Virtual Mentor

JOURNAL DISCUSSION
Are There Blueprints for Building a Strong Patient-Physician Relationship?
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Fredericks M, Odiet JA, Miller SI, Fredericks J. Toward a conceptual reexamination of the patient-physician relationship in the healthcare institution for the new millennium. *J Natl Med Assoc*. **2006;98(3):378-385.**

Although much has been written about the patient-physician relationship, perhaps the most fundamental question is whether or not a good relationship even matters, and, if so, what can physicians do to enhance its quality. Fredericks et al. studied the impact of the society, culture and personality (SCP) model, the impact of the socially meaningful interactions (SMI) model, and the institution of the family upon the patient-physician relationship [1]. Their analysis identifies reasons why, ultimately, a good patient-physician relationship does matter.

Fredericks et al. begin by assuming that a good patient-physician relationship is worthwhile only if it positively affects the patient in a meaningful way. Berry et al. documented that patients' trust and commitment to their primary care physician were positively associated with adherence, and that adherence and commitment were both linked to healthy eating behavior [2]. Others have shown that trust in physicians improves outcomes and increases patient satisfaction, compliance with a medical regimen, and adherence to a healthy lifestyle (e.g., healthy eating behavior) [2-10]. These positive effects could be quite substantial, given that about 40 percent of deaths are caused by modifiable behavior, including poor diet, physical inactivity, substance abuse, and poor strategies for coping with stress [2].

Patients look for several characteristics when choosing and developing a good relationship with a physician. Fredericks et al. posit that physician empathy is the most important trait, saying that "the good doctor cares about the well-being and feelings of the patient, and the patient knows" [11]. Berry et al. suggest that the doctor's ability to gain the trust of the patient is most important [2]. Physicians obtain patients' trust and convey respect by listening carefully to them, gaining knowledge about them, explaining issues clearly and forthrightly, and treating them as partners in their own care [2]. Other virtues patients seek include availability, benevolence, compassion, competence, honesty, integrity, knowledge, reliability, respectfulness, sincerity, and understanding. All of these attributes lead Berry et al. to the conclusion that the patient-physician relationship is a key component in the delivery of high-quality health care [2].

Fredericks et al. isolate, operationalize, and interpret major models of the relationship that bear upon the educational practice and decision making of today's physicians [1]. They assert that there is a crisis in the patient-physician relationship, with several contributing stressors—the mass media, managed care, malpractice litigation, medical errors, direct-to-consumer advertising, availability of online health information, e-mail communication between patients and physicians, access to pharmaceuticals online and across U.S. borders, and use of complementary and alternative medicine [1]. Fredericks et al. also mention the effects of escalating health care costs on patients and physicians. Implicit in the managed-care stressor is the diminishing amount of time physicians have to spend with patients. Given that the average physician visit is between 15 to 20 minutes, many patients feel that their doctor is rushing and that they do not have time to ask questions and get answers or describe all of their symptoms and concerns. Together these stressors can contribute to a lack of trust, understanding, and loyalty between a patient and a physician, and they can prompt doctors to become closed, defensive, and dissatisfied in their careers.

Fredericks et al. briefly discuss two proposed solutions—the hospitalist movement and concierge medicine—but then quickly turn to the SCP model and SMI for guiding future improvements. The SCP model assumes that the genetic basis of personality is transformed into the finished product—the adult person—via a learning process in a social environment [1]. In this environment, the value system of a culture is internalized [1]. In other words, each patient's personality develops through a combination of nature and nurture through socially meaningful interactions (SMI). Fredericks and colleagues then submit that "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" [11].

Under the SCP model, several patient factors (social class, age, race, ethnicity, and family background) influence the patient-physician relationship and may also affect health care access, utilization, quality of care, or personal definitions of health [1]. Other factors that are important but were not mentioned as part of the SCP model are gender, environment (urban, suburban, or rural), religious background, and insurance status. Betancourt asserts that physicians must become culturally competent to deliver excellent care [12]. Doing so according to the SCP model involves the physician's taking into account the background and sociocultural context of the patient.

The patient's family also influences the relationship. "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" [13]. Along with instilling health and illness behaviors, families also provide end-of-life care, experience caregiver burdens, and may seek long-term care placement of their relatives. Despite this integral family role, many physicians are reluctant to discuss death and dying with patients and their families. Yet, Emanuel et al. note that close to 90 percent of

caregivers (e.g., the family) felt death and dying discussions were not stressful, and almost 20 percent found them helpful [14].

In response to these multiple influences on illness behavior, Fredericks and colleagues recommend the participatory decision-making (PDM) model—also known as shared decision making—as the framework for the patient-physician relationship. With a goal of improving patient understanding, involvement in decisions, and outcomes, the participatory decision-making model supports patient autonomy and restrains physician paternalism [1]. One study of race, gender, and partnership in the patient-physician relationship concluded that all patients prefer participatory visits; patient satisfaction was tightly correlated with PDM score for all patients, regardless of patient ethnicity [15].

If patients are to participate in decision making, they must have at least a lay person's understanding of the evidence upon which the physician is basing his or her clinical recommendation. Communicating this evidence is not always easy for physicians; using the PDM model requires them to (1) understand the patient's experience and expectations, (2) build the partnership with empathy and trustworthiness, (3) be able to convey the evidence and uncertainties in a way that makes sense to the patient, (4) present the recommendations and the rationale behind them, and (5) check the patient's understanding and agreement [16].

In strong relationships, physicians are able to identify and respond to the patient's unvoiced desires [1]. Half of all primary care visits include one or more clues, and studies show that nearly 10 percent of all patients have something they want to ask their physicians but don't [17, 18]. One topic patients wish their physicians would raise is prescription-drug costs. In one survey, 35 percent of patients who avoided medications because of cost never discussed the topic with their doctors, and in those cases, 66 percent of the physicians did not ask about their patients' ability to pay for prescriptions [19]. When drug costs were discussed, 72 percent of patients found it helpful [19]. Clearly costs associated with health care services and drugs can impact the patient-physician relationship.

Despite its many valuable lessons and insights, the Fredericks et al. article misses several key points. In the brief discussion of medical error, the word "apology" appears once, despite the fact that disclosing errors, offering heartfelt apologies, and providing just compensation have been shown to satisfy patients, reduce litigation, and, in some instances, decrease malpractice premiums [11, 20]. Likewise, Fredericks et al. give insufficient attention to patient counseling, the informed-consent process, and patient preferences in shared decision making. These difficult communication tasks take on greater significance when there is clinical uncertainty, a situation in which the patient's values and attitudes become even more important. One long-standing obstacle to a good patient-physician relationship is the power imbalance between the two parties, yet Fredericks et al. do not suggest how to address this concern.

Obviously, the quality of the patient-physician relationship is critical to outcomes, patient satisfaction, compliance, and the ability to make lifestyle changes. Physicians must be aware of the many stressors inherent in today's U.S. health care delivery system and include the patient's sociocultural and family context in their patient interactions. Physicians should embrace the participatory decision-making model and support the patient's autonomy. Doctors need to be sensitive to the patient's clues and unvoiced desires. When a medical error occurs, there should be prompt disclosure, a heartfelt apology, and fair compensation so that the integrity of the relationship is not derailed by the patient's feeling a need to resort to malpractice litigation. Physicians must be empathic and gain their patient's trust. The key to a good patient-physician relationship was espoused perhaps most simply by Professor Francis Weld Peabody of Harvard Medical School—"the secret of the care of the patient is in the caring for the patient" [21].

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