Good Physician-Patient Relationship = Improved Patient Outcome?

Marjorie A. Bowman, MD
Winston-Salem, North Carolina

The paper by Bertakis et al[1] in this issue of *The Journal of Family Practice* addresses patient satisfaction with specific physician behaviors. The results suggest overall patient satisfaction with the discussion of psychosocial issues and with the lack of physician dominance.

A discussion of psychosocial issues is frequently considered important but is not consistently believed to be a necessity of the physician-patient interaction. Family physicians have been particularly strong advocates of dealing with the nonmedical context of the physician-patient relationship, and family physician educators have incorporated education regarding this relationship into residency training programs. Much of this is taught under the rubric of "behavioral sciences." Perhaps it is time to establish a scientific basis for this emphasis on the effects of developing a positive physician-patient relationship. Does the educational effort in this area pay off for patients in the long run?

The first major issue is the relative importance of the physician-patient relationship as compared with other aspects of medical care. Most studies, including the study of Bertakis et al,[1] suggest that patient ratings of biomedical competence correlate best with overall satisfaction, whereas other physician behaviors, such as dealing with psychosocial concerns, have a smaller role. If the patient believes the physician is medically incompetent, a nice physician-patient relationship that includes discussion of psychosocial topics will not overcome this deficiency.

The second major issue is terminology. The literature on patient satisfaction and psychosocial concerns suffers from unclear and nonrepetitive use of terms that may or may not be related. In attempting to place the work of Bertakis et al[1] in perspective, this is of tantamount importance. What is "psychosocial concern"? Is it interpersonal skills? Is it patient-centeredness, open questions, empathy, allowing the patient to discuss psychosocial problems, permitting patient exposition, or physician-initiated discussion of psychosocial problems? Or is it partnership and emotional support, one concept of Bertakis et al? What is the relationship of the discussion of psychosocial concerns to the physician-patient relationship? Can one incorporate some aspects of physician behavior, but ignore psychosocial issues, and still get good results? Each of these concepts,[2] along with the affective tone of the interaction and nonverbal encouragement, are intimately intertwined. They are also all too often lumped together in the literature in an unclear fashion.

Bertakis et al[1] note several studies that indicate a positive effect of discussion of psychosocial issues on patient satisfaction. Particularly when related concepts are considered, however, the literature appears inconsistent. For example, neither the knowledge[3] nor discussion[4] of a patient's psychosocial problem are sufficient for satisfaction to automatically occur. In one study,[4] almost one half of the patients did not feel helped by a discussion of nonmedical problems and were not more satisfied. In another study,[5] patient centeredness (primarily open-ended questions and responses) did not increase patient satisfaction either.

If discussing psychosocial issues and permitting patient exposition are truly important in the physician-patient relationship, and I suspect they are, then teaching physicians to appropriately use these skills should result in improved patient satisfaction. In one interventional study done in Australia[6] it was found that general practitioners who received 6 hours of training on patient satisfaction and on the psychological variables in the physician-patient interaction had patients who were more satisfied and less anxious after a visit as compared with the patients of a control group of physicians. Putnam et al[7] trained internal medicine residents to increase patient exposition and physician explanation, but found no increase in patient satisfaction. Other studies have

Department of Family and Community Medicine, Bowman Gray School of Medicine, Wake Forest University. Requests for reprints should be addressed to Marjorie A. Bowman, MD, Bowman Gray School of Medicine, Wake Forest University, 300 S Hawthorne Rd, Winston-Salem, NC 27103.

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used patient rather than physician interventions.[8,9] Thus, the few interventional studies that exist insufficiently clarify what should be done.

It is likely that both the biomedical and emotional needs of the patient must be met for the patient to feel satisfied, or, at least, for optimal patient satisfaction. As Martin and Bass[4] found, the patients who believed that the "doctor tells me all I want to know about my illness" and the "doctor gives me a chance to say what is really on my mind" felt helped, were more satisfied, and had higher rates of compliance. Similarly, if the patient has a need to discuss "sensitive" topics such as psychosocial concerns, the physician-patient interaction must be such that the topic can be introduced and appropriately handled. This may be true whether the patient is fully conscious of his or her need[10] or whether the patient believes he or she should discuss the sensitive issue with the physician. Furthermore, the patient's evaluation of the physician's affective tone or ability to discuss psychosocial issues probably affects the evaluation of the physician's biomedical abilities.[11,12] Alternatively, the *lack* of sufficient attention to psychosocial issues may be even more related to *dissatisfaction* than the *presence* of attention is related to *satisfaction*.

Since family medicine has been the primary medical proponent of psychosocial issues, the primacy of biomedical competence and the secondary nature of other aspects of the physician-patient interaction raise important questions for the discipline. What is the actual role of psychosocial issues? Previous attempts to identify the importance of these factors in medical care have been insufficient. Could it be that we are wrong? Or is it that the "softness" and complexity of the interaction between psychosocial issues, the related concepts, the physician's behavior, and patient medical problems have inhibited our ability to find simple answers?

We perform in the physician-patient relationship daily, yet we do not understand it. Family physicians, by virtue of their specialty's role in primary care and their professed belief in psychosocial medicine, have the major responsibility for clarifying the terminology, determining what is important for practice, and deciding just how, after all is said and done, patient outcomes will be improved. We need to be more critical and focused. As a start, a committee or working group could develop specific terminology that could be widely accepted and serve as a basis for more critical research. As research increases in sophistication and encompasses both the biomedical and sociological domains, we are in an excellent position to finally move forward on these issues. Perhaps it is time to "put up or shut up."

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