions would be too difficult emotionally and thus ineffective for the patient and family, a recent study has shown that the reverse is true. Almost 90% of caregivers (i.e., the family) felt such discussions were not stressful, and nearly 20% found them helpful.[53] The burden of care-giving on the family is often substantial. Family members who are themselves elderly, ill and disabled often perform care-giving. It can be the equivalent of a full-time job for 20% of caregivers and result in further financial burden. Yearly U.S. costs can range from $3–6 billion dollars.[54]

These stressors often lead families to seek long-term care placement. Several patient and caregiver characteristics are predictors of future placement. Older caregivers (> 65 years of age) feeling a greater sense of burden are more likely to have their loved one in a long-term care facility.[55] While many caregivers experience depressive and anxiety symptoms (15–20%) prior to long-term care placement, these symptoms did not change after placement, especially for spouses.[56] Two recent studies found that caregivers often experience relief after the death of a loved one, when it was preceded by prolonged suffering and significant caregiver burden.[57,58] One study suggests that, in addition to the known risk of psychiatric morbidity of care-giving, the risk of caregiver death is 60% higher than noncaregiver controls.[59] In recognizing the burden of care-giving, Rabow et al. recently proposed five areas of opportunities for physicians to be of service to the family: a) promote communication, b) promote advance care planning and PDM, c) support home care, d) demonstrate empathy for patients and their family, and e) participate in family grief and bereavement. In providing compassion and empathy, physicians have much to offer to patients and their family (Figure 3).

CONCLUSION

We have reexamined some select concepts in the patient–physician relationship so that physicians in the new millennium can utilize them. We have focused upon the impact of SCP (Figure 1), SMI (Figure 2) and the institution of the family (Figure 3) upon the patient–physician relationship. It is hoped that present and future physicians will internalize and make use of these select concepts in their future roles as physicians. In the SCP model, we have noted the impact of the patient–physician relationship upon social class, age, race, ethnicity and family back-

ground of a patient. In the SMI process, we have noted the profound impact of empathy on the patient–physician relationship. With regard to the institution of the family, we have asserted that the family is the unit of health because it is the unit of living. Thus, the family is related to health by the part of biological inheritance and through nurturing.

Implicit in our analysis of this paper is the focus that future medical students integrate, synthesize, and actualize values and virtues such as empathy, caring and understanding with a deep commitment to self-reflection so they can deliver care that involves the ingredients of quality, affordability, availability, accessibility and continuity for their patients. If these values are taught constructively and well, then medical students will be able to transmit the traditions of excellence, dedication and creativity of the healthcare profession. On balance, it is essential that physicians recognize the implications of the SCP system for the prognosis, treatment and diagnoses of a patient in the patient–physician relationship. To be understood properly, beliefs and attitudes toward health and illness must be examined in a societal and cultural context. Since these beliefs and attitudes are strongly ingrained in each patient, the medical student must learn to utilize his or her knowledge of cultural variations in a patient's perception of health and illness in order for care to be effective. Such a concern for care epitomizes the dictum promulgated by Professor Francis Weld Peabody of Harvard Medical School—namely, "the secret of the care of the patient is in the caring for the patient."[60]

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