Public Trust and Initiatives for New Health Care Partnerships

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EFFECTIVE COMMUNICATION ALLOWS THE physician to understand the patient's expectations and concerns; to obtain accurate information, thereby facilitating diagnosis; to plan and manage the course of treatment; and to gain the patient's understanding, cooperation, and adherence to treatment. Despite universal recognition of the importance of communication, the demands of medical education and practice typically result in physicians' paying less attention to their communication skills than to what are commonly viewed as more pressing medical and economic concerns. Rapid changes in health care organization and medical practice also diminish effective communication, which is essential to the cultivation of patients' trust in their doctors and their health institutions. Many medical institutions and practitioners now are seeking new ways to engage patients in their own care and to command their trust and loyalty. In this article I will examine the social forces that are changing medical relations and will describe recent institutional initiatives for developing new health partnerships of patients and providers.

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Medical Authority and Placebo Effects

In recent years medical authority has been under attack, not only by health care managers but also by patients, many of whom are better educated, more sophisticated, and better informed than patients of past years. Traditionally, doctor–patient relationships have been paternalistic, exemplified in medical sociology by the Parsonian model of the sick role (Parsons 1951). In this earlier, influential model, patients put themselves in the hands of physicians, believing that their professional training, expertise, and ethics made them the appropriate agents for diagnosing problems and prescribing treatment. The accepted cultural authority of physicians allowed them to define illness, authorize their patients' release from daily responsibilities, and serve as gatekeepers to important secondary benefits. Moreover, the patient's acceptance of medical authority facilitated the physician's influence and the placebo effect. This effect, deriving from the therapist's credibility and the patient's belief in his or her doctor's ability to effect a cure, has long been recognized as a catalyst for many positive outcomes (Shapiro 1959; Beecher 1959; Frank and Frank 1991).

Theoretically there are many reasons to believe that placebo effects are less powerful than they were in the past, although no direct empirical study has been done on this issue. As their education increasingly centers on biomedical science, and as they more commonly are guided by randomized, controlled studies, most young physicians are trained to view their interventions with skepticism. Instructed to practice evidence-based medicine, they are probably more detached and less committed to the effectiveness of their treatment strategies. Trained to be candid with their patients, and aware that patients are now more informed and sophisticated than before, they are likely to convey a tentative attitude toward unproven treatments. Physicians tend toward optimism in their prognoses (Christakis 1995), but improved scientific training and the weakening of prohibitions about sharing doubts and uncertainties with patients probably diminish the influence of suggestion.

The placebo effect is also probably diminished by the ready availability of information about treatments and by the uncertainty that is often conveyed about the effectiveness of various medical interventions. Patients can now turn to an extraordinary amount of often conflicting treatment advice from newspapers, magazines, books, television, and

the Internet (Impicciatore et al. 1997; Silberg, Lundberg, and Musacchio 1997). These sources promote uncertain and untested remedies and challenge many established practices. Moreover, there is a continuing stream of information on practice variations, unnecessary care, poor quality of care, fraud and abuse, care inappropriately withheld, and lack of continuity or comprehensiveness of care. While patients have more information than ever before, much of it is a confusing melange, not necessarily applicable to their particular circumstances.

The old way—of using the authority of physicians to reinforce expectations of treatment and of achieving a therapeutic head start through the biological factors that underlie belief and hope—had its built-in advantages. A therapeutic advantage now is less likely to come from patients' belief in the omnipotence of physicians but is, rather, more apt to be drawn from the ability of clinicians to develop relationships of mutual trust. These relationships are characterized by empathy and caring and are driven by technical competence and by actions that help patients cope constructively with the uncertainties of illness and the gaps in our medical knowledge. In short, changing conditions require a different model of clinician–patient relationship.

The Consumerist Model

The paternalistic doctor–patient relationship is gradually yielding to a more consumerist one that is based on a participatory ethic and a change in the balance of power. This is hardly surprising because medicine both reflects and influences the culture in which it is embedded. The cultural context is changing in many ways, but two features are especially prominent: First, medical activity must respond to the desire for autonomy and self-determination that is so characteristic of people in Western democratic nations and that manifests itself in patients' demands to be told about treatment options and to participate in decisions regarding their care. Consumers now have a far greater voice in both the type and the location of the treatment they receive, largely as a result of pressure from groups outside of the medical establishment, including women and disability and gay rights activists. These constituencies campaigned for changes in the management of childbirth and the treatment of AIDS, which are now an integral part of mainstream medicine.

The second feature is the impact of changing patterns of disease and disability. To the extent that much of the work of the doctor focused on acute treatment and infectious disease, the attack on specific etiological targets gave shape to medical approaches. Now that the daily work of clinicians is more commonly defined by the management of chronic disease and the prevention and modification of high-risk behaviors, the practice of medicine has become intertwined with people's conceptions of their lives and the ways that their illnesses intersect their life stories and aspirations (Mechanic 1995; Wagner, Austin, and Von Korff 1996). In these matters patients are as much experts as their doctors, and prescriptions for care have to fit meaningfully into the realities of their daily lives. Early studies provided little evidence that consumerist behaviors were important aspects of doctor–patient interactions (Haug and Lavin 1981). Although a consumerist model is now more common, the transactions characteristic of this model still are in a minority (Roter et al. 1997). This situation may change as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) become more prevalent, as consumers are permitted to make meaningful choices among potential health care options, and as patients participate more fully in decision making. Health care information, particularly when it pertains to quality, is in a formative stage and often does not provide the specificity that most patients want. However, more information is available to more patients now than in the past.

Psychosocial Aspects of Care

The interconnectedness of life circumstances, psychosocial and behavioral responses, and physical morbidity is widely recognized. More research is now being directed to behavioral risk factors, the disabling effects of depression, anxiety, and other psychological morbidities on everyday activities, and the influence of distress on the cause and course of disease and on illness behavior patterns. Moreover, the somatization of psychosocial distress, and its presentation as physical illness, has become recognized as an important part of the everyday practice of primary care physicians throughout the world (Sartorius et al. 1990). Such behavior is a major source of help-seeking and supports a costly trajectory of investigation and assessment.

By the 1950s, Michael Balint, a psychoanalyst interested in general practice, initiated what came to be called “Balint Groups,” in which he and others of similar persuasion worked with general practitioners to help them understand how psychosocial dynamics affected their medical practices. In the United States, a broad interest in the patient, which is usually traced to Francis Peabody, who wrote on this topic in the 1920s, found expression in George Engel’s influential paper, published in *Science*, on the biopsychosocial model (Engel 1977). Although basic ideas about stress, coping, and social support and the effects of psychological states on physical responses were well known by then, in more recent years extensive investigation has documented such patterns more rigorously (Cohen, Tyrrell, and Smith 1991; Cohen et al. 1997). A large gap remains between theory and findings and their translation into medical practice. Despite uncertainties, medical practice still requires a way of building on psychosocial processes and on the potential for modifying patient expectations and behavior (Cassell 1979, 1991). Trust in the physician is fundamental to realizing this potential (Mechanic 1996).

The Bases of Trust in Physicians

Healing is achieved by the application of specific scientific interventions and by the physician’s empathy, support, guidance, and care. Successful healing depends on the physician’s credibility and the patient’s belief in the provider’s competence and caring (Frank and Frank 1991). Increasing competitiveness in medicine and the demand for improved efficiency and productivity create barriers to communication. Sufficient time and continuity of care are important for effective communication, but as patients shift among plans and doctors, and as physicians are pressured to see more patients, the satisfaction of both may suffer. Also, as physicians increasingly are responsible for allocating care as well as treating their patients, and as potentially perverse financial incentives associated with such allocation become widely known, patients have more occasions to doubt their physicians (Mechanic and Schlesinger 1996). Their skepticism is heightened when they are denied services they consider essential and when the perceived financial inducements for withholding services are large.

Careful attention to allocation issues is necessary and inevitable, and managed care in one form or another is here to stay. The idea of a

personal physician has itself been called an archaic notion, and it has been suggested that new, highly specialized group organizations will deal with patients' needs, drawing on variously trained personnel to fulfill different functions, and that "smart systems" of care will reduce the need for specialized expertise (Hurley 1997). In this sense, medicine would come more closely to resemble organizations in which the personnel are differentiated by function but are viewed as interchangeable within their areas of expertise. The analogy has been made to the small shopkeeper, who may at one time have provided expertise, caring, and special consideration, but who is rapidly being replaced by discount outlets and superstores that lack some of the earlier amenities but offer similar products at reduced prices. Such superstores may employ staff with comparable expertise, but their sheer size and impersonality reduce the likelihood that customers will find an informed person to help them with any out-of-the-ordinary requests.

This analogy, while having a certain plausibility, is not entirely apt. Some patients will trade a close personal doctor–patient relationship for reduced costs and convenience, particularly in dealing with routine illnesses and concerns (witness "docs in the box"). However, when they are seriously ill and are facing the uncertainties and difficult decisions associated with such illnesses, most patients want to be cared for by a clinician they trust. They may require referrals to other clinicians, but often the specialist's credibility is contingent on the patient's trust in the physician who makes the referral. Trust is to some extent transferable, which allows the specialist the opportunity to build on confidence achieved by proxy.

A trusting relationship also facilitates patient disclosure and cooperation in treatment, makes it easier to modify unhealthful behavior, and reduces the likelihood of disputes, complaints, and lawsuits. It also contributes to the clinician's sense of being appreciated and protects against frustration and burnout. Trust, and the openness of communication that it encourages, increases the human sensibilities of both patient and doctor and heightens the quality of their interactions. Trust has costs for both parties because it binds each to obligations that may at times be inconvenient or risky. A violation of trust can result in extreme hurt, anger, humiliation, and even retribution. However, as in any other important personal relationship, trust becomes an investment in the continued possibilities for human learning and growth.

Responses of Physicians and Health Care Institutions

If organizations seek longevity in a community, they appreciate that trust is a valuable investment. They can build it at a social level through initiatives designed to convey to the public that they are high-quality institutions committed to the welfare of the community and that they recruit, train, and supervise their personnel with this commitment in mind. Health care plans, hospitals, and medical groups are now aggressively marketing their services to the general public, highlighting their capacities and quality and emphasizing their trustworthiness. The goal is to evoke the image of an institutional management whose quality is so high that the public can only infer an equally superior level of performance by its various personnel. Alternatively, institutions and plans often herald the accomplishments of their doctors and other staff members as indicators of overall institutional quality.

A good reputation is useful to have, but people generally are most influenced by their personal experiences and by those of their relatives and friends. There are exceptional institutions (e.g., the Mayo Clinic, the Harvard Medical School, or the Johns Hopkins Hospital) that have long-established national reputations for excellence. In most communities, and in most everyday care, however, people make selections on the basis of informal knowledge and experience (Mechanic 1989).

A hospital or health plan relays as its most powerful advertisement the message that its physicians and nurses are not only competent and accomplished but also caring and committed to patient interests. Competence and caring are the essential tools of medical care and must take center stage in the undergraduate and postgraduate educational training of young physicians. In recent years we have heard many laments about the overspecialized technical orientation of physician training and the neglect of the interpersonal aspects of medical care. Many medical schools are now working hard to correct these problems, taking steps to develop patient-oriented interpersonal skills, to improve physician sensitivity and empathy, to increase appreciation for diversity, to sensitize physicians to ethical dilemmas, and to shed more light on the behavioral aspects of care (Marston and Jones 1992).

Developing Interpersonal Skills

The development of interpersonal skills is part of the required curricula early in medical school as students initially come into contact with patients. In many schools instruction continues in subsequent years and is also common during residency training, particularly in general internal medicine, family practice, pediatrics, and psychiatry, or in programs that combine these areas by drawing on faculty from more than one department. Typically their focus is on interviewing skills and on recognizing and dealing with patients' psychosocial concerns, but the topics of patient diversity, communication of bad news, death and dying, and ethics are increasingly often addressed as well.

Despite the recognition accorded to sensitive interviewing and effective patient communication, and amid much exhortation about their importance, mastery of the required skills is not yet perceived as critical to the main business of the medical endeavor. Beyond required courses, usually during the first two years of medical school, and in some primary care residency programs, further training is highly self-selected. However, health care plans that are sensitive to how their physicians communicate with patients are beginning to encourage physicians whose difficulties with interpersonal relations have elicited patient complaints to enroll in programs that teach communication skills. They are also developing their own educational materials for clinicians (Frankel and Stein 1996). Nevertheless, no matter how good the training and materials, the structures and pressures of medical practice often stand in the way of achieving the desired quality of communication, despite evidence that strategies for establishing rapport with patients and giving them a feeling of being understood need not take more time (Roter and Hall 1993).

Effecting changes in physician behavior is notoriously difficult, whether it involves improving the detection and treatment of psychosocial distress (Schade, Jones, and Wittlin 1998), increasing patient participation in care (Wagner 1997), or upgrading communication skills. Doctors who are trained in a primary care track or who are taught interviewing skills have a more participatory decision-making style (Kaplan et al. 1996). This approach is associated with higher patient satisfaction, greater patient involvement, and better medical outcomes (Kaplan et al. 1996). Intensive instruction in interpersonal skills is probably needed, although even this strategy has produced little evidence of lasting effects.

As in many other areas of behavioral change, reinforcement should be ongoing. One way to do this is to build reinforcement into organizational systems, clearly delineating incentives for the desired behaviors (Scott et al. 1995). Other organizational arrangements remain important, like the pace of patient care, as doctors with greater patient loads are less likely to adopt a participatory decision-making style (Kaplan et al. 1996).

Medical education has added a significant component to instruction in the psychosocial and behavioral areas, through an emphasis on experiential learning and on facilities to aid the process of self-learning (Marston and Jones 1992). Through the use of role playing, simulated patients, video recording, and other technologies, students receive immediate feedback on their verbal and nonverbal communication and are thereby helped to recognize and modify troublesome interactional habits. Video feedback of interviews is one of the most effective ways of improving communication skills (Goldberg and Huxley 1980). Such feedback can be threatening and can lead to defensive behaviors, but when students are properly prepared and are given appropriate support, this kind of training is well received.

Most training in communication and psychosocial issues focuses on the skills that can make a difference in effective communication. Its success also depends on students' attitudes and priorities and on organizational arrangements, which can either facilitate or impose barriers to such training. The first factor depends on student selection and the attitudes of important role models. Bright candidates are adept at conveying the outlooks they perceive as valued; a short interview thus does not suffice as an effectively revealing screen. Most students, however, are highly motivated to become good doctors, and they look to their preceptors and faculty for indications of what is important. It is no accident that medical schools staffed with visible and highly regarded medical faculty interested in the communication process typically have developed the most successful programs in this area.

The skills that are learned have to be adaptable to the realities of practice, to patient flow, and to financial and other incentives. Taking time with the patient is central, but many factors get in the way of doing so. Doctors face increasing expectations and obligations, often requiring trade-offs and compromises between the ideal and the real. Shortcuts are not necessarily bad, but they have to be thoughtfully developed and consistent with risks and benefits (Mechanic and Parson 1975).

The viewpoints of doctor and patient may differ in several areas: First, doctor and patient view health differently, with the doctor typically focusing on a specific morbidity and the patient typically being more concerned about his or her functioning and general sense of well-being (Mechanic 1978). Although these concerns may overlap, they differ in important ways. In moving expeditiously toward a differential diagnosis, physicians commonly inhibit patients' expressions of their concerns and close off opportunities for significant empathic or affirming responses (Suchman et al. 1977; Waitzkin 1991). They may also discourage the disclosure of concerns that are more important to the patient than the presenting symptoms. This is particularly true of psychosocial areas, where patients may feel inhibited about revealing stigmatizing information unless the physician signals his or her interest and receptivity (Ginsberg and Brown 1982). Physician interviewing skills are critical to uncovering the sources of distress (Goldberg and Huxley 1980).

Organizational Initiatives

In an earlier article I identified seven types of initiatives that have been launched by health institutions with the goal of eliciting trust either in the institutions or in the providers of care (Mechanic 1996): solicitation of consumer feedback; informational programs for patients and the public; staff and professional education and sensitivity training; sponsorship of support groups; patient empowerment programs; ethics consultation; and programs to improve patient-professional relationships. I also identified a wide range of other initiatives with these aims: the encouragement of community involvement and leadership; the transformation of large and complex institutions from impersonal providers into user-friendly, responsive, and helpful centers of care; and the improvement of educational efforts.

In a recent essay, Lawrence Weed (1997) argued that traditional medical training rewards memorization to the exclusion of other skills, leading to outdated and inefficient use of medical knowledge and poor medical judgment. He maintained that new information technology allows knowledge to be more reliably integrated into practice, thereby improving the ability of clinicians to assess the diagnostic and treatment options pertaining to each patient's needs. These tools could be

used to help patients consider trade-offs and make choices that are consistent with their own values and goals. "In this way information tools would prevent the paternalism of providers that flourishes when uninformed patients become passive objects in the medical care process" (Weed 1997, 233).

Although new technologies are emphasized in medical care, their potential to enhance doctor–patient communication and patient involvement in treatment has been overlooked. We tend to be intrigued by innovative hardware, but technology refers as well to the application of hardware, software, and organizational processes to the achievement of desired goals. Even the process of caring itself can be viewed as a technology and thereby as subject to enhancement by effective organizational arrangements (Scott et al. 1995).

Approaches to a New Partnership

In building trust there is no substitute for competence and caring. I have described some of the important efforts that are being made to improve communication and to develop the technical skills of doctors. However, health professionals must function in the larger economic and institutional framework, and experience indicates that modifying the interpersonal skills and behaviors of individual clinicians alone, without appropriate institutional supports, has uncertain results (Scott et al. 1995). Medicine is no longer a simple activity between doctor and patient. It inevitably involves many people and encompasses larger systems of care, all of which affect assumptions, expectations, and behavior.

There are thus multiple, intersecting levels of intervention, each having an impact on what ultimately transpires between doctor and patient. In the broadest sense, the institutional structures of medicine, health care entitlements, definitions of responsibilities, and social and ethical norms define the context of care. The rapid changes taking place in health care arrangements, modifications in coverage, and managed care practices can affect the relations between doctor and patient. At a lower level of organization, the manner in which medical care groups are organized and governed, the pace of practice and the patient load, the bureaucratic features that doctors and patients must deal with, incentives affecting professional work, established clinical pathways and practice guidelines for the care of patients—to name only a few organizational

factors—can significantly enhance or detract from effective care. Much of the potential for innovation exists at this intermediate level of organization (Wagner 1997).

As part of a larger project on trust, I attempted to catalog the range of activities initiated by physician groups, medical plans, and health care organizations with the goal of improving communication, creating a sense of security for patients and their families, and finding new ways to involve patients in their own care. I have constructed this catalog through a short survey that sampled members of the Institute of Medicine, medical school deans, and members of the American Academy on Physician and Patient. I asked each respondent to nominate programs that contributed to a sense of trust. Because of the size and diversity of the health sector, characterizing innovations is no easy task. There are many initiatives. A few, like patient satisfaction surveys and various types of focus and support groups, are now used almost universally. The majority of innovations, however, are local, are initiated by persons who believe strongly in them, involve relatively small populations, and remain unevaluated. Many represent efforts to build structures and approaches that are consistent with new ways of relating to patients and communities in a changing health care environment. Respondents describe these initiatives as efforts to build patient and public trust, but very few of them have been seriously evaluated, and almost none has been explicitly demonstrated to increase trust. Yet they reflect the diversity of our health care system and the dedication and inventiveness of many health professionals and institutions.

In surveying this range of activities, I see no useful analytic scheme for classifying them. In contrast, it seems more helpful to describe individual initiatives that I find intriguing and that may have wider applicability than others that are tied to specific local settings. I do this with full appreciation of the enormous difficulty of achieving the widespread adoption of any social innovation. Much creative energy has been channeled into programs devised to make patients active participants in their care, into self-management programs, into developing practice guidelines, and into many other aspects of the caring process, but these have not had a serious impact on organized health systems (Gold et al. 1995; Wagner 1997). In the examples below, I seek to convey the various ways that patients and their families could become more actively involved in partnerships with health organizations and health professionals. Such involvement has been shown to result in better informed

patients and improved disease outcomes (Greenfield, Kaplan, and Ware 1985; Roter and Hall 1993).

The Uses of the Internet

The impact of the Internet on our lives has often been exaggerated, and there are those who remain skeptical of its potential. The fact, however, is that the Internet has become a significant informational resource on health for millions of people. Books, articles, and other aids on how to access online health sources are now available (Ferguson 1996), and articles on the use of the Internet for medical professionals now commonly appear in medical journals (Millman, Lee, and Kealy 1995; Peters and Sikorski 1997). It is apparent that the Internet offers enormous resources, although the sheer quantity of information and its variable quality and accuracy can be bewildering and counterproductive. The Internet, however, offers easy access to general information, discussion groups, support groups, and often opportunities to ask questions and receive feedback from qualified professionals. Some organizations that provide medical information report the names and credentials of experts who have reviewed the data for accuracy. Expert reviews, accreditation, and other ways of differentiating good from poor information is very much needed (Silberg, Lundberg, and Musacchio 1997).

One innovative use of the Internet is the Comprehensive Health Enhancement Support System (CHESS) that was developed by the Center for Health Systems Research and Analysis at the University of Wisconsin–Madison. CHESS is an educational/supportive technology with modules for AIDS, breast cancer, and other serious health problems that are accessed through personal computers placed in the homes of patients or family members (those, for example, who are caretakers of patients with Alzheimer's disease or partners of alcoholics) (Gustafson et al. 1993, 1994). CHESS offers eleven services: answers to frequently asked questions; a library of articles and other informational resources; access to relevant discussion groups; the ability to direct questions to an expert; decision aids; and personal accounts of people with similar problems, to name a few.

CHESS has undergone randomized studies, which have revealed it to have high acceptability and use, to be accessible to persons with little education and minority status, and to improve patients' participation in

treatment and their quality of life (McTavish et al. 1994; Boberg, Gustafson, and Hawkins 1995; Pingree et al. 1996; Gustafson et al. 1997). CHESS and related approaches are still in the early stages, and much remains to be developed. Experience with CHESS, however, illustrates the potential contribution to patient awareness and involvement of carefully screened information and decision aids and of access to support groups.

The Uses of Videotapes

Videotapes have long been an obvious but unexploited technology for patient education. Patients often wait for hours in clinics and hospitals or have long periods of time with little to do. There are thus many opportunities to use video technology to inform patients about their illness conditions, self-care, and other pertinent aspects of their treatment and health. Because many people now have video players at home, and the technology is inexpensive, videotapes can be either distributed to patients at low cost or provided on loan.

John Wennberg (1990) and his colleagues brought the possibilities of this technology to a wide audience with their patient decision-making aids. Using videotape presentations to enhance patient decision-making in the treatment of benign hypertrophy of the prostate and other conditions, they have shown that patients' treatment preferences are often more conservative than those of their physicians and have revealed the importance of taking such preferences into account. Patient education videotapes are used at individual institutions in some departments but are not widely disseminated or shared. Among the more common uses are preparing and instructing patients for certain procedures and treatments (e.g., childbirth, endoscopy), informing patients about their rights, improving the informed consent process, acting as aids to inform patients about their condition at the time of diagnosis, and instructing patients in self-care.

Such instructional technologies can either enhance the quality of care and clinician-patient interaction or depersonalize it. They should be used in conjunction with personal follow-up to answer patients' concerns and questions and to provide the necessary link between generic educational material and patients' unique situations. When used in this fashion, good materials can add depth to clinician-patient interaction, help patients to formulate their questions and concerns more clearly,

and aid clinicians in formulating more appropriate and responsive feedback.

Innovative materials are being prepared at individual institutions, but there is no adequate mechanism for cataloging, sharing materials and experience across institutions, or easily availing them to patients or patient organizations. Many video presentations are customized for individual institutions and services, and clinicians often feel that materials should reflect their specific treatment pathways. Nevertheless, it should be possible to create clearinghouses so that programs and organizations can learn from one another, to exchange and share educational modules, and to facilitate the adaptation of available materials to various clinical settings. With the growth of managed care, such educational programs may receive increased attention.

"Customer" Service Programs

Many health plans, hospitals, and other health institutions, faced with growing competition for patients and increased public expectations, have initiated programs to improve customer services. Typically these are directed to nonprofessional staff, but some are tailored to physicians and nurses. Some are superficial while others employ sophisticated strategies to make use of patient participation and feedback.

"Patients and Families First" is such a program that was developed for professional and support staff at the cancer and geriatrics centers at the University of Michigan Hospitals. It is a one-day course for staff with streamlined, two-hour modules for nurses and physicians. The course has been endorsed by physician and nurse leaders in the institution. Among its themes are basic guest relations, patient evaluations of quality of service, steps to provide excellent service, effective communication, nonverbal communication, active listening, telephone communication skills, and complaint resolution. Patients participate in the program by sharing their experiences at the hospital with staff. The course also uses small group exercises and other interactive activities. More than 200 physicians, patients, and support staff have taken part.

Such programs, however well organized, need to be formally evaluated. A single intervention is unlikely to have much effect unless it is reinforced in various ways. There is still much to learn about how to improve organizational routines and individual responses. A related program at the University of Michigan Hospitals, adopted from a program

at the MD Anderson Cancer Center, is the M Greeter Service. Hospital employees and other volunteers greet and assist visitors to the medical center, make them feel welcome, and direct or escort them to their destinations. The intent of this modest effort is to make a complex, confusing, and sometimes intimidating medical center more user-friendly.

Critical Pathways for Patients

Substantial research suggests that preparing patients for what lies ahead helps them to cope with their illnesses and improves outcomes (Benyamini and Leventhal 1997). Such research, however, has typically focused on specific diagnostic or surgical procedures in contrast to more complex courses of treatment. In recent years, critical pathway guidelines have become common, primarily for the treatment of high-volume diagnoses in hospitals. These guidelines provide systematic directions, defining goals and outlining the necessary sequences for achieving them in a cost-effective way. Guidelines are used as management tools to assist evidence-based decisions, to monitor the progress of care, and to ensure that treatment proceeds in an appropriate and timely way.

Critical pathways are now commonly used, but there are many uncertainties about their variety, validity, implementation, and cost-effectiveness (Pearson, Goulart-Fisher, and Lee 1995). Nevertheless, patient pathways are being developed that are based on the same materials used by the staff; these allow patients to monitor the course of their own care. In one study, patients undergoing cardiac bypass graft surgery were given a compendium and were then compared with patients who did not receive these materials (Shulkin and Ferniany 1996). Although the researcher found no statistically significant differences in satisfaction between patients who received the guidelines and those who did not, the results nevertheless suggest that the information was helpful.

Both theory and the existing research literature (Benyamini and Leventhal 1997) offer reasons to anticipate that well-executed patient pathways should improve important patient outcomes, but practice settings offer little evidence to support this belief. Patient pathways are now being developed that are written in clear, nontechnical language and sometimes illustrated with pictures. Problems have arisen when expected staff procedures are not carried out as specified by the pathways, and some guidelines are now being redefined according to

phases, rather than being charted in days or hours, in order to avoid upsetting patients when treatment does not progress according to specified time lines. Many uncertainties about how best to develop and implement patient versions of guidelines still remain, but their potential for improving communication and understanding is considerable. Patients who can anticipate the course of their future care, who have their questions answered, and who can prepare themselves adequately for most eventualities are more likely to be better partners in their own care.

Educational Aids

Many educational aids are now available for training health professionals, support staff, patients, and concerned family members. These aids may use actors to simulate patients so that clinicians can improve communication skills, or they may rely on computers to assist in mapping out the best course of treatment through treatment simulations. The technologies may be as simple as clearly labeled pill boxes for patients who must follow complex medication regimens or as complex as the elaborate equipment for self-care that has been constructed for persons with significant disabilities and chronic diseases.

One particularly intriguing innovation is a training/curriculum package that includes an audiotaped simulation for health professionals, students, and family members of schizophrenics to help them understand the experience of hearing hallucinatory voices (Deegan 1996). Participants tackle a series of interactive and cognitive tasks while listening to a specially designed audiotape. The simulation helps the participants appreciate the impact of such an experience and to examine their assumptions and practices in dealing with persons who live with disability.

Physicians have repeatedly noted in their memoirs how their own serious illnesses and their experience with the medical care process transformed their views of medical care (Heymann 1995; Stetten 1981). It is probably more than coincidence that many medical leaders in their later years, particularly when facing inevitable infirmities, demonstrate increased interest in broader issues of functioning and psychosocial concerns. The young more typically feel invulnerable and find it more difficult to understand fully the pain and frustrations associated with decrements in function. It is believed that physicians who have suffered

a serious illness in their youth often are more empathetic and understanding (Geiger 1975).

Conclusions

A survey of the medical care environment uncovers impressive and innovative programs for teaching communication skills to clinicians, for developing empathy and leadership in patient-oriented care, and for helping patients become better-informed and more effective participants in their treatment. A striking number of these innovations are local, fueled by the energies of a small group of dedicated clinicians and researchers. More often than not, these innovations are neither known nor recognized by other divisions of the parent institution or by the health services field.

A number of organizations seek to focus on communication issues and to modify how medicine is practiced, but their efforts are modest relative to the size and complexity of the health care sector. The American Academy of Physician and Patient, comprising some 600 health care professionals who are involved in patient-centered research and education, promotes a professional network, work groups, and courses and educational resources related to doctor–patient communication. The Bayer Institute for Health Care Communication organizes courses and workshops around the country that are now commonly used by large HMOs like Kaiser–Permanente. Other foundation-sponsored organizations, like the Picker/Commonwealth Program for Patient-Centered Care, based at Boston’s Beth Israel Hospital and Harvard Medical School, and the C. Everett Koop Institute at Dartmouth University, are identifying patient concerns and developing strategies and educational approaches to increase the responsiveness of care. The Program for Biopsychosocial Studies at the University of Rochester has an impressive educational program in effective communication and humane care and offers excellent interdisciplinary training experiences for medical students and primary care clinicians.

Much greater efforts are still needed to identify innovative approaches, to facilitate new health care partnerships, to evaluate alternative strategies and programs, and to disseminate ideas on the best forms of practice. Most innovators remain invisible, isolated in their efforts, with few career rewards in this difficult and underfunded area. Those

who pursue it enter an uncertain and precarious trajectory in academic settings. Whatever the barriers, the reality is that patient trust depends on the capacity of clinicians and health organizations to communicate effectively and to involve patients in new partnerships. The failure to develop effective approaches will contribute to the continuing erosion of public esteem for medicine and doctors.

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