Improving Physicians' Relationships with Patients

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Managed care physicians express many concerns about difficulties they experience in communicating and relating to patients (Table 1). These concerns are not limited to managed care, but the conditions and arrangements of managed care practices create unique issues. For in daily patient care, physicians encounter an astonishing variety of personalities in their patients, who have perplexing, unpredictable, and fatal illnesses. Serious illness and uncertainty provoke emotional distress in patients and their doctors.¹ The explosion of medical knowledge introduces enormous complexity into medical work and the demands of keeping current are severe. Among the problems doctors face are setting limits, giving complex explanations, working with difficult emotions, managing disagreements, detecting and managing mental illness, discussing end-of-life matters, resolving cultural and racial issues, and talking with patients' relatives.² Unfortunately, physicians seldom approach these and other interviewing problems in a focused or systematic manner, and frequently lack expert communication skills, whether they are generalists or specialists, in managed care settings or not.³

Some of these predicaments are magnified by managed care.^{4,5} Patients may be dissatisfied when they lack a choice of plan or physician.⁶ Often they feel entitled to more than the allowed benefits or misunderstand those limits, and the physician has to bear the bad news when something requested is denied or not covered. Patients are scheduled for increasingly shorter visits without respect to individual physician style or visit complexity. The plan creates ambiguity in the relationship: for whom is the doctor working, and is the plan or the doctor responsible for quality, care, and decision making?⁷ As participants in a seemingly impersonal system, patients worry their confidentiality will be breached. Plans that exclude mental health services may limit the physician's role in situations that patients would like their doctor to handle.^{5,8}

Plan success in the marketplace is critically determined by the relationships between practitioners and their patients. As plans' ability to cut costs vanishes (many plans have cut costs more than they can afford), the major way they can sustain enrollment is to improve

the quality of communications and relationships.⁹ As Cleary and Edgman-Levitan put it, "being treated with respect and being involved in treatment decisions, aspects of care not included in many satisfaction surveys, are paramount issues for patients."¹⁰ Complaints, suits, and quality of word-of-mouth recommendations all affect plan enrollment.

One aspect of care most determined by the interview concerns mental disorders and psychosocial issues, as data about these derive from the interview and only come out in a trusting relationship. Mental disorders and psychosocial issues contribute heavily to plans' unnecessary costs.¹¹ For example, patients referred to mental health departments average 11 medical visits in the year prior to the referral, and only 4 the subsequent year.¹² A hospitalized patient comorbid for untreated depression costs an additional \$2,500.

To assist physicians and managed care plans that seek to improve relationships and communications skills in their practitioners, this article reviews data on the importance of interviewing, outlines the published evidence about teaching strategies, details one such course for managed care as an example of how these issues are approached, and concludes with steps recommended for organizations wishing to establish local programs on doctor-patient relationships and the medical interview.

THE IMPACT OF THE MEDICAL INTERVIEW

Physician-patient talk of all kinds has been related to highly important outcomes of care.^{3,13,14} High-quality medical interviews require good communication skills, determine the nature of the doctor-patient relationship, and enhance the satisfaction of patients^{9,15,16} and providers.^{17,18} Interview-related variables are the most important determinants of compliance.¹⁹ Better interviews independently improve biomedical and disease outcomes.²⁰ Higher-quality communication diminishes doctor burn-out,²¹ malpractice suits,^{22,23} and resource utilization.²⁴ Interview skills can be taught and learned, and acquired skills are utilized and endure.^{15,16} Thus, managed care plans that dedicate attention and resources to interviewing quality can expect immediate and long-term rewards (Table 2).

Many physicians currently in practice have deficient education concerning the doctor-patient relationship and psychosocial medicine.²⁵ Few have ever been observed interacting with a patient. Most have inaccurate ideas about how they communicate and how patients react to them because they seldom get objective feedback about their interactions. Surveys that query generalist physicians regarding their wishes for better training show psychosocial medicine at the top of the list.²⁶

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Table 1. Communication and Interview Dilemmas of Managed Care Physicians*

Negotiating effectively with patients who demand unnecessary surgery or medications
Building trust with patients who are frustrated or angry at the managed care system
Containing the rambling patient
Assuring adherence to treatment plans
Effecting lifestyle change: smoking, drinking, diet, exercise
Telling patients with symptoms they have no disease, and no more tests will be done
Finding and managing hidden agendas
Managing mistakes in care, whether physician or system problems
Responding to system pressure to be "efficient"

*Reported by American Academy of Physicians and Patients course participants.

Table 3. Principles of Teaching About the Medical Interview

Teach using a framework that includes evidence-based functions and structures
Teach knowledge, skills, and attitudes simultaneously
Use adult educational models
Include a task orientation
Create a learning climate that while safe and nonjudgmental also sets standards
Teach skills through practice with expert feedback and repeat practice
Include time to discuss personal feelings about work and the learning (self-awareness)
Prepare learners to reenter the unchanged environment once they have changed
Reinforce teaching through systemic mechanisms
Teach only what is empirically validated
Use methods of documented effectiveness

TEACHING AND LEARNING ABOUT MEDICAL INTERVIEWING

In the 1970s, solid, empirical interviewing research began to be merged into an evidence-based conceptual framework that describes the medical interview as having 14 structural elements and 3 functions.^{4,27} Each function and structural element has specific observable behaviors associated with it that relate to better outcomes,²⁸ and can be monitored, taught, and tested. In parallel, innovative educational methods²⁹ (summarized in Table 3) improved on lecture-style force-feeding and passive, "do what I do" apprenticeship.³⁰

In 1980, Lipkin created an educational model for higher-order learning in medicine, especially concerning the medical interview and doctor-patient relationship, that synthesized work of Rogers and Engel. He postulated that teaching knowledge, skills, and attitudes simultaneously might produce better results than teaching them in isolation. If the learner knows what to do but not how

to do it, new knowledge will not translate to new action. If the learner knows how to do it but not why, new skills will be clumsily and inflexibly applied, if used at all. If the learner knows how and why to do something but does not believe in it or feel it is acceptable, the learner will not try or sustain new strategies. In addition, Lipkin introduced a task orientation to focus and motivate the learning by tapping into the competitiveness and achievement orientation of members of the medical professions.

Evaluations of Lipkin's model have borne out its utility and value. For example, Gordon and Rost summarized data from six courses following the initial course sponsored by the Society of General Internal Medicine in 1983.³¹ They document that participants' skills in detecting and teaching interview skills improved during the course, that behavioral changes persisted up to 1 year, and that physicians' views of their role and satisfaction improved, with some even describing major career improvements. Levinson and Roter randomized participants to differing course models, and found that those participating in the Lipkin model had patients with improved quality of life and physician behaviors that endured.¹⁵ Also, Roter et al. used a shortened version of the model in a randomized controlled trial, and showed improved patient and physician outcomes.¹⁶ In Britain, Fallowfield, Lipkin, and Hall showed change in practice behavior, attitudes, and teaching activities among 178 senior oncologists.² The model has been used to teach about substance abuse, pain, death and dying, teaching, and other complex matters with comparable effect.³²

Other models of teaching about these issues exist and have been studied. Maguire³³ and Gask et al.³⁴ showed learning and behavior change in United Kingdom medical students and practitioners. The Bayer Institute workshops on the medical interview and on specific interview problems are under active study.¹⁶ The Northwest Center for Physician Patient Communication adapted the

Table 2. Rewards of Programs Improving Physician Knowledge and Skill in the Medical Interview

Increased
Accuracy and completeness of medical information gathered
Patient satisfaction
Physician satisfaction
Staff satisfaction
Enrollment
Decreased
Testing and procedures
Use of doctor shopping and emergency departments
Disenrollment
Physician burnout
Malpractice suits

Lipkin model to 4-hour courses as well as longer efforts. The Permanente Center for Physician Education has 1-day workshops that are popular but not yet independently evaluated. Many organizations such as the American College of Physicians and the American Psychosomatic Society have sponsored workshops on interviewing and psychosocial topics, but without adequate evaluation and follow-up.

Maguire et al. have shown experimentally that advanced students trained in a model of the type described not only show immediately improved skills, but those skills also endured and increased during the 6 years of their study.³⁵

In summary, the quality of interviewing matters, and educators have shown that use of a modern, integrated model leads to significant behavior change that endures and expands over time. For these reasons, it is a practical and valuable undertaking to train physicians to higher standards of medical interviewing in managed care practices using state-of-the-art models.

To illustrate how such training may be implemented, we describe a 1-day interviewing course, based on the Lipkin model, that was developed for managed care organizations. This example addresses the typical challenges encountered when teaching in managed care settings, such as cost, low motivation and participant resistance, integrating cognitive foundation with attitude change and skill building, and demonstration of measurable system outcomes (Table 4).

COURSE IMPLEMENTATION

A Course Structure Must Balance Costs Against Training Intensity

In the early 1990s, discussion with industry leaders suggested that the existing courses, which lasted 2 to 5 days, were too long. The principal cost to a plan of training physicians is their lack of productivity during the training. Pilot courses with physicians from Maine and Boston, Massachusetts, demonstrated the feasibility of adapting the Lipkin model to a 1-day format. Cost considerations precluded videorecording or the use of patients or actors. A structure was developed with one facilitator

Table 4. Challenges in Course Development for Physicians Working in Managed Care Settings

Buyers want to balance course costs and training intensity
Physicians may lack motivation for change in interviewing style or skills
Coerced attendance and fear of exposure increase participant resistance to learning
Learning decays rapidly unless knowledge, skills, and attitudes are addressed
Major behavioral and attitude change requires reinforcement
Buyers want to demonstrate connections between measurable system outcomes and course activities

for each 10 participants, and with video playback, live demonstrations, overhead projections, handouts, and a laminated card as learning aids (Table 5). The course provides managed care physicians with perspective, skills, and ideas with which to improve their interactions with patients. A physician may then more efficiently use 15 allotted minutes, produce more personal and patient satisfaction and improve clinical outcomes. However, with such limited time, other methods must resolve systems problems, such as the scheduled visit length, the manners of the receptionist, and the quality of printed, patient education information.

Motivation and Resistance to Change Must Be Given High Priority in Planning

Seasoned clinicians with a time-honored interview style will not easily be induced to explore and change their interactions with patients. Many physicians feel coerced by management and actively resist participation in courses of any type. Furthermore, learning styles vary, and interview content varies greatly with disease, patient, specialty and task.² Course structure and faculty behavior must anticipate learners' skepticism as well as their

Table 5. Example of a Schedule for a 1-day Course on Medical Interviewing

8:00	Introduction and Initial Activities Description of course structure and process. Skill exercise: reflective listening. Recording individual learning goals that will guide today's work.
9:00	Didactic Segment The three function model. Skill demonstration: video, faculty, and story demonstrate skills.
10:15	Small Group Work (10 participants) Working on individual learning goals. Focus on responding to emotions. Opportunity to reflect on today's work together.
12:45	Didactic Segment Non-verbal communication. Further elaboration of the three function model. Skill demonstration: video, faculty, and story demonstrate skills.
2:00	Small Group Work (Same groups of 10) Focus on giving information and developing individualized treatment plans. Special attention to non-verbal communication.
3:30	Large Group Skill Demonstration Faculty and volunteers learn skills by working on difficult situations.
4:15	Closing Opportunity to reflect and report on today's experiences. Evaluations. Feedback. Future plans.

sensitivity to observation and criticism. Learners' initial activities need to be planned to demonstrate to them that the benefits of active engagement outweigh the risks. Therefore, the day starts with an agenda review (see Fig. 1), to show that the day is as tightly structured as traditional medical learning activities, and that the teaching is evidence-based.

An early motivational activity facilitates discussion of learners' current attitudes and values, and some exploration of their resistance to change. In groups of three, one participant shares thoughts or feelings about learning interviewing at this time and another reflects back to the speaker the message they have heard. This "reflective listening" exercise directs participants to alternate speaking and reflecting without questions or discussion. This motivational strategy allows reluctance and resistance to be spoken and heard. Listening with complete acceptance and without evaluation or judgment, experiencing being listened to in this way, and discussing the experience models active listening and highlights that the need for improvement is universal.

The Knowledge Problem: Integrating Scientific Competence with Caring Relationships

Research indicates that patients appreciate and value a balanced approach to the relief of suffering.^{10,13,14} Cognitive presentations provide a researched and credible rationale for establishing a balance between modern science and relationship-centered healing approaches. The course organizes its didactic lessons around the Three-Function Model of the Medical Interview.³⁶ It emphasizes the empirically demonstrated connections between healing and the building of alliance and trust, between patient adherence to a plan and the physician's adoption of a participatory decision-making style,⁹ and then the course assists clinicians to operationalize these concepts in the managed care setting.

Because of the demonstrated importance of nonverbal communication to care outcomes,^{37,38} planners include a cognitive segment on this aspect of interviewing.

Teaching Skills for Managed Care Encounters

Ample educational research supports that learning a skill is different than understanding concepts.³ Aristotle said, "We are what we repeatedly do. Excellence, then, is not an act, but a habit." Active learning of skills and practicing under observation in a simulated setting is not a customary activity in continuing medical education. Skills practice must be thoughtfully introduced and managed to overcome the anxiety and resistance engendered by exposing one's thinking and skills to scrutiny and feedback by colleagues. Lipkin and Williamson³⁹ describe assumptions that guide effective skills teaching (Table 6) and Cohen-Cole and colleagues⁴⁰ detail techniques for the use of role playing.

Table 6. Assumptions That Guide Skills Teaching*

Learners wish to do well and do their best
Learners can recognize the need to learn
Learners know best about how they learn
Intense personal work provokes discomfort, but also eventually leads to growth and satisfaction
Learners respond to the same values as patients do, namely, respect, empathy, caring and competence

*Modified from Lipkin and Williamson.³⁹

In our course example, skills are described succinctly, shown on video, and demonstrated. Participants practice skills in straightforward exercises that ensure success through reasonable expectations and the use of learning aids. Facilitators encourage participants to establish personal goals and to assure the relevance of their learning efforts by applying the skills to role-played situations of their own choice. Participants work on new skills in small groups in which they receive individual attention and feedback. Facilitators need to be specifically trained in these methods to be able to observe, encourage, and challenge the learners with sufficient respect and dignity to surmount discomfort and progress toward growth and satisfaction.⁴¹ In our experience, nonphysician facilitators without special training are not able to accomplish this portion of the work because they do not understand the unique difficulties of being practitioners in the managed care setting.

Self-Awareness

Learning a new cognitive framework and skills will improve physicians' effectiveness. However, events that challenge, provoke, or torment doctors take place regularly, and unless physicians can surmount them, new knowledge and skills will atrophy and old habits will return. Managed care physicians face the dilemmas shown in Table 1, and also witness suffering and dying, struggle to obtain truly informed consent, engage ethical issues such as assisted suicide and denying new treatments, and experience disrespectful treatment by confused, hostile, or entitled patients.^{42,43} To address these needs, the course includes opportunities for participants to share thoughts, feelings, beliefs, and values about work experiences and reactions to the difficult patients they encounter in managed care practice.⁴⁴⁻⁴⁶

Educational Outcomes, Reinforcement of Education, and System Outcomes

Over 1,000 physicians in managed care settings have participated in courses like the one we describe. At the conclusion of the day, participants rate the experience highly. Managed care plans have devised varied methods to reinforce new behaviors, with local programming such as booster workshops and the creation of a communications

consultation team to assist physicians with communication dilemmas.

In one study, randomly selected physicians participated in focus groups 6 to 12 months after taking a course. Comments included: "My practice group has changed for the better since our 6 docs took the interviewing course—especially the behavior of the previously identified poor communicator—with both patients and the entire staff"; "In my first week back from the course, I had two patients thank me for my time despite the fact that my time allotments had not changed"; "Now that I value my relationships more highly, I find that I actually receive sustenance from my patients and go home feeling much less drained than previously"; "I have completely changed my approach to obtaining informed consent for my plastics procedures, and my patients and I are much happier with these changes."

How Might Managed Care Organizations Develop Programs to Improve Relationships?

Through survey research and leadership discussion, managed care plans need to measure their local needs with regard to medical interviewing, doctor-patient relationships, and psychosocial medicine. Then, they will be able to explore options for resolution of major problems as well as to ensure overall system improvement. Steps in establishing options might include reviewing the references we have cited, interviewing the leading groups providing this type of training, and answering the questions listed in Table 7.

CONCLUSION

The overall health and success of managed care plans depend on excellence in the medical interview, superior doctor-patient relationships, and effective manage-

ment of psychosocial medical problems. Effective teaching of physicians will improve physician behavior, medical outcomes, and patient satisfaction. No effective course can give simple answers to complex problems such as those posed in Table 1. Learning better interviewing skills, which include skills for improving the doctor-patient relationship and for practicing psychosocial medicine, can be accomplished by using an integrated model that teaches knowledge, skills, and attitudes together, by employing the learners' own problems as motivation, and by the use of well-trained teachers. Using these approaches can improve medical interviewing and doctor-patient relationships in a plan's practices, improve efficiency and cut costs, decrease patient disenrollment, increase enrollment, and help retain satisfied physicians in the practice group.

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Table 7. Questions to Ask in Establishing a Plan Approach to Managed Care Issues

What are our strengths?
What are our deficiencies?
How do these impact on our quality of care?
How do these impact on our economic well-being?
Whom can we identify to work with us on this?
Are these services:
Well established?
Nationally known and highly regarded?
Documented to be effective in convincing ways?
Sponsored by legitimate sponsors?
Based in sound theory?
Provided by practitioners or nonpractitioners?
Able to work within our time frame?
Reasonably priced?
Able to provide consultation?
Able to train our own trainers based on prior experience?
Are we ready to make the necessary financial and time commitment?

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