Physicians, Patients, and Third Parties: Everybody's Talking But Is Anybody Listening?

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Remember recently when you were about to rush out of one examining room and into the next? Your patient grabbed your hand, looked into your eyes, and, in a trembling voice, implored, "I have come to love you as my family doctor, but now . . . you are too busy, and you don't listen to me. Please come back, I need you to listen!"

It is certainly getting harder, much harder, for me to hear my patients. Instead, I hear calls for more efficiency, greater productivity, more objectivity, and less cost—all of which herald a future of objective, managed medicine, a future with third parties. I hear demands to implement the Clinical Laboratory Improvement Act (CLIA),[1] the Americans with Disabilities Act (ADA),[2] new Occupational Safety and Health Administration (OSHA) regulations,[3] new and multiple managed care guidelines and directives, and a new resource-based relative value scale (RBRVS) requiring more documentation for less compensation, and to lower costs and reduce referrals.[4,5] Most of these intrusions into clinical practice address reasonable concerns, but their implementation increasingly disrupts patient-doctor relationships.[6,7]

The article by Ron Epstein and colleagues[8] reminds us of the importance of these relationships. It brings us back to our origins and suggests that we look again at the interaction and communication between patients, their families, and family doctors.[9] But is anybody listening? Does anyone have the time?

In 1992, the Doctor-Patient Interaction Working Group of the Society of Teachers of Family Medicine (STFM) presented a symposium at the Society's annual meeting at which time they described, compared, and contrasted four different views about doctor-patient communication. The article by Ron Epstein, who organized the symposium, represents a summary of the key material presented that day. Gabe Smilkstein overviews the landscape of patients and doctors and prophetically exclaims that *relationship* is the "heart" of medicine. He pleads to all of us to hear, not only the diagnosis, but also the patient. Ian McWhinney then provides the philosophical ground from which a healthier dialogue between patients and doctors can grow. He invites us to open ourselves to the patient's feelings, to master active listening, and to share power. Stephen Cohen-Cole gives us the tools for tilling and planting the rich soil. He describes the three functions of the patient-doctor interview and explains how and why to use them. Tom Campbell then teaches us to recognize and respond to weather changes and weeds; he provides practical approaches to the systemic and family context of illness. Finally, Ron Epstein encourages us to become more self-aware and to have a better appreciation of the harvest—to pay attention to and care for our own feelings and expectations in patient-doctor relationships.

Missing from the article by Epstein et al are the effects that time, money, and third parties have on the average busy clinician who wants desperately to apply the wisdom these authors impart. But that is why there are at least three reasons that reading this timely article is worth any extra effort required by the average busy clinician: (1) the academic dialogue about doctors and patients needs community practitioner input; (2) health policy planners keep forgetting that relationship matters, and they need to hear that from community family practices; and (3) the article reminds us of who we are, what we do, and why we do it.

What we must make academicians hear.

Academicians must learn to implement their lofty ideals within the pragmatics of everyday practice. They must understand that time and money matter. They are essential ingredients in practice organization and clinical care.

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The literature describes many examples of physicians' failure to hear the psychosocial context of patients' concerns.[10] The dedication, variety, and creativity of family physicians is rarely acknowledged in these accounts. The many ways a multiplicity of patient styles and needs are efficiently, caringly, and effectively balanced against the time and economic contingencies of practice have not been studied. Despite the difficulties, family doctor-patient communication in busy offices often works well.[11] Compassion, love, and miracles still somehow occur.[12]

Most of the research on "doctor-patient communication" has been done in academic practice settings where medical students, residents, or faculty serve as the "doctor" model. The presumption has been that each clinical encounter is a self-contained moment and that the brief communication between a resident and unfamiliar patient is qualitatively similar to that which occurs between a patient and a physician who have known, cared for, and trusted each other for years. The critical importance of past experience with patients and their families, previous telephone conversations with patients, interactions with office nursing staff, nurse practitioners, or front desk staff, office layout and policies,[13] and kinds of encounters are all usually discounted. Physician motivation[14] and the use of intuition are rarely included. My own research in a busy, private group practice setting demonstrated the importance of intuition, continuity of care, and the process of distinguishing between various types of visits: routines, ceremonies, and dramas.[15] Routines, the simple everyday infections and traumas, do not require the same level of listening and intimacy as the more emotionally complex dramas, such as a patient with chronic fatigue or a child having temper tantrums in a family experiencing divorce. Much more needs to be learned about how we do what we do in practice and what facilitates or obstructs our success.[16] Collaboration between family practice researchers and practicing family physicians is essential.

What we must make health policymakers hear.

Policymakers must hear the voices of family physicians and patients speaking in unison. At present, physicians and patients each have separate lobbies. The American Academy of Family Physicians (AAFP) speaks for the benefit of family doctors. We, as family physicians, may believe that also means patients, but health policymakers tend to lump all doctors together and separate us from our patients. This has too often resulted in family physicians suffering for the sins of specialists. I believe this is our responsibility; let us assume it and change this misconception. Patients are in our offices; the specialists are not. Let us claim the relationships that matter most, empower them, defend them, and never negotiate them unless we do so together. I do not feel better about my practice because I know Hillary Clinton listened to the AAFP or to the AMA. I would rather she had listened to community family physicians and their patients. The AAFP and STFM need to collaborate with patient groups so that they may have a unified voice in negotiations with policymakers.

What we must hear.

Our grumblings are a good start—the kind of self-awareness discussed by Epstein. Listening to the discontent of our patients, as suggested by Smilkstein, is a next step. I suspect we will find that we and our patients are feeling out of control. McWhinney[8] and Howard Brody[17] ask us to share power with our patients. Imagine family physicians and their patients working together for their local common interests. Patients might better understand the frustrations of practice and be more likely to support changes that enhance family medicine.

Many methods for improving patient-physician collaboration already exist and can be useful. The range of such models includes sharing decision-making with patients,[18] seeking advice from patient groups,[19] training patients to be more involved in their own health care,[20] and conducting periodic focus groups with selected patients about practice concerns.[21]

Conclusions

The 21st century is around the corner. With it will come more elderly patients, increasingly expensive and morally challenging technologies (such as genetic engineering), more patients with multiple chronic illnesses, escalating costs, and an information explosion. All of these changes will simultaneously magnify and increase both the number and complexity of choices facing family physicians and their patients and the number and complexity of third parties. The implications for practice organization are difficult to anticipate. What becomes ever more certain, however, is the importance of the patient-physician relationship within which the choices will be made.

Epstein and his colleagues invite us to renew the conversation about doctors and patients. Their article is a powerful and helpful reminder of the importance of listening. I read it as a warning! We should not listen individually—as patients, as physicians, as third parties—but rather as a community of healing. Relationships matter! Is anybody listening?

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