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## TIPS FOR COMMUNICATING WITH PATIENTS IN MANAGED CARE

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### The Managed Care Milieu

Promoting health and alleviating illness and suffering are the essence of doctoring and the focus of the physician-patient relationship. Regardless of whether a patient is cured, comforted, or enlightened about the role she plays in her own health, the outcome of the physician-patient encounter depends on communication. Through effective communication, physicians are more likely to positively influence health outcomes for their patients. In one author's recent words, "communication is the pathway to a medicine that is patient-oriented instead of disease-oriented" [1].

Effective communication has never been more important than in the current setting of health care practice, where the character of the physician-patient relationship is undergoing significant change [2]. Twenty years ago, a patient was free to choose a physician according to convenience or personal preference and could expect to have a long-term relationship with that physician. In this setting, mutual trust and familiarity could develop, laying the foundation for better communication. Today, the influences of managed care have set the stage for less automatic trust between physicians and patients and, thus, communication problems. These influences affect both sides of the physician-patient relationship [3].

From the patient's point of view, managed care limits opportunities to develop long-standing, trusting relationships with physicians. It also encourages a consumer perspective of health care in general and physicians in particular. Competition among managed care plans causes employers to change the plans they offer to

their employees and causes health systems and physician practices to change the plans they accept. As a result, patients have less choice regarding their physician and less continuity with any one physician. Managed care's emphasis on patient education and empowerment, combined with increasing Internet access to medical information, has led patients to desire more involvement in health care decision making. Patients also now have specific expectations for visits to physicians. Patients are less likely to accept a physician's advice on faith than they were in the past. Relatively healthy patients now commonly expect to be in charge of their own health maintenance efforts, with only guidance from their physician.

From the physician's point of view, certain elements of the current health care environment can lead to a feeling that there is little that one can control. Physicians are increasingly aware of the limited time available for each patient visit and of the need for utilization management. Managed care plans may use financial incentives and restrictions on tests or treatments that are very expensive or deemed medically inappropriate as a way to influence physician decision making. Feeling constrained by these factors, physicians may be tempted to revert to a more traditional authoritative, or *paternalistic*, mode of physician-patient interaction, in which the patient passively yields to the physician's choices and recommendations and does not share in decision making. However, it is even more important in the managed care environment to allow and encourage full patient participation in health care. Managed care emphasizes efforts to maintain health and prevent disease, and these efforts often include encouraging healthier habits in patients. When treatment involves significant behavioral change for the patient and long-term compliance is crucial, a collaborative mode of interaction is usually more appropriate.

The physician-patient relationship may be adversely affected if managed care factors and pressures ultimately dictate how physicians and patients interact with each other. However, if physicians take the time to learn how to communicate most effectively with their patients while working within the constraints of a managed care system, communication improves, as does patient care.

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The purpose of this article is to demonstrate how a collaborative communication and decision-making approach can work for physicians and their patients, even in the milieu of managed care. Indeed, this approach may be especially effective in returning emphasis to patient care in an environment where this aspect of doctoring has seemingly been neglected.

### General Principles of Physician-Patient Communication

#### Basics of Good Communication

Effective physician-patient communication is recognized as an essential skill for physicians in practice [4–7]. Physicians should be aware that communication with patients is a complex process and keep in mind the following principles, all of which contribute to the overall outcome of physician-patient communication.

To be effective, communication must be a two-way process—both physician and patient need to offer and accept information. During a clinical encounter, a physician should be careful to ensure that communication is satisfying to both parties. A physician should allow a patient to describe his health concerns, even if they do not seem relevant to the physician. It is also important to make an effort, early in the encounter, to elicit the patient's primary agendas and to address them appropriately [8].

Physician-patient communication typically involves only the patient and the physician (ie, a dyad). However, a third party sometimes may be involved, as in the case of the parents of a pediatric patient or the adult child, spouse, or friend of an elderly patient with cognitive impairment. In such situations, the third party can potentially facilitate communication if they help to identify the needs of the primary patient and to ensure that treatment recommendations are followed correctly. A third party can also potentially complicate the process of communication. For example, a patient's daughter may be worried about the swelling in her mother's legs, whereas the patient's chief concern is that she has not been sleeping well. These are clearly different agendas that both need to be addressed by the physician. In some cases, the involvement of a third party in a patient's health decisions may not be obvious to the physician. Levinson [7] refers to "the invisible third person in the room" to describe the relative or friend of the patient who may influence what the patient says or does while in the office. By explicitly asking whether the patient has any concerns of her own or of her friends or relatives, the physician can directly address this potential source of additional input.

Finally, the physician should recognize that nonver-

bal cues can speak as powerfully as verbal cues. Aspects of nonverbal communication include body language (ie, the manner in which the physician physically attends to the patient), proper use of space (eg, standing or sitting, maintaining a respectful distance), paralanguage (eg, rate of speech, pitch, inflection, volume, use of pauses), and touching (eg, placing a hand on the patient's shoulder to indicate the physician understands the difficulty of his illness) [9]. For example, a physician who asks, "What other questions do you have?" would seem to be adopting an open communicative approach to soliciting the patient's story. However, if she speaks these words as her hand is on the doorknob and she is turning to leave the examining room, the patient will likely feel that the physician is not actually open to answering the questions she is ostensibly soliciting.

#### Value of Patient Participation in Decision Making

In recent decades, many have questioned the value and appropriateness of a traditional physician-centered approach to communicating with patients and making decisions regarding patient care. Such critics generally hold that physicians who take this approach are less interested in addressing patient concerns expressed "in the voice of the life world" [10] and are more interested in having patients provide clinical descriptions that can be readily fit into diagnostic categories.

Several theoretical models of physician-patient relationships have been advanced over the past 30 years, all of which emphasize the importance of understanding how a patient's health influences and is influenced by other aspects of the patient's life. *Patient-centered care* promotes understanding and responsiveness to the needs, desires, and preferences of the patient [11,12]. *Relationship-centered care* is a newer paradigm that focuses on the relationships involved in providing care (eg, physician-patient, community-physician, and physician-physician) as the foundation for health care [13]. *Patient empowerment* has been advocated for chronic diseases (eg, diabetes, asthma) as a way to encourage patients to take responsibility for the self-management of disease in collaboration with their physicians [14]. More recently, a shared model of decision making has been proposed [15]. In this model, the patient and physician share an equal exchange of information and both are involved in the final decision.

For the purposes of this article we define two general styles of communication—*authoritative* and *collaborative*—that subsume other, more detailed models and represent a continuum from less to more patient participation in medical decision making. **Table 1**

**Table 1.** The Authoritative and Collaborative Approaches to Communication: A Comparison

	Authoritative Approach	Collaborative Approach
<b>Most useful for</b>	Acute problem (eg, emergency illness)	Chronic illness, preventive health issue (eg, behavior change)
<b>Control of conversation</b>	Physician	Physician allows patient more control in order to elicit important patient agendas
<b>Expertise</b>	Physician's knowledge and expertise take precedence	Patient's understanding of condition and ability to assess plausibility of lifestyle modifications are combined with physician's expertise and knowledge
<b>Problem identification</b>	Patient recognizes a problem  Patient and physician agree about the nature and seriousness of the problem	Patient may not recognize a problem  Patient and physician may hold divergent views about the nature and seriousness of the problem
<b>Decision making</b>	Physician makes the most important decisions regarding patient's health and well-being (eg, diagnosis, treatment)	Patient makes the most important decisions regarding patient's health (eg, smoking, seat belt use, exercise)
<b>Transfer of information</b>	"Lesson" given by physician to patient	Two-way conversation, with both physician and patient offering information crucial to decision making
<b>Empowerment</b>	Physician is empowered to prescribe medications, treat, and ameliorate disease	Patient feels empowered by support and education from physician to use resources to treat/control patient's disease or condition

outlines the key differences between these two styles of communication. The authoritative style can be thought of as the traditional physician-centered model, where decision making lies almost entirely with the physician. When treatment revolves around caring for patients with acute illness, an authoritative style of communication is usually effective and efficient. For example, a patient with acute appendicitis or meningitis is unlikely to negotiate with his physician on the course of care that is recommended.

However, the situation is quite different when the illness is chronic and the treatment involves significant behavioral change for the patient. For example, a 50-year-old, overweight building supervisor recently diagnosed with diabetes, who has long enjoyed a beer after work and an evening snack of cookies or ice cream, may need education and support to give up his habits. The lifestyle changes intended to improve the management of diabetes may be monumental for the patient. In these situations, collaborative communication may be more likely to promote healthy behavior and lifestyle changes for the long term. The collaborative style of communication is characterized by an emphasis on the patient's goals, needs, and decision-

making ability. The approach also hinges on the patient's recognition of his role and responsibility in the self-management of a chronic disease, as well as his relative expertise in selecting treatment options that will best fit his circumstances.

### Understanding and Applying a Collaborative Approach

The traditional authoritative approach to a clinical encounter—which is still used by some physicians and is expected by many patients—assumes that the physician will dispense advice and then move on to the next patient. However, this approach may backfire in encounters with a patient who is assertive about her right to have a physician listen to her concerns at greater length and truly understand her perspective. An authoritative approach also may not work if a patient is too hesitant to voice confusion or dissatisfaction. Either way, failure to address patient concerns may result in the loss of patients from a practice.

The following scenarios illustrate basic elements of the authoritative and collaborative approaches to physician-patient communication. Given the realities of the typical managed care practice setting, the more

traditional authoritative style of communication may need to make way for a more collaborative style.

### **Scenario 1: Successful Communication Using an Authoritative Approach**

In the following scenario, Dr. Maren, a family physician who has been practicing in a multispecialty staff-model health maintenance organization, successfully uses an authoritative communication approach with a 25-year-old patient with asthma.

Mr. Rhodes has been Dr. Maren's patient for 5 years, as have both his parents. Dr. Maren diagnosed Mr. Rhodes with moderate persistent asthma 3 months ago, and today he comes in for a scheduled follow-up visit.

As the visit begins, Dr. Maren asks, "Are you using your inhalers as I instructed and finding that your asthma symptoms have gotten better since your last visit?"

"Well, to be honest Dr. Maren, I haven't been using the inhalers and now I'm having even more trouble breathing than before." He then quickly adds, "Doctor, I really want to feel better, and I know that you told me to use these inhalers. But I can't remember how the different medications work. Can you remind me?"

Dr. Maren teaches Mr. Rhodes about how albuterol and beclomethasone work in asthma and explains how and when he should take each medication. Mr. Rhodes takes notes as Dr. Maren speaks. At the end of the visit, he thanks Dr. Maren for taking the time to explain his asthma medication regimen to him. At the follow-up appointment 6 weeks later, Dr. Maren finds that Mr. Rhodes has followed instructions and is now successfully treating his asthma with the inhalers.

Why does this approach work with Mr. Rhodes? In this scenario, Mr. Rhodes recognizes that he is feeling poorly because he has not been taking his medications, and Dr. Maren has the knowledge and confidence to help him learn to use his inhalers correctly. This is the traditional medical model, with the physician as the authority figure. The process of communication is fairly uncomplicated: Mr. Rhodes accepts his physician as the authority figure, and Dr. Maren is happy to step into that role. The visit ends with a plan to help Mr. Rhodes take his medications on a regular basis as prescribed, and doing so results in a positive health outcome for him. Thus, the encounter is successful.

One reason the authoritative approach works in this situation is that the communication between Mr. Rhodes and Dr. Maren is effective and satisfying to both of them, with no need for either party to stop and reflect on the particulars of the interaction. Because

physician and patient agree on the definition of the problem and the treatment, time constraints do not impinge on the exchange of information. The long-standing relationship between Mr. Rhodes and Dr. Maren also helps the encounter move swiftly. The strong physician-patient relationship and seeming lack of time pressures in this scenario are reminiscent of the practice of medicine at an earlier time, when physicians and patients were free to develop long-term relationships not affected by outside forces such as varying insurance carriers and cost containment.

### **Scenario 2: Failed Communication Using an Authoritative Approach**

In this scenario, the authoritative approach leads to an unsatisfactory result for Dr. Maren and Ms. Williams, a new 37-year-old patient who comes in later that day. Ms. Williams' employer recently switched health plans, and she presents for a routine annual physical examination.

Running 30 minutes behind, Dr. Maren enters the room and smiles quickly at his new patient. While taking her history, Dr. Maren learns that Ms. Williams is a smoker who has had a pack-a-day habit for nearly 20 years. Believing that Ms. Williams shares his opinion that smoking is an undesirable habit, Dr. Maren asks, while looking at her chart, "Ever try to quit?"

Looking rueful, she acknowledges that she reads and hears a great deal of information about the health hazards related to smoking. She describes her job on the assembly line of a major automobile manufacturer as "stressful." She then adds, "Between the stress of my job and my 2 kids at home, smoking is the only thing I do for myself."

"Smoking poses many risks to your children's health, Ms. Williams," Dr. Maren warns her.

"Have you ever smoked, Dr. Maren?" she asks.

Dr. Maren says that he has never smoked and cannot imagine why she would ask this question. Because Dr. Maren is running late for his next patient, he does not have time to explore her question further and instead closes the visit with his strongest possible recommendation to quit smoking. Ms. Williams simply shrugs and says, "We'll see."

When Dr. Maren sees one of her children the following month for an unrelated illness, he notes from the pack of cigarettes in Ms. Williams' purse that she is probably still smoking.

What is different about Dr. Maren's encounter with Ms. Williams, and why does the authoritative approach fail? The physician-patient interaction in this scenario is

more complex than what transpired between Dr. Maren and Mr. Rhodes. It is also unsatisfying for both parties, largely because a traditional authoritative approach was attempted when a more collaborative approach was needed. Dr. Maren, acting on what he knows to be medically sound advice for treating what he views as a fairly straightforward problem, makes a recommendation to change a behavior that is leading to a negative health outcome. He took the same approach with Mr. Rhodes. A comparison of the first and second scenarios reveals several fundamental differences and highlights reasons why a collaborative communication style would have been more effective with Ms. Williams.

First, Ms. Williams and Dr. Maren do not share the same view of the “problem” (ie, smoking). In fact, Ms. Williams views smoking as a solution to a problem (ie, stress). She also does not see Dr. Maren as a valid source of information about this issue, because he has never smoked nor tried to quit smoking. Second, Dr. Maren fails to address the important cue from Ms. Williams that smoking is a way of relieving stress. An acknowledgment from Dr. Maren that her lifestyle is an important factor in making medical decisions might have alleviated some of the uneasiness Dr. Maren generates with his offhand comment. Third, time constraints prevent Dr. Maren from engaging in a more detailed discussion of Ms. Williams’ smoking and stress. This highlights the need to streamline communication by allowing the patient to have more control in the conversation so that important patient agendas can be elicited and addressed.

Although Dr. Maren works under similar time pressure in both encounters, this constraint is not as apparent in the first scenario because Mr. Rhodes’ concern is clear and fits well within the time allotted for a standard office visit. Mr. Rhodes and Dr. Maren also have a long history of working together, and Mr. Rhodes trusts Dr. Maren’s expertise in asthma management. The second scenario, however, introduces specific challenges. Although the visit was to be a straightforward annual physical examination, Dr. Maren feels the need to spend time discussing Ms. Williams’ smoking habit, and this discussion does not fit neatly into the time allotted for the appointment. The behavior change involved in smoking cessation will require agreement from the patient and much support from the physician. Dr. Maren is obligated to learn what factors encourage Ms. Williams’ smoking and what aspects will be helpful in encouraging her to quit so he can begin appropriate counseling and treatment with this new understanding. Ms. Williams’ questioning of whether Dr. Maren has ever smoked may be her way of saying, “How can you know what quitting smoking is like if

you’ve never smoked?” Similarly, Dr. Maren may take from Ms. Williams’ ambivalence at the end of the visit that she does not understand the risks associated with smoking. Unfortunately, the misunderstandings between the patient and physician in this scenario are unresolved because communication was ineffective.

### **Scenario 2 Revisited: Applying a Collaborative Approach**

It is possible to envision a more positive outcome of the encounter between Ms. Williams and Dr. Maren if a collaborative communication approach is applied.

Dr. Maren opens the visit by introducing himself to his new patient with a friendly handshake and by asking Ms. Williams what her most important concern is today. She tells Dr. Maren that she has no real concerns, that she is simply there for a routine physical. Upon learning that Ms. Williams is a smoker, Dr. Maren decides to broach the subject of smoking cessation at today’s visit. Dr. Maren believes that smoking is a detrimental habit with no health benefits. But acknowledging that Ms. Williams makes decisions in the context of her own needs, he begins the conversation about smoking in a nonthreatening manner.

“Tell me about your smoking, Ms. Williams.”

“Well, I’ve been smoking for almost 20 years,” she sheepishly admits. “But I really enjoy it. It relieves stress.”

“I’ve never smoked myself,” confesses Dr. Maren, “But I’m sure it would be very challenging to quit. Let’s think about other ways we could relieve your stress.” Dr. Maren suggests that Ms. Williams list the risks and benefits of smoking from her point of view, in the hope that he might come to better understand her perspective toward smoking. Dr. Maren expresses his concern for her and her children’s health, given the duration of her smoking. His comment incurs no immediate negative reaction from Ms. Williams. At the end of the visit, Dr. Maren asks her to set up a follow-up appointment in a month so they can continue this conversation and complete the unfinished physical examination. Ms. Williams agrees.

At the follow-up appointment, Ms. Williams and Dr. Maren design a smoking cessation program tailored to Ms. Williams’ needs. By her next annual physical, she has been smoke-free for 63 days.

How does Dr. Maren behave differently in this scenario? Why does Ms. Williams behave differently? This version of the scenario has a different feel than the first for several reasons. Dr. Maren makes good use of non-verbal cues with a friendly handshake and by devoting his attention entirely to Ms. Williams. Furthermore, he

**Table 2.** Tips for Successful Collaborative Communication in Managed Care

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### **Building trust**

- Build rapport through use of verbal and nonverbal communication
- Ask the patient what the most important issue is for him
- Make it clear to the patient that you are his advocate
- Be vigilant for potential ethical conflicts of interest
- Help the patient identify what underlying concerns prompt his request for a specific test or treatment

### **Overcoming time constraints**

- Elicit the patient's agenda at the start of the visit
- Pay attention to subtle clues about the patient's personal life or emotional state
- Ask about cultural beliefs and treatments

### **Assisting patients with health information**

- Help the patient identify useful Internet information
  - Become familiar with good patient education Web sites (eg, [www.medlineplus.gov](http://www.medlineplus.gov))
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immediately attempts to elicit any agendas she may have for this visit, which will help him save time by addressing the issues of most concern to her. Dr. Maren assures Ms. Williams that their visit will be a two-way exchange of information through his use of a nonjudgmental, open-ended prompt: "Tell me about your smoking." He also acknowledges his lack of personal experience with smoking cessation and asks Ms. Williams to provide more information about how quitting smoking would impact her life.

These gestures set up a relationship where Ms. Williams' needs and values are important and she will play a large role in decision making. Ms. Williams is happy to offer the information Dr. Maren seeks and to take an active role in her health care decisions. Dr. Maren successfully expresses his concerns for Ms. Williams' health, while providing opportunities for her to develop a plan that may allow her to quit smoking successfully. These small, but significant, behavior modifications result in a more successful and satisfying patient encounter.

### **Tips for Successful Collaborative Communication**

As the preceding scenarios illustrate, applying a collaborative approach may help overcome potential problems of physician-patient communication that arise in managed care settings. However, effectively involving

patients in clinical discussions and care decisions is challenging and requires practice and perseverance. Suggested strategies for achieving success with a collaborative communication approach follow (Table 2).

### **Building Trust**

The frequent changing of primary care physicians that occurs when patients switch health plans or when provider groups decide not to contract with certain health plans is a seemingly unavoidable hazard of the competitive managed care world. Often the patient's employer or the physician's medical director mandates these changes, and individual patients and physicians have no control over the threat of severed relationships. In this modern practice setting, physicians do not have years to build a mutually trusting relationship with each patient. It is not surprising that in one survey, physicians cited a lack of trust or agreement with patients as the largest frustration in communicating with their patients [6].

Physicians who are skilled in collaborative physician-patient communication will become acquainted with their patients more quickly and will more easily develop relationships that promote their patients' well being. Beginning a new patient encounter with the intention of listening and understanding the patient's point of view will go a long way toward building rapport and trust [12]. Asking the patient, "What is the most important issue for you to address today?" will highlight the issue that deserves the physician's time and attention. Patient satisfaction is also improved when patients feel that their physician has listened to and heard their concerns [16]. Failure to take this approach may result in a poor outcome, as was seen in the first scenario involving Dr. Maren and Ms. Williams. Dr. Maren did not address Ms. Williams' need to alleviate stress. He also made poor use of nonverbal communication, examining paperwork instead of directing all of his attention toward Ms. Williams.

Another impediment to building trust in the physician-patient relationship lies in the physician's fiduciary responsibility both to the patient and to a health plan, which is inherent in managed care [17,18]. This potential conflict has caused the public to be increasingly suspicious that physicians bend to managed care pressures to control costs and thus place economic incentives above doing what is best for patients. Furthermore, patients covered by insurance plans where health care is prepaid may feel entitled to whatever tests are available [19].

The collaborative style of communication may be helpful in these cases. For example, asking a patient

who requests magnetic resonance imaging for a benign-sounding headache why he wants the test may allow the physician to discover a legitimate and worrisome concern (eg, "I'm afraid I have an aneurysm just like my friend had before he died"). The physician can then address and possibly alleviate the patient's concern without approving an expensive and unnecessary test. On the other hand, some concerns may be alleviated by referral to a specialist. It is important that the patient is reassured of his physician's role as patient advocate and that the physician attempts to alleviate the underlying concerns that prompt a request for a test. The collaborative model requires physicians to approach the physician-patient relationship as a more equal one, with a greater tolerance for patient participation in decision making [12,20].

### **Overcoming Time Constraints**

Time constraints are a reality of the current practice environment [3]. To maximize the quality of time with each patient, the physician needs to be aware of the patient's potential agendas. Dealing with the patient's acute issue is important, but it is also essential for the physician to pay attention to the clues given by the patient about her life or emotional state. Although it may appear counterintuitive, a collaborative style of communication can actually save time in the long run. Levinson and colleagues [21] have shown that visits with missed clues were often longer than those where the physician noticed the clue.

Using a collaborative style, the physician can get to the heart of the patient's concerns more quickly. For example, an open-ended comment such as, "Tell me more about the stress at work and how it impacts your smoking" will allow the patient to offer more details about her life, providing important insights into the factors that may significantly impede her ability to quit. Asking patients to highlight all their concerns up front may also make the visit more efficient [22].

Another possible impediment to time-efficient physician-patient communication is a difference in cultural beliefs about the causes and cures for health problems. The population of the United States is racially, socioeconomically, and culturally diverse. This diversity increases the likelihood that patients will not understand or agree with the doctor's treatment advice and that physicians will not be aware of alternative treatments and beliefs that may augment or conflict with their treatment plans. The collaborative style can be used to draw out cultural beliefs through open-ended, nonjudgmental statements such as, "Tell me about any treatments that you or your family use to help control your illness."

### **Assisting Patients with Health Information**

A recent factor that has greatly influenced the physician-patient relationship is the plethora of information now available to the public about health and illness. With the proliferation of print and online health information, physicians are no longer the only health educators for their patients. Although some patients may be able to make savvy choices about the value and efficacy of various treatment options, others will need help from their physician in evaluating the reputability of the information to which they have access. Given accurate information and a well-informed patient, a physician can help the patient think through the value of different treatments, thereby enabling a mutually agreed upon choice of the most acceptable course of action. Patients who have less access to accurate information or who are less well prepared to compare and analyze different courses of action may require a different approach to decision making.

Patient access to health information can ease collaborative communication and decision making as well as complicate communication. As patients feel more empowered, they may request tests that are not medically indicated. For example, based on information gleaned from reading, surfing the Internet, or speaking with other people with similar health concerns, a patient may ask for tests that his physician considers unnecessary based on her knowledge and education. Again, it is important that the physician attempt to alleviate the patient's underlying concerns that prompted the request for the test and reassure the patient that she is his advocate. A physician cannot possibly be aware of all the information available to the public. But through an open discussion of the material with her patient, the physician can help him identify whether the information source is reliable and how and whether it applies to him [23]. In addition, it is advisable to be familiar with some of the more useful patient Web sites (eg, the National Library of Medicine's layperson's site: [www.medlineplus.gov](http://www.medlineplus.gov)).

### **Conclusion**

A high-quality physician-patient relationship improves patient outcomes, increases satisfaction with care, and makes the practice of medicine enjoyable [20]. While the realities of daily medical practice in the modern managed care era may appear to work against developing and maintaining such a relationship, it is more important now than ever before for physicians to nurture close, trusting, and mutually respectful relationships with their patients. Adopting a collaborative style of communication will allow physicians to sustain such

relationships with their patients, irrespective of the managed care context in which they practice.

### References

1. Bensing JM, Verhaak PF, van Dulmen AM, Visser AP. Communication: the royal pathway to patient-centered medicine [editorial]. *Patient Educ Couns* 2000;39:1-3.
2. Lurie N. Preparing physicians for practice in managed care environments. *Acad Med* 1996;71:1044-9.
3. Gordon GH, Baker L, Levinson W. Physician-patient communication in managed care. *West J Med* 1995;163:527-31.
4. Cassell EJ. *Talking with patients*. Cambridge (MA): MIT Press; 1985.
5. Quill TE. Recognizing and adjusting to barriers to doctor-patient communication. *Ann Intern Med* 1989;111:51-7.
6. Levinson W, Stiles WB, Inui TS, Engle R. Physician frustration in communicating with patients. *Med Care* 1993;31:285-95.
7. Levinson W. Improving communication with patients. *Hosp Pract (Off Ed)* 2000;35:113-4, 117-20.
8. Shapiro J, Yu R, White MK. Reconciling doctor and patient agendas: a case illustration. *Semin Med Pract* 2000;3:30-6.
9. Cohen-Cole SA. *The medical interview: the three-function approach*. St. Louis: Mosby Year Book; 1991.
10. Mishler EG. *The discourse of medicine: dialectics of medical interviews*. Norwood (NJ): Ablex Publishing Corporation; 1984.
11. Laine C, Davidoff F. Patient-centered medicine. A professional evolution. *JAMA* 1996;275:152-6.
12. Roter D. The enduring and evolving nature of the patient-physician relationship. *Patient Educ Couns* 2000;39:5-15.
13. Tresolini CP, Pew-Fetzer Task Force. Health professions education and relationship-centered care: conference proceedings. San Francisco: Pew Health Professions Commission; 1994.
14. Anderson RM, Funnell MM, Butler PM, et al. Patient empowerment. Results of a randomized controlled trial. *Diabetes Care* 1995;18:943-9.
15. Charles C, Gafni A, Whelan T. How to improve communication between doctors and patients. Learning more about the decision making context is important [editorial]. *BMJ* 2000;320:1220-1.
16. Bertakis KD, Roter D, Putnam SM. The relationship of physician medical interview style to patient satisfaction. *J Fam Pract* 1991;32:175-81.
17. Pearson SD, Sabin JE, Emanuel EJ. Ethical guidelines for physician compensation based on capitation. *N Engl J Med* 1998;339:689-93.
18. Levinson W, Gorawara-Bhat R, Dueck R, et al. Resolving disagreements in the patient-physician relationship: tools for improving communication in managed care. *JAMA* 1999;282:1477-83.
19. Gallagher TH, Lo B, Chesney M, Christensen K. How do physicians respond to patients' requests for costly, unindicated services? *J Gen Intern Med* 1997;12:663-8.
20. Joos SK, Hickham DH. How health professionals influence health behavior: patient-provider interaction and health care outcomes. In: Glanz K, Lewis FM, Rimer BK, editors. *Health behavior and health education: theory, research, and practice*. San Francisco: Jossey-Bass; 1997:216-41.
21. Levinson W, Gorawara-Bhat R, Lamb J. A study of patient clues and physician responses in primary care and surgical settings. *JAMA* 2000;284:1021-7.
22. White J, Levinson W, Roter D. "Oh, by the way ...": the closing moments of the medical visit. *J Gen Intern Med* 1994;9:24-8.
23. Boyer C, Selby M, Scherrer JR, Appel RD. The Health On the Net Code of Conduct for medical and health Websites. *Comput Biol Med* 1998;28:603-10.

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