Articles

The Role of the Physician in the Emerging Health Care Environment

M. ROBIN DiMATTEO, PhD, *Riverside, California*

What do patients want from their physicians? This article reviews research on the role of the physician attained through surveys of the public and of physicians. The results from the two groups are surprisingly similar; communication is seen as an essential component of the physician's role. Further, we found that the public's ratings of the medical profession depend heavily on their experience with personal physicians. This paper reviews previous research on the importance of effective communication to patient satisfaction, adherence, and the outcomes of treatment, and it considers ways in which physician-patient communication is being affected by recent changes in the health care system. Suggestions for medical education and for the structure of primary and specialty patient care are offered.

(DiMatteo MR. The role of the physician in the emerging health care environment. West J Med 1998; 168:328–333)

National and international surveys conducted in the early 1990s have suggested that Americans are less than enthusiastic about their health care system. The US has the highest level of health care spending per person in the world, but it reports the lowest level of health care system satisfaction.[1] In one survey, only one-quarter of Americans responded that the health care system works even reasonably well.[2] Another survey pointed to significant dissatisfaction, with over 70% of respondents rating the American health care system as fair or poor.[3]

In contrast to these findings, fully 88% of surveyed Americans are satisfied with the quality of care they receive from their own personal physicians.[2] Individual practitioners are generally rated higher than the profession they represent. Research attempting to resolve these apparently contradictory findings has provided some insights into what Americans want and need from their physicians and how they view physicians' roles. One study simultaneously surveyed Americans' evaluations of the health care system, the profession of medicine, and their personal physicians.[3] The majority of respondents had only a moderate amount of confidence in the medical profession, with less than 30% expressing a great deal of trust or confidence in doctors in general. Most respondents, however, rated their own personal physicians quite high. Furthermore, there was a significant positive relationship between ratings of the medical profession and ratings of personal physicians. Respondents who had the most confidence and trust in their own doctors gave the highest ratings to the medical profession. This research suggests the possibility that Americans' feelings about the profession of medicine may be influenced strongly by their relationships with their own personal physicians and by the quality of the interactions they have with them.

In our research on public perceptions of physicians' roles, we examined what people want from physicians.[4] In a nationwide random sampling of respondents, questions were asked about the expected role of the physician in caring for patients, and respondents were asked to evaluate the performance of their own personal physicians.

This work began in the early 1990s, when The Pew Health Professions Commission developed 17 practitioner competencies reflecting a shifting trend in medical care toward a more community-based approach. In this approach, patients are expected to be more active in their health care, and issues of cost are taken into consideration when making treatment decisions. For medical education to reflect the perceived needs of communities, it was deemed imperative to identify which physician competencies would be considered to be most important by patients. In spring of 1991, a Harris survey examined the importance of various competencies to medical practitioners.[5,6] In 1992, a nationwide survey of households was conducted. Of the 640 respondents, 63% were women and the average age was 42.6 years. Respondents were asked what they thought about the importance of seven of the previously developed competencies.[4] The following competencies were studied: diagnosing and treating illness, communicating with the patient, conducting practices ethically, cooperating with other health

From the Psychology Department, University of California, Riverside, California.
Reprint requests to M. Robin DiMatteo, PhD, Professor of Psychology, University of California, Riverside, CA 92521.

professionals, promoting preventive care, using technology correctly, and considering costs to the patient.

While all of these competencies were rated as important, three received the highest ratings: diagnosis and treatment, communication, and ethical conduct. When respondents to the survey rated their own physicians, however, those physicians were, for the most part, not rated highest on these components of care. Physicians received their highest ratings on ethical conduct and cooperation with other health professionals, but they received their lowest ratings on communication with patients and on consideration of the cost of treatment to patients. Note, then, that although respondents considered communication to be one of the three most important skills for physicians to have, they rated their own physicians lowest on communication in comparison to other skills. The physician's age and gender did not affect ratings, nor did the congruence or lack of congruence between physician and patient gender. It was also found that patients' and physicians' ratings were nearly identical, suggesting that in the role of the physician, patients and physicians value the same things.[5,6]

There are several important implications of these findings. Respondents saw their physicians as most lacking in communication skills and in sensitivity to the costs of treatment for patients. Because respondents' evaluations of the entire medical profession were strongly influenced by their associations with and the quality of care provided by their physicians, the importance of individual providers' attention to communication and the cost of care to patients appears to be paramount. Finally, this research did not find that patients enrolled in health maintenance organizations (HMOs) were any less or any more satisfied with any aspect of the care they were receiving than those not enrolled in HMOs.

Research on physicians' and patients' views of the physician's role suggests that there is considerable congruence. Physicians' beliefs about what matters in patient care are very similar to patients' beliefs: technical skill, ethical conduct, and effective communication are important, and attention to the cost implications for patients is critical. There is a discrepancy, however, between what is important to a patient and how well their physicians are fulfilling their needs. Communication, attention, and sensitivity to cost are important to patients but tend not to be highly characteristic of their physicians.

These findings suggest some important implications for medical education. Certain skills of effective communication are necessary for good medical care, and there should be clear focus on and attention to this arena at all levels of medical education—from premedical preparation to continuing medical education for physicians in practice. Physicians will need adaptive skills in a broad spectrum of areas, particularly in communication. From the maintenance of practice to the prevention of disease to the enhancement of patients' treatment outcomes, communication is essential to the effective delivery of health care.

The Role of Effective Communication

Based on over three decades of social science research about physician-patient interaction, there is considerable evidence for the importance of effective communication in medical practice. Most medical care in the United States takes place in, or is initiated from, the private consultation between physician and patient. Limitations in communication, however, often prevent patients' access to essential medical and preventive health information, active participation in health care decisions, and appropriate adherence to medical recommendations.

What is known about the medical visit is based on research that has involved recording (by standardized observation, audiotape, or videotape) and painstakingly analyzing thousands of medical care visits. This research demonstrates that physician-patient communication is sometimes so poor that half of patients leave their doctors' offices not knowing what they have been told and what they are supposed to do to take care of themselves.[7] Physicians often use medical terms that patients do not understand, and patients may be too intimidated and lack sufficient skill to articulate their questions. Although most diagnoses in primary care medicine can be made by taking a complete history and listening to what patients have to say, research shows that physicians spend very little time listening to their patients and limit patients' transmittal of information.[7]

More than 90% of patients highly value having as much information as possible from their physicians and want to know about potential risks and alternatives to treatment recommendations. Such information, however, is often not forthcoming from their physicians.[8,9] In one study, analyses of medical visits that averaged 20 minutes found that less than one minute was spent giving patients any information at all.[10] Observations of physician-patient interactions show that physicians often discourage voicing of concerns and expectations, as well as requests for information.[11] The influence of physicians' behavior and the character of the physician-patient relationship make it extremely difficult for patients to assert their needs for information and explanations. Disempowered, they may be unable to achieve their health goals. Further, poor communication compromises the confidence that Americans have in the medical profession.

Lack of sufficient explanation, poor patient understanding, and lack of consensus between physician and patient lead to therapeutic failure. An average of 40% of patients in the US fail to adhere to the recommendations they have received from their physicians for appropriate care, a serious problem known in the medical literature as "patient noncompliance." Noncompliance consists of such actions as failing to take antibiotics correctly, forgetting to take hypertension medication, and continuing dangerous and unhealthy lifestyles.[12] By failing to adhere, many patients become sicker; their physicians change their treatments (such as increasing drug dosages) and are misled about the correct diagnosis. The time and money spent on the medical visit can be wasted when communication is ineffective.

Recent Changes in the Role of the Physician

Over the past several decades, there has been considerable interest among social scientists in examining the roles of physicians and patients compared to one another. In the 1950s, sociologist Talcott Parsons argued that physician authority was paramount in making decisions about patients' lives.[13] Such authority was acceptable to Americans in light of the post–World War II explosion of medical effectiveness, and medicine was seen as a "miracle-working" profession. Few patients questioned or challenged their physicians (and their cohorts, who are now elderly, continue to defer to physician authority more than other age groups). By the 1970s, many patients began to see themselves as consumers and challenge physician authority, insisting on self-determination.[14] Some have turned completely from medicine to alternative practitioners. By some estimates, fully one-third of the US population uses alternative health practitioners instead of or in addition to allopathic physicians for the treatment of (most often) chronic ailments.[15] Patients cite the effectiveness of alternative practitioners' communication, their understanding of patients as people, and their focus on the quality of life as some of the most important reasons for seeking alternative health care.

The consumer orientation in the United States fostered a general awareness of the importance of patients' involvement in issues of their own health and health care. For all the potential effectiveness of medicine, the absence of patient involvement has contributed to poor medical decisions in which patients have been exposed to treatments that failed to meet their needs or that were associated with more risk of harm than potential benefit. Studies consistently show that the best medical outcomes occur when patients are fully informed and involved in decisions about their care—in which they are educated and active consumers. Involved patients are also more adherent to medical recommendations that have been jointly decided on, and they are more responsible for their health-related behaviors (such as exercise, smoking cessation, and dietary modification).[16]

A prominent issue in the new era of managed care is that of the erosion of trust in the physician-patient relationship.[17] Recent changes in the physician's role in response to the requirements of managed care payers are potentially problematic for the physician-patient relationship. Many physicians and patients complain that their time together is more limited than ever, and at worst, patients see their physicians as agents of a bureaucracy, intent on withholding care for the sake of financial profit. In such an environment, building trust is a significant challenge. Given the central role of trust in the physician-patient relationship, it is more important than ever to train physicians to build trusting relationships with their patients through concern with the patient as a person, emphasis on the patient's quality of life, collaborative decision making, partnering between physician and patient, and supportive verbal and nonverbal communication.

The managed care revolution can, in another way, present a potential opportunity to have a positive and lasting impact on the way that medicine is practiced and care is provided for patients. In fee-for-service structures, physicians are reimbursed for doing things to patients—that is, providing services such as treatments, diagnostic tests, and surgeries. Physician-patient verbal communication is not reimbursed and runs the risk of being dispensed with entirely. In the ideal managed care environment, the goal is to keep patients healthy while reducing the cost of services. This is a goal that can be accomplished with efficient, effective communication in such realms as history-taking and patient instruction and by modifying patient lifestyle. Quality communication between physician and patient is likely to result in greater patient responsibility and adherence, earlier detection of problems, better prevention of medical crises and expensive intervention, higher quality outcomes, and overall lower costs of care.

The Physician's Role in an Emerging Health Care System

Before suggesting an assignment of roles to any one health professional, it will be helpful to examine the necessary elements of providing effective care to patients. Responsibility for the various elements can be divided among primary care physicians, specialists, and ancillary health care providers in many possible configurations. More important than the assignment of individual duties is the recognition that certain elements of patient care are essential to effective treatment, and that these elements might best be provided by a health care *team* that is working together in an effective manner.

The provision of health care ranges from primary prevention to the management of terminal illness, with considerable range between the extremes. When a patient is in good health, preventive life style adjustments (smoking cessation, low-fat diet, sun-screen and safety-belt use, etc.) are centrally important elements of care. As health professionals learn about a patient's psychological functioning, life experiences, and current life situation, more effective behavioral methods can be instituted to assist the patient in establishing a health-promoting life style. Screening (such as a regular mammography) also requires an effective therapeutic relationship, helping the patient to be adherent and committed to regular follow-up.

When the patient presents with a troublesome symptom, ideally a relationship has been established between health care professional and patient so that the health care professional can assess the symptoms in context. What is the patient's habitual response to pain? Is emotional distress at the root of the complaint, or is the patient typically stoic, suggesting a potentially serious problem? Knowing something about a patient's usual style of functioning can be essential in assessing his or her condition, taking an effective history, and establishing possibilities for diagnosis.[18] Open discussion, frankness in the patient's expression of concerns, acceptance,

and support by the physician are critical to the provision of quality medical care.

Recommendations for treatment must develop from collaborative discussion between physician and patient, taking into account not only the patient's physical findings but also his or her expectations, outcome preferences, level of acceptance of risk, and costs associated with the treatment recommendation. These costs encompass not only monetary charges, but interference with daily responsibilities such as work and child care as well as symbolic features such as assaults to the patient's sense of self. Choices among care options need to be made collaboratively between a health care professional and his or her patient to maximize patient adherence and to assure the best outcomes for the patient's quality of life.[19]

When the patient has a serious illness, choices about the management of that condition should depend upon the patient's and the family's values. Choices regarding end-of-life decisions would ideally generate from discussion among the physician, the patient, and the family. Health care professionals closest to the family would be the ideal facilitators of the decisions and coordinators of the care delivered by specialists. A critically important element of medical practice involves coordinating all elements of care delivered to the patient to ensure that, for example, diagnostic tests are not unnecessarily repeated, appropriate choices are made regarding home care, the patient's dignity is maintained, and the family is able to provide effective support and to be supported themselves. This element of care would involve the availability of a "clearinghouse" for information to the patient and his or her family and translation of recommendations by specialists into "quality of life" terms to which patients and their families can relate. A knowledgeable, supportive physician needs to be an advocate for the patient and family in choices among various avenues for treatment by emphasizing patient preferences and expectations and by guarding the patient's quality of life, autonomy, and dignity.

Certainly, no one health care professional can fulfill all necessary elements of the health care role outlined above. These elements require a health care team, composed of physicians and allied health professionals. Of course, because teamwork is not acquired naturally, support from experts on team-building and organizational facilitation may be needed. A critically important role of the primary care physician and staff is to build the kind of team that can provide the comprehensiveness of care described above.

The role of the specialty physician should be defined not so much in terms of training and specialty identification, but rather in terms of function with the patient. One model for a physician who is trained as a specialist might be to carry out the activities and roles identified above in terms of fully caring for the patient as a person with, perhaps, additional emphasis on a particular chronic and possibly debilitating condition. A second model might instead involve the specialist as a consultant to the primary care physician, solving the more complex, specialized clinical puzzles in the care of the patient and leaving the more comprehensive care of the patient as a person to the primary care team. The specialist in this second model would have access to the latest technical knowledge and expertise and would educate the primary care physician in long-term maintenance and care of the patient within the guidelines for total patient care outlined above. The specialist operating in this second model would provide input regarding the complex quality of life decisions made by the primary care physician in collaboration with the patient. After decisions are made that take into account the complexities of patients' lives, values, and preferences, the specialist may act to implement these interventions (surgery, for example). In the second model, the specialty physician also needs to develop strong skills for communicating with patients, patients' families, and other medical professionals. One would expect, however, that in this second model, the specialist can rely on some of the skills of the primary medical team and thus concentrate somewhat more on the very technical aspects of medicine.

It should be recognized that dealing effectively with the psychosocial complexities of patient care is as much a scientific undertaking as any other intervention in medical care. Effective choices about communicating with patients, making collaborative decisions, and assessing and promoting quality of life need to be based upon scientific research and empirical inquiry, just as choices of medications and technical procedures are.

Ideally, there should be many scientific and research aspects to the physician's role. A physician should think and act as a scientist, formulating hypotheses regarding each clinical puzzle that is faced, collecting unbiased data, and sorting through these data in light of the massive scientific medical literature. Unfortunately, the exigencies of community medical practice challenge the implementation of such a scientific approach. Community (nonacademy based) medical practice may become based more upon habit and community standards and as such may lead to inappropriate use of services.[20] Ideally, when making clinical decisions, practicing physicians will be consulting databases that do the following: guide them through the literature; summarize clinical appropriateness parameters; help with the complexities of decision making; summarize the latest unpublished findings, ongoing research programs, and clinical trials; provide training in human behavior, including patient adherence, preventive medicine, and life style modification; and provide extensive patient education materials. Such databases could be developed from corporate and academic partnerships, and use in community medical practices would ideally be widespread.

Communication within medical teams and communication with patients can be enhanced by the use of communication specialists, who train physicians and provide them with valuable tools for effective information management and exchange, trust and relationship building, optimization of clinical reasoning, and avoidance of cogitive biases in decision making. Physicians' skills in

diagnosis and treatment and their practices in general can benefit enormously from training in communication and caring for the patient as a whole person. Furthermore, the therapeutic relationship often requires physician training in cultural awareness and sensitivity. Physicians should ideally be proficient in at least one language in addition to English, and should be well versed in relevant cultural issues.

The Role of University-based Medical Education Centers in Medical Practice

The strongest possible argument can be made for the active involvement of university-based medical education centers in effecting changes in the roles of physicians and the practice of medicine. Research and clinical faculty of these universities should function actively as opinion leaders in the wide geographic areas in which they are located. Their faculty should be actively involved in guiding the establishment of and adherence to parameters of practice in medical communities by means of professional societies and as medical leaders in managed care organizations. Standards of practice at university medical centers should be promoted as the standards of practice for area communities; these standards should include not only diagnostic and treatment measures but also such patient-centered issues as quality of life assessment, communication, effective decision analysis, and end-of-life care. There should be a very strong presence of the university medical centers in continuing medical education. Faculty should develop research collaborations with traditionally influential entities such as pharmaceutical corporations, maintaining their intellectual autonomy but having an appreciable influence on the practice of medicine nationally.

In sum, faculty whose research and practice contribute to the understanding of the practice of medicine in its broadest form should not remain in an "ivory tower;" rather, they should maintain significant visibility in the community of medical practice.

Medical Education

Medical education has traditionally emphasized physician authority and strictly deemphasized patient autonomy. This should change. Studies of physician training have found that medical students' skills related to talking with patients actually decline as their medical education progresses, and, over time, physicians-in-training tend to lose their grasp on their patients' total picture of health.[21] Furthermore, the emotional and physical brutality of medical training, particularly during internship and residency, fosters at best the suppression of empathy for patients and the substitution of technique and procedure for talk, and at worst bad feelings for and derision of patients.[22]

Changes in medical education are necessary to produce physicians capable of fulfilling the complex roles demanded of them in today's health care environment. First of all, there should be serious consideration of training models such as the "New Pathway" program at Harvard University, in which diagnosis and treatment are taught within the context of patient problems, and medical students are taught throughout their four years to treat patients in the context of patients' lifestyles, families, jobs, cultures, and social systems. Such a program needs to have an emphasis on effective communication, social skills training, language fluency, and cultural awareness. Short of a complete change in the structure of training, considerable curriculum development time should be devoted to psychosocial issues in medical practice (for example, trust and relationship building, patient adherence, stress, coping, challenges of serious illness, death, and dying). Medical training (whether for primary care or specialty training) should incorporate three things at all levels and in all aspects of learning: an unambiguous emphasis on the patient as a person, and as an autonomous and equal participant in medical decisions; training of the highest quality in effective communication with patients and in the recognition and effective management of the psychosocial aspects of patient care, and a clear and unambiguous focus on the physical and emotional well-being of physicians-in-training. Physicians-in-training should have taught to them, and modeled for them, a collaborative approach to patient care, with respect for the human body, mind, and spirit.

Conclusion

The role of physicians in today's health care environment is changing in some predictable ways. It has been known for decades that communication and care of the patient as a person are essential elements to achieving good health care outcomes. Collaborative decision making, with physicians and patients participating as partners, is becoming clearly essential to the achievement of patients' goals and the attainment of life, to the extent possible, as the patient would prefer to live it.

Surveys tell us that patients want physicians who can skillfully diagnose and treat their sicknesses as well as communicate with them effectively. Research clearly demonstrates that effective communication is indispensible to successful diagnosis and treatment. Furthermore, patients want their personal values and preferences to be respected, and they want to be active participants in their health care.

It is essential that medical education produce physicians who can deal effectively with a broad range of psychosocial issues presented to them in patient care. In addition to recommendations for screening and primary prevention, physicians need to help patients to modify their behavior, make choices among multiple care alternatives, and cope with deteriorations in their health status, as well as the "challenges to meaning" that those events entail.

There is evidence from research that such expansion of the physician's role can result in some startlingly positive outcomes. In various studies, patients have been

given information, trained in the skills necessary to request information during the medical visit, and taught to negotiate solutions with their physicians and take responsibility for decisions about their own care.[23] In other studies, the structure of the medical interaction has been arranged to force communication and joint decision making (such as having patients and their physicians coauthor medical charts).[24] The results of these interventions show that patients have become much more active, asked more questions, been more satisfied with their care, had much greater alleviation of their symptoms and have more improvement in their overall medical conditions, less distress and concern about their illnesses, greater sense of control over their health and their lives, better adherence to (the jointly decided-on) treatment, and more positive expectations for their health.

Acknowledgment

The author would like to acknowledge the support of the Center for Ideas and Society at the University of California, Riverside, and the Office of the President at the University of California.

REFERENCES

1. Blendon RJ, Leitman, R, Morrison I, Donelan K. Satisfaction with health systems in ten nations. Health Aff 1990; 9:185–192

2. Jajich-Toth C, Roper BW. Americans' views on health care: a study in contradictions. Health Aff 1990; 9:149-157

3. DiMatteo MR, Shugars DA, McBride CA, O'Neil EH. Americans' views of health professionals and the health care system. Health Values 1995; 19:23–29

4. McBride CA, Shugars DA, DiMatteo MR, Lepper HS, O'Neil EH, Damush TM. The physician's role: views of the public and the profession on seven aspects of patient care. Arch Fam Med 1994; 3:948–953

5. Shugars DA, O'Neil EH, Bader JD. Survey of Practitioners' Perceptions of their Education. Durham, NC: The Pew Health Professions Commission, 1991

6. Shugars DA, Vernon TM, Richardson WC, O'Neil EH, Bader JD. Is health professions education part of the solution? Health Aff 1991; 10:280–282

7. DiMatteo MR. The Psychology of Health, Illness, and Medical Care: An Individual Perspective. Pacific Grove, CA: Brooks Cole, 1991, pp 185–223

8. Mazur DJ, Hickam DH. Patients' preferences for risk disclosure and role in decision making for invasive medical procedures. J Gen Intern Med 1997; 12:114–117

9. Wu WC, Pearlman RA. Consent in medical decision making: the role of communication. J Gen Intern Med 1988; 3:9–14

10. Waitzkin H, Stoeckle JD. Information control and the micropolitics of health care: summary of an ongoing research project. Soc Sci Med 1976; 10:263–276

11. West C. Routine complications: troubles with talk between doctors and patients. Bloomington, IN: Indiana University Press, 1984

12. DiMatteo MR. Adherence. *In* Feldman MD, Christensen JF (Ed): Behavioral Medicine in Primary Care: A Practical Guide. Stamford, CT: Appleton & Lange, 1997, pp 136–140

13. Parsons T. The Social System. New York, NY: Free Press, 1951

14. Haug MR, Lavin B. Consumerism in medicine: challenging physician authority. Beverly Hills, CA: Sage, 1983

15. Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL. Unconventional medicine in the United States: prevalence, costs, and patterns of use. N Engl J Med 1993; 328:246–252

16. DiMatteo MR. Health behaviors and care decisions: an overview of professional-patient communication. *In* Gochman D (Ed): Handbook of Health Behavior Research II: Provider Determinants. New York, NY: Plenum, 1997, pp 5–22

17. Mechanic D, Schlesinger M. The impact of managed care on patients' trust in medical care and their physicians. JAMA 1996; 275:1693–1697

18. Cassell EJ. Doctoring: the nature of primary care medicine. New York: Oxford, 1997

19. DiMatteo MR. The physician-patient relationship: effects on the quality of health care. Clin Obstet Gyn 1994; 37:149–161

20. Leape LL, Park RE, Solomon DH, Chassin MR, Kosecoff J, Brook RH. Does inappropriate use explain small-area variations in the use of health care services? JAMA 1990; 263:669–672

21. Helfer RE. An objective comparison of the pediatric interviewing skills of freshman and senior medical students. Pediatrics 1970; 45:623–627

22. Mizrahi T. Getting rid of patients: contradictions in the socialization of physicians. New Brunswick, NJ: Rutgers University Press, 1986

23. Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care: effects on patient outcomes. Ann Intern Med 1985; 102:520–528

24. Fischbach RL, Sionelo-Bayog A, Needle A, DelBanco TL. The patient and practitioner as authors of the medical record. Patient Couns Health Educ 1980; 1:1–5