The Patient-Provider Relationship

Opportunities as well as Problems

Bernard Lo, MD

The doctor-patient relationship may be threatened by new financial and organizational arrangements that raise concerns about conflicts of interest and weaken patient trust. Consider a 34-year-old salesman who presents with a 6-day history of low-back pain without neurologic symptoms. The pain started when he twisted to pick up his 14-month-old daughter. Although the pain has improved somewhat with bed rest, ibuprofen, and a heating pad at night, he is concerned because he has not previously experienced such persistent back pain. He is otherwise healthy and has no neurologic findings or bone tenderness. He wants to see an orthopedic surgeon or get a magnetic resonance imaging (MRI) scan. "I've done what the nurse advised when I called in, but I still haven't recovered. This is more serious than the back problems I've had in the past," he says.

In this situation, practice guidelines do not recommend referral to a specialist or imaging studies because of the low likelihood of serious disease and the high likelihood that symptoms will resolve on continued conservative therapy. However, patients in managed care may question whether the referral and tests truly are not indicated, or whether physicians are simply trying to save money for themselves, the physician group, or the health care plan. Furthermore, patients may question whether physicians are exercising independent clinical judgment or merely doing what the managed care organization directs them to do. Even a perception that physicians have conflicts of interest may lead patients to question physicians' recommendations to forgo referrals or tests, no matter how sound the recommendations. As a result, trust in physicians may be undermined.

In this article, I will analyze conflicts of interest in the doctor-patient relationship and the opportunities within managed care to strengthen the patient-provider relationship and to teach about it. I will focus on the doctor-patient relationship because patients presenting for care are more concerned about what the doctor (or nurse practitioner) says and recommends than about doctor-doctor relationships or doctor-organization relationships.

CONFLICTS OF INTEREST

Conflicts of interest are present in any health care system. Under fee-for-service reimbursement, "self-referral"

presents serious ethical problems. In some studies, physicians who invest in diagnostic imaging centers refer patients for studies at a significantly higher rate than physicians who do not have a financial stake in testing.^{1,2} Thus, patients with back pain might be referred for costly, unnecessary imaging studies if seen by physicians who will benefit from increased use of diagnostic tests.

Conflicts of interest in managed care evoke strong concerns because beneficial interventions may be withheld. Traditionally, physicians have been regarded as fiduciaries who are trusted to act in the best interests of the patient, not in their own self-interest or the interests of third parties. Such trust may be called into question by new financial and organizational arrangements. Patients may fear that physicians are no longer independent professionals but rather are agents of managed care organizations or acting in their personal self-interest. On the public policy level, such concern has led to increasing regulation of managed care, for example, regarding gag rules, length of stay after childbirth and mastectomy, and disclosure of financial incentives and practice guidelines. On the clinical level, patients may believe that they are more likely to receive interventions if they are insistent. In some cases, the doctor-patient relationship may become adversarial rather than collaborative.

VARIATION WITHIN MANAGED CARE

The term "managed care" is applied to a wide range of organizational structures and procedures. It is essential to distinguish different types of financial incentives, utilization review procedures, organizational structures (e.g., staff-model vs network HMOs), and market environments. For instance, some specialists are being reimbursed by capitation.³ Consider how the back pain scenario might be resolved if the specialists were reimbursed by capitation rather than discounted fee-for-service. Under discounted fee-for-service, specialists still have a financial incentive to see more patients. However, if specialists are capitated, they have incentives to educate primary care physicians to care for common conditions appropriately. Several interesting research questions can be asked about capitation of specialists. Would referrals to orthopedic surgeons for back pain become more consistent with evidence-based practice guidelines under capitated reimbursement? Would patient satisfaction or trust or clinical outcomes be different? Similarly, point-of-service plans, the fastest growing form of managed care, may affect the patient-provider relationship. Suppose the patient with back pain has a point-of-service plan. If he remains worried about cancer or some other serious condition, he

Received from the Program in Medical Ethics, the Center for AIDS Prevention Studies, and the Division of General Internal Medicine, University of California, San Francisco, Calif. (BL).

Address correspondence and reprint requests to Dr. Lo: Room C 126, 521 Parnassus Ave., San Francisco, CA 94143-0903.

could decide whether relieving this anxiety was worth the cost of a specialist visit or imaging study that was not authorized by practice guidelines. Do patients in point-of-service plans, who have such a choice about specialist visits, have greater satisfaction with their care or better functional outcomes?

POTENTIAL TO STRENGTHEN THE PATIENT-PROVIDER RELATIONSHIP

In light of considerable publicity about the shortcomings of managed care, it is important also to keep in mind its potential benefits. Managed care organizations could make specialist expertise available without an office visit by the patient, for example, through telephone or curbside consultation with specialists. Suppose the patient with back pain continues to request referral to an orthopedic surgeon after discussions with the primary physician. The primary physician could call the specialist while the patient is in the office, discuss the case, and develop a mutually acceptable plan for care. The patient may be reassured because the specialist has provided timely input and will be available later if the clinical situation changes. In some cases, urgent access to a full visit to a specialist may be needed and can be facilitated by such telephone communication. Capitated reimbursement gives organizations the flexibility and incentive to compensate specialists for such consultations, rather than reimbursing only for office visits. Furthermore, managed care organizations, particularly large multispecialty groups or staff-model HMOs, have the organizational resources to support such telephone consultations. Issues such as documentation of telephone consultations and quality control need to be addressed.

Managed care also has the potential to address patient concerns and problems that are often overlooked. Critical pathways and disease management programs can provide comprehensive, interdisciplinary care and help ensure that such issues as exercise, physical therapy, and return to work are addressed. For example, the patient with back pain may be worried about how he can pick up his child or drive on business trips. Critical pathways or other innovations to address issues not easily resolved by an individual physician may increase use of physical therapists, occupational therapists, and self-care courses, while decreasing physician visits, referrals to specialists, and imaging studies. Although such innovations in the delivery of care are intended to improve the quality of care as well as reduce costs, some patients may view them as primarily cost-containment measures. Thus, in designing and implementing such innovations, it is crucial to present them to patients in ways that enhance acceptance. It may be important to have a single caregiver, such as a primary care physician, be responsible for coordinating care for the episode of back pain.

Patients and physicians who are disgruntled by managed care may yearn for a golden age of medicine. However, managed care is here to stay because fee-for-service

reimbursement led to intolerable increases in the cost of health care, with little evidence that the quality of care improved proportionately. Payers—employers, individual patients, and taxpayers—are unwilling to accept continued steep increases in premiums. Publicity on such issues as gag rules and length of stay after childbirth have highlighted concerns that physicians may no longer be acting in the best interests of patients. Clearly serious problems and abuses in some managed care organizations need to be acknowledged and corrected. However, physicians also need to think about the potential benefits of managed care and to develop better modes of delivering care. It is important that physicians not consider managed care and managed care leaders to be villains. Physicians often are in a position to make decisions about the delivery of health care, as when large multispecialty physician groups contract with managed care plans to assume risk. Yet physicians who have the power to change organizations put in place the same structures, procedures, and incentives to manage a fixed pool of resources as do the executives of health plans.⁴ Thus, physicians who criticize the utilization review and financial structures set up by insurance plans need to take responsibility for devising better alternatives when they have decision-making power.

TEACHING ABOUT THE PATIENT-PROVIDER RELATIONSHIP

Education has long interested generalists. I would like to suggest some further opportunities for education concerning managed care.

Responding to Patient Concerns About Conflicts of Interest

These concerns can arise in several ways during patient-doctor interactions. Patients may request interventions that the physician does not believe are indicated; for example, the patient with back pain explicitly requested referral to an orthopedic surgeon or an MRI scan. How should physicians respond to such requests? Physicians need to learn to elicit and deal with the underlying reasons for such requests. If the patient's concerns are not addressed, he may not listen to explanations of why a test or x-ray is not needed. Physicians need better training in the psychosocial aspects of care, particularly because with shorter appointment times they will need to address these issues more efficiently. In addition, doctors need to consider alternatives to providing the requested interventions. How useful are such strategies as a follow-up visit or telephone call, referrals to physical therapy and self-management groups, and assurance that the referral or test will be ordered later if needed?

More dilemmas occur when the patient questions whether interventions are being withheld in order to save money. How should physicians respond to such concerns?

Which responses by physicians are counterproductive, heightening rather than assuaging patient concerns? It is likely that the physician will need to acknowledge the patient's underlying emotions and not simply provide information about financial arrangements. In other cases, patient concerns about conflicts of interest and trust may be unspoken rather than explicit. If a patient is not accepting the recommendations of evidence-based practice guidelines, it may be helpful for the physician to probe whether the patient has concerns about conflicts of interest.

Educating Patients About Managed Care

Physicians need to help educate patients about such issues as evidence-based medicine, practice guidelines, utilization review, and financial incentives. Such education will promote informed decision making by patients, correct misunderstandings, and possibly impair patient satisfaction and trust. Such information is particularly important for patients in point-of-service plans, who need to make decisions about whether seeking care outside the provider network or without authorization of the primary care physician is worth the added out-of-pocket expense. To make such decisions, point-of-service patients will need to understand how practice guidelines and utilization review work.

We do not know what information about guidelines, utilization review, and incentives patients would find useful. When do patients want information about physician incentives—when they join a health plan or physician group, or when they face decisions about costly or controversial medical interventions? Who should provide information—individual health care providers, physician groups, or managed care plans? What level of detail do patients want? How can physician privacy be respected while also providing sufficient information to patients to inform and reassure them? Effective patient education will require imaginative research as well as program development.

Educating Physicians in Practice About Managed Care

When physicians are practicing in managed care settings, they face on a daily basis the issues discussed in this supplement. There are more “teachable” moments for full-time practitioners than for residents and medical students. In addition, clinicians in practice are highly motivated to improve their skills because often they receive feedback from managed care organizations regarding utilization of resources and patient satisfaction. Managed care organizations are eager to improve their physicians' performance because their patient satisfaction and clinical outcomes are rated on “scorecards.” Some managed care organizations provide in-service training to physicians regarding such topics as doctor-patient communication skills and the treatment of back pain. Medical educators need to consider how to develop effective in-service

and continuing medical education programs on these topics. There are many practical challenges, such as how to fit such education into busy practice schedules and how to overcome reluctance to discuss with colleagues videotapes of patient interviews.

Balanced and Evidence-Based Teaching

Just as there are concerns about conflicts of interest in our clinical role, we must also be sensitive to conflicts of interest in our teaching role. Teachers must ensure that educational programs within managed care organizations present all pertinent evidence and considerations, even those that may be contrary to the interests of the organization that is supporting the educational program. For instance, shortening the duration of the doctor-patient interview tends to eliminate discussions of biopsychosocial issues. A managed care organization may want to increase efficiency. In teaching about doctor-patient communication, faculty members need to suggest that it may be counterproductive to compress interviews beyond a certain limit.

Organizations that fund educational activities may have a financial stake in changing physician behavior in certain ways. To avoid conflicts of interest in teaching, financial support needs to be separated from control over the selection of speakers and topics and the presentation of conclusions. Guidelines for drug company sponsorship of continuing medical education programs may set useful precedents on how to ensure independence and balance.⁵ Because academic health centers are also subject to marketplace forces, faculty members need to ensure that on-campus teaching is balanced and free of bias as well.

CONCLUSIONS

New financial and organizational arrangements present challenges to the patient-provider relationship. Even when evidence-based guidelines do not recommend specialty referrals or imaging studies for back pain, decisions may be difficult because patients have concerns about conflicts of interest or do not trust physician recommendations. Physicians need to address such patient concerns and explain the reasoning behind their recommendations. Furthermore, physicians need to play an active role in designing new ways of delivering care that take advantage of the potential in managed care to provide coordinated, comprehensive interdisciplinary care.

This work was supported in part by the Robert Wood Johnson Foundation and Center grant MH42459 from the National Institute of Mental Health.

REFERENCES

1. Hellman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noether M. Frequency and costs of diagnostic imaging in office

- practice—a comparison of self-referring and radiologist-referring physicians. *N Engl J Med*. 1990;323:1604–8.
2. Council on Ethical and Judicial Affairs, American Medical Association. Conflicts of interest: physician ownership of medical facilities. *JAMA*. 1992;267:2366–9.
 3. Caisson N. Get your specialists thinking about costs: subcapitate them. *Med Econ*. 1997;74:93–101.
 4. Kerr EA, Mittman BS, Hays RD, Siu AL, Leake B, Brook RH. Managed care and capitation in California: how do physicians at financial risk control their own utilization? *Ann Intern Med*. 1995;123:500–4.
 5. Ubel PA, Arnold RM, Gramelspacher GP, et al. Acceptance of external funds by physician organizations: issues and policy options. *J Gen Intern Med*. 1995;10:624–30.