As managed care has proliferated in the United States and other countries, it has transformed patient-doctor relationships, including those between older patients and their physicians. This transformation has occurred rapidly, with little preparation for either clinicians or patients. In any assessment of managed care's impact, the effects on patient-doctor relationships deserve attention. The debate so far has raised many potential problems, few of which have received serious enough analysis to exert an impact on health care policy, either within or outside the managed care industry.

The impact of managed care illustrates a more general principle: changes in the health-policy environment establish the pattern for changes experienced in patient-doctor relationships. Important constraints emerge from the economic structure of the health-policy environment. Such constraints currently include the financial and contractual arrangements that physicians and patients make with managed care organizations (MCOs).

GATEKEEPER VERSUS DOUBLE AGENT

Advocates of managed care often claim that this method of organizing services can and should actually improve the patient-doctor relationship. For instance, since MCOs generally assign patients to a single primary care physician, that physician presumably can provide continuity and can help improve the coordination of services. The primary care provider can communicate about preventive services and encourage their use. Because managed care services are mostly paid in advance through monthly capitation payments, the predictability of copayments required for each outpatient visit also may reduce financial barriers to access for some patients.

Older patients, who often may be treated for a variety of chronic diseases, may benefit greatly from this approach. With one physician overseeing the patient's care, redundancy of services and conflicting drug and treatment protocols, which can result when two or more doctors are treating a patient without knowledge of the other's treatment plan, are less likely to occur. Under such a plan, the relationship between the primary care physician and the patient becomes central to the care of the patient. All
information about the patient's health care should be channeled through the primary care physician, who works with the patient to identify what services are needed. The primary care physician who is familiar with an older patient's values and goals for care can act as an advocate for the patient when the patient must interact with other health care providers.

There is no consistent evidence that continuity of care has improved, nor has a single research project conclusively demonstrated improved patient-doctor communication processes or patient satisfaction in managed care systems. The limited studies comparing communication and satisfaction in managed care versus fee-for-service sectors have found either no difference or observations disfavoring managed care.\[8\] \[10\] \[37\] The adverse impact of managed care on communication processes and the patient-doctor relationship also has received attention in several influential editorials and position papers,\[3\] \[4\] \[6\] \[14\] \[28\] \[29\] Further, the claimed advantages of managed care in the arenas of communication and interpersonal relationships have not been assessed in detail for growing subgroups of enrollees, including older people, minorities, the poor, non-English speakers, and the chronically ill.

Managed care refers to primary care practitioners as "gatekeepers." That is, such physicians tend the gate, keeping it closed for expensive procedures or referrals to specialists or emergency visits, and open the gate only when it is absolutely necessary for preservation of life or limb. The reason for tending the gate carefully is very clear: that is how physicians and plan administrators and plan shareholders keep enough of patients' capitation payments to break even or make a profit.

Double-agent, as Marcia Angell\[3\] and others have pointed out, probably has become a more cogent way to think about physicians' role as gatekeeper under managed care. In essence, while continuing to pose as advocates for patients, doctors in actuality work as double agents for both patients and MCOs.

Thus, although physicians have a responsibility to provide their patients with high quality health care, they also are required to provide this care in a cost-effective manner. This means limiting patient access to certain services and health care products. One role of the physician under managed care may be to justify the limitations of care that a patient receives. An assumption underlying the limitations is that sound practice guidelines exist that assure quality health care to patients. The following interaction between a doctor and 69-year-old patient recorded in a managed care practice in the authors' current research on doctors and older patients demonstrates how doctors explain these limitations to their patients:

PATIENT: They're going to burn my heart

DOCTOR: Right

PATIENT: And then they're going to put a thing in it. But they can't do it because of insurance until ...

DOCTOR: Right

PATIENT: Until they've exhausted everything--which I can understand ...

DOCTOR: Well that's ... uh ... not an easy task and there are risks involved. I wouldn't want anybody doing that until I've exhausted other things either so it's not just insurance. It's ... it's common sense too.

In some instances under managed care, patients clearly have been deprived of services that were necessary to them, and cost-saving has become an explanation for service that is denied a patient. In this instance, however, the doctor justifies the policy of the insurer, explaining that it makes sense. The doctor does not indicate, however, that the policy makes sense because it reflects practice guidelines that are based on research and experience identifying benefits and risks to patients.

Not all physicians interpret the intercession of managed care practice guidelines as beneficial. Circumvention of the guidelines is another option. An example is the following interaction between a doctor in an MCO and his 68-year-old female patient. The doctor sits at a desk covered by paperwork. Whereas in the past his attention may have been drawn to the patient's chart, now the doctor's attention is on what appears to be insurance forms. The doctor looks up at the patient from time to time as they talk, but before and after the physical exam the doctor primarily concentrates on filling out these forms:
DOCTOR: And as always you have your medications written out. Have you had any recent changes?

PATIENT: Yes ... I can't believe it that they took Maxair away from me.

DOCTOR: They did. Okay.

PATIENT: Says you agreed or ...

DOCTOR: Well I had to agree if it's not on the ... uh ... not on the uh approved list.

PATIENT: I ... I ... they sent me a small amount to use ...

DOCTOR: Okay.

PATIENT: ... when I get symptoms. I'm doing a lot more huffing and puffing without it but ...

DOCTOR: Are you using Proventil uhm instead?

PATIENT: No.

DOCTOR: Okay.

PATIENT: No, they just left me with two then, the Serevent and the Flovent.

DOCTOR: We'll get you back on ...

PATIENT: There's the letter ... that blue thing.

DOCTOR: We'll go ahead and give you the Proventil you can use in place of that.

PATIENT: But you know I feel better, strangely enough.

DOCTOR: ... . Now how much of the Maxair were you using?

PATIENT: I used it two puffs four times a day, for years, since the beginning I had that. 'Cause that's the only one that worked ... fast.

DOCTOR: Now this letter isn't saying you can't use it.

PATIENT: Well they're not sending me that amount. I'm only to carry it for emergencies so they sent me a small amount.

DOCTOR: Oh okay, so they're saying you shouldn't be using it four times a day every day.

PATIENT: No ... right.

DOCTOR: Okay ... And you're just using it now when you need it but it could still be four times a day.

PATIENT: No.

DOCTOR: How many times are you using it a day?

PATIENT: Twice is the most I've done.

DOCTOR: Okay ... And you think you're having more huffing and puffing because of that?

PATIENT: A little, but I feel better at the same time ... so ...
PATIENT: One less medicine.

DOCTOR: Well, there's some value in that.

Although traditionally researchers have found evidence of a paternalistic approach to the relationship on the part of the physician, here we find an interruption of that relationship by the MCO, which now takes on a paternalistic role, determining what is right for the patient without seeing or talking to the patient. In this instance, as it turns out, the patient actually feels better taking medication under the MCO restriction compared with the doctor's previous order. The doctor might best respond to the patient by probing the patient's remark about "feeling better," determining whether the decreased medication is sufficient for relieving the patient's breathing difficulties, and allowing the patient to continue with fewer medications. Instead, the approach the doctor takes is to identify another medication that will serve the same purpose as the medication the patient is no longer allowed to use. Thus, the doctor must reestablish his authority by circumventing the ruling of the MCO to regain his paternalistic status.

Whether there has been a change in the relationship based on the interference of the MCO is difficult to determine. This patient has seen the doctor for 10 years. She rates him as excellent on his communication skills and 2 weeks following the visit says that she has done everything he told her to do. She says that she can trust his expertise and that it is in her best interest to do what he tells her to do.

Proponents of managed care argue that failure to coordinate care through the primary care provider has been one of the reasons MCOs have not been financially successful. An example of how patients are referred to specialists within some MCOs is seen in the following interaction between a doctor and his 69-year-old patient.

DOCTOR: Do you need any referrals today?

HUSBAND: No.

DOCTOR: Well ... uh ... no ... uhm ... They, uh ...

HUSBAND: I talked to the nurse about this.

PATIENT: Did you? They called me two weeks ago and told me I don't need referrals for Dr.------ any more.

DOCTOR: Okay.

HUSBAND: Well you do, now,

DOCTOR: I think if you see him for ...

HUSBAND: It's for a Pap test.

DOCTOR: If you see him for a Pap test there's no problem.

PATIENT: Ohhh.

DOCTOR: But if you end up seeing him for a problem--let's say you have profuse bleeding and you need to see him--then you would need a referral.

PATIENT: Okay.

DOCTOR: The eye doctor you don't need a referral for, uhm ...

HUSBAND: What about mammograms?

DOCTOR: I don't know. You'll have to check with the girls at the desk.

PATIENT: Well I just had one and they like to killed me.
HUSBAND: Well she said that. She told us at the same time she told us about not a referral for the Pap test, we don't need a referral for the mammograms. That's what the woman said up here. But we already had it.

DOCTOR: If there's any question, check with my girls.----- can answer it for you.

The doctor initiates the discussion of referrals, not by indicating to the patient what services are needed for this patient's care beyond those he himself can provide, but by asking the patient what services the patient has identified a need for. The responsibility for referrals has moved to the patient and the "girl" at the desk, who is familiar with the various insurers and can tell the patient when a referral is necessary. The patient determines what referrals might be useful and tells the medical assistant what specialist she wants to see. The assistant checks the patient's plan to see if a referral is needed and obtains it from the doctor if necessary.

The patient in this instance is telling the physician that she went to have a mammogram and possibly a Pap smear, but this does not appear to have been the result of a discussion with her primary care physician nor does this physician indicate that he has received the results of these examinations and will be discussing them with her. In this case the patient still lacks the continuity that is the goal of managed care. Although the patient is receiving a mammogram and Pap smear, appropriate preventive care for a woman her age, it appears that this has occurred as a result of her own initiative. Other preventive examinations may be necessary of which she is unaware and will not initiate on her own. The relationship between the doctor and this patient appears to be good. She has been his patient for 5 years and reports doing everything he tells her to do.

These pictures of interactions under managed care, however, do not portray the conflict physicians experience while they are "continuing to pose" as patient advocates. Perhaps "continuing to pose" as patient advocates may not convey the conflict adequately. Recently an author (HW) spent nearly a day advocating for a single patient, a 58-year-old psychologist with a displaced fracture of her elbow, to various MCO bureaucrats, in order to convince them that she really did need an orthopedic appointment today rather than in 3 weeks, and also really needed surgery in 3 days rather than possibly in the indefinite future. In dealing with this and similar cases, the doctor has experienced several feelings:

- Anger that the nature of managed care led to a critical delay in a patient's evaluation and treatment;
- Awareness that financial considerations underlie all these decisions, that he and his colleagues would receive a bonus at the end of the year if they could hold down emergency room use, that the paltry $7 per month that two of his colleagues received to cover all outpatient care for each of these patients would decrease even further if use became much higher, and that his own motivation to provide services subtly decreased with such managed care patients, because doing more work was not associated with more income (he also thought of Health Net's chief executive officer at the time, Roger Greaves, who reportedly received a salary of almost $3 million, plus bonuses and stock options, and who seemed the main beneficiary of doctors' good work as gatekeepers [8]);
- Frustration that these emotions deviated enormously from those he had expected to have in medicine, a career he selected with the assumption that he mainly would have the opportunity to serve those in need and to receive an adequate salary for doing so, not linked to patients' ability to pay or insurance coverage;
- Most of all, awareness that his communication with managed care patients was becoming distorted by the structural nature of these payment arrangements, and that the openness and honesty he valued were becoming ever more tenuous.

Although, as the reader may have surmised, these are the unique experiences of one of the authors (HW), many clinician colleagues are burning out at the energy such maneuvering takes, with little apparent benefit for either patients or the physician gatekeepers. At the very least, doctors find that such activities lead to rationing of services by inconvenience. [20] That is, when obtaining services for patients entails such inconvenience, an incentive arises not to pursue the matter vigorously, thus decreasing the probability that the patient will receive the services, even though needed.

More often, clinicians feel an inherent conflict--either ethical, financial, or both--between patients' interests and those of the managed care systems that physicians represent as gatekeepers. This is the essence of physicians' work as double agents. Clinicians experience this conflict even when they supposedly benefit financially by keeping the gate closed.
FINANCIAL AND ORGANIZATIONAL ISSUES

From the patient's viewpoint, the structure of managed care constrains the very nature of the communicative process. Instead of exploring possible options with full participation in decision making, the patient must make a case strong enough to be accepted by the gatekeeping physician. Financial interests, by which up to 80% of physicians' annual income may be at risk if they do not adequately restrict services under managed care contracts, reinforce the physician's skeptical appraisal. Under these conditions, as patients become more aware of such financial relationships, patients' trust of their physicians may erode seriously.

Further, the communicative process increasingly occurs under constraints of time. The on-call doctor, unpaid for time spent on the phone in the middle of the night, is not disposed to lengthy and supportive conversation, especially with a patient who is a stranger. For more routine encounters during daylight hours, additional constraints on communication arise, as the productivity expectations of MCOs create standards that require physicians to see greater numbers of patients per unit of time. From the organizational viewpoint, the fixed prepaid capitation received per patient exerts pressure to maximize the number of patients seen by each salaried practitioner in each patient-care session. Since MCOs strive to fill doctors' schedules, patients may have to see practitioners other than their own, including physician substitutes like nurse practitioners and physician assistants; such organizations frequently employ midlevel practitioners to handle overflow from physicians' full schedules. Physicians employed by MCOs therefore enjoy little discretion in determining how much time to spend with each patient.

Conversely, structural constraints in the patient-doctor relationship did not begin with managed care. Under the prior fee-for-service system, communication between patients and doctors suffered from a variety of problems, some tied to the financial underpinnings of that particular form of practice organization. For instance, encounters between primary care practitioners and patients tended to be hurried, and little time was spent communicating information. Interruptions and dominance gestures by physicians commonly cut off patients' concerns. Further, exploration of issues in the social context of medical encounters, which patients experienced as important components of their lived experience of illness, tended to become marginalized in patient-doctor encounters.

The financial structure of fee-for-service medicine created an incentive to maximize patients seen per unit of time, and decrease the time devoted to in-depth exploration of patients' concerns. In contrast to managed care, this productivity constraint usually permitted the practitioners substantial discretion in choosing how much time to spend with a given patient. Patients' dissatisfaction with communication under the fee-for-service system nevertheless continued to rank among their most frequently voiced complaints about US medical practice. In recent years, even before the advent of managed care, patients' dissatisfaction with communication, by which up to 80% of physicians' annual income may be at risk if they do not adequately restrict services under managed care contracts, reinforce the physician's skeptical appraisal. Under these conditions, as patients become more aware of such financial relationships, patients' trust of their physicians may erode seriously.

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Under managed care, time constraints will continue to be a problem specific to interactions with older patients. The cognitive, sensory, and functional impairments that occur among older patients can result in inefficient visits when the patient is hard of hearing or requires information to be presented slowly and repeated for clarification. For older patients with chronic diseases and complicated medication schedules, the review of medications may use up the time allotted for a visit.

The relationship between a doctor and older patient also may be affected by the presence of a third person at the visit. The third person is often a spouse or other family member but also may be a paid caregiver. Although there are clearly benefits for older patients when a companion is present as an advocate for the patient's interests, this is not always for the best. On the contrary, the doctor may address questions and information to the companion, ignoring the patient and referring to the patient in the third person. Although interactions with a companion present do not appear to affect the length of an interaction, they affect the opportunity for the patient to introduce topics that may not be appropriate for discussion when a third person is present. This opportunity can only be regained if doctors set aside some time during the visit to be alone with a patient, as Greene and colleagues recommend. In the author's study of patients in a managed care setting, they have seen no evidence that encounters with older patients have been assigned a longer appointment. Variability has only occurred within practice sites with a range of 10 to 20 minutes per patient based on the dedication of the site to managed care protocols.

A routine examination for a 91-year-old woman with her doctor of 5 years is an example of what occurs when a patient is frail and somewhat slow in her responses to the doctor. This patient is accompanied by...
her daughter-in-law. As the encounter begins, the doctor speaks directly to the patient. After a review of medications, the doctor asks the patient about any concerns. She mentions stiffness on one side of her body. "If it gets much stiffer, I'm not going to be able to live by myself because I won't be able to dress myself." The doctor examines the patient on the examining table, asking her questions and checking her strength.

Once the examination is finished, the doctor turns to the daughter-in-law. In giving information about his findings, he says, "It may be related to even a stroke she's had ... I think it's possible that she's had a small stroke at some time." His explanation of the possible cause of the weakness continues in the third person to the companion.

As the encounter ends, the doctor asks for other questions. Here the companion acts as an advocate for the patient, and the benefit of the presence of a third party, especially for a frail elderly patient, is evident:

Physician: Any questions at all?

Patient: Oh, I don't think so (turns to look at daughter-in-law).

Companion: I was just wondering if maybe she needs a little physical therapy or occupational therapy or whatever it's called to, uh, get these, uh, joints limbered up.

Physician: Well that that's a good point and that might help. I'd like first of all to make sure ...

Companion: Right

Physician: ... what we're dealing with and then to get her into therapy would make a lot of sense.

A concern under managed care is that physicians, as double agents, may limit services to older patients because of ageist attitudes that older patients are less worthy of costly treatments than younger, more productive patients. This concern existed under fee-for-service as well. [22] Another concern may be that physicians under managed care are no better prepared to deal with the needs of older patients, and that they may overlook the need for support services because of the biomedical nature of their training. Because this patient's care is occurring in a managed care setting, a first thought may be that the physician has not recommended physical therapy because there is an incentive to keep costs low by restricting the use of ancillary services. Instead, because the doctor recommended a change in medication that might prevent further strokes, another explanation for this treatment plan may be that it is a biomedical response to a patient problem. The physical therapy, which is an important aspect of care of allowing the patient to continue to live alone, does not deal with the patient's disease but with the patient's contextual experience with disease. It is difficult to determine whether the doctor ignores this aspect of care because of a financial incentive not to incur further costs for this patient or because biomedical training causes doctors to ignore the contextual aspects of disease and illness. His willingness to add this treatment suggests that the latter may be the case here.

SOCIAL CONTEXT AND PATIENT-DOCTOR COMMUNICATION

One of the authors' research interests over the last few years has been how patients and doctors deal with social problems in medical encounters. [43] [45] The following encounter, which conveys an older woman's loss of home, community, and autonomy, illustrates this problem.

Case History

An elderly woman visits her doctor for follow-up of her heart disease. During the encounter she expresses concerns about decreased vision, her ability to continue driving, lack of stamina and strength, weight loss and diet, and financial problems. She discusses her recent move to a new home and her relationships with family and friends. Her physician assures her that her health is improving; he recommends that she continue her current medical regimen and that she see an eye doctor.

From the questionnaires that the patient and doctor completed after their interaction, some pertinent information is available. The patient is an 80-year-old white high school graduate. She is Protestant, Scottish-American, and widowed, with five living children whose ages range from 45 to 59 years; she...
describes her occupation as "homemaker." Her doctor is a 44-year-old white man who is a general internist. The doctor has known the patient for about 1 year and believes that her primary diagnoses are atherosclerotic heart disease and prior congestive heart failure. The encounter takes place in a suburban private practice near Boston.

The patient recently has moved from a home that she occupied for 59 years. The reasons for giving up her home remain unclear, but they seem to involve a combination of financial factors and difficulties in maintaining it. During silent periods in the physical examination of the patient's heart and lungs, the patient spontaneously narrates more details about the loss of possessions and relationships with previous neighbors, along with satisfaction about certain conveniences of her new living situation. Further, as the patient speaks, the doctor asks clarifying questions about the move and gives several pleasant fillers, before he cuts off this discussion by helping the patient from the examination table:

P: Yeah... [moving around noises] Well, I sold a lot of my stuff.

D: Yeah, how did the moving go, as long as (word inaudible)

P: And y'know take forty ni-fifty nine years accumulation. Boy, and I've got cartons in my closet it'll take me till doomsday to, ouch.

D: Gotcha.

P: But I've been kept out of mischief by doing it. But I've got a lot to do, I sold my rugs 'cause they wouldn't fit where I am. I just got a piece of plain cloth at home.

D: Mm hmm.

P: Sometimes I think I'm foolish at 81. I don't know how long I'll live. Isn't much point in putting money into stuff, and then, why not enjoy a little bit of life?

D: Mm hmm, (words).

P: And I've got to have draperies made.

D: Now, then, you're (words).

P: But that'll come. I'm not worrying. I got an awfully cute place. It's very very comfortable. All electric kitchen. It's got a better bathroom than I ever had in my life.

D: Great... Met any of your neighbors there yet?

P: Oh, I met two or three.

D: Mm hmm.

P: And my, some of my neighbors from Belmont here, there's Mrs. F--and her two sisters are up to see me, spent the afternoon with me day before yesterday. And all my neighbors um holler down the hall (words) ... years ago. They're comin', so they say. So, I'm hopin' they will. I hated to move, 'cause I loved, um, I liked my neighbors very much.

D: Now, we'll let you down. You watch your step.

P: You're not gonna let me, uh, unrobed disrobed today.

D: Don't have to, I think.

P: Well!

D: Your heart sounds good.

P: It does?
After the doctor mentions briefly that the patient's heart "sounds good," he and the patient go on to other topics. The doctor's cutoff and a return to technical assessment of cardiac function (he previously has treated her congestive heart failure) have the effect of marginalizing a contextual problem that involves loss of home and community.

From the patient's perspective, the move holds several meanings. First, in the realm of inanimate objects, her new living situation contains several physical features that she views as more convenient, or at least "cute." On the other hand, she apparently has sold many of her possessions, which carry the memories of 59 years in the same house. Further, she feels the need to decorate her new home but doubts the wisdom of investing financial resources in such items as rugs and draperies at her advanced age.

Aside from physical objects, the patient confronts a loss of community. In response to the doctor's question about meeting new neighbors, the patient says that she has met "two or three." Yet she "hated" to move, because of the affection that she held for her prior neighbors. Describing her attachment, she first mentions that she "loved" them and then modulates her feelings by saying that she "liked them very much." Whatever the pain that this loss has created, the full impact remains unexplored, as the doctor cuts off the line of discussion by terminating the physical examination and returning to a technical comment about her heart.

Throughout these passages, the doctor supportively listens. He offers no specific suggestions to help the patient in these arenas, nor does he guide the dialogue toward deeper exploration of her feelings. Despite his supportive demeanor, the doctor here functions within the traditional constraints of the medical role. When tension mounts with the patient's mourning a much loved community, the doctor returns to the realm of medical technique.

Even before managed care made its inroads into clinical practice, many practitioners felt reluctant to get involved in helping to improve the contextual problems that patients face, no matter how important such problems may be. Doctors may rationalize that there is not time, or intervening in social problems goes beyond the medical role. The answers have never been simple, but the productivity expectations and financial structure of managed care discourage efforts to deal with such problems even further. We have worked out some preliminary criteria to guide practitioners in addressing contextual concerns.

These criteria address the question of to what extent physicians should intervene in the social context. The answer to this question partly depends on clarification of the practitioner's role, especially the degree to which intervention in the social context comes to be seen as appropriate and desirable. Practitioners reasonably may respond to this analysis by referring to the time constraints of current practice arrangements, the need to deal with challenging technical problems, and a lack of support facilities and personnel to improve social conditions. How doctors should involve themselves in contextual difficulties without increasing professional control in areas where doctors claim no special expertise, therefore, takes on a certain complexity.

Our research, however, suggests that the presence of social problems in medical encounters warrants more critical attention. Elsewhere, we and others have spelled out suggestions for improving medical discourse by dealing with contextual difficulties more directly. 

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In considering the time and costs devoted to contextual discussion and intervention, a point of concern especially to MCOs, a third criterion suggests that doctors and patients consider effects of contextual conditions on outcomes of care, such as prognosis, functional capacity, and satisfaction. Regarding the above encounter, for instance, the geriatric literature provides extensive evidence that social isolation, lack of convenient transportation, financial insecurity, and inadequate nutritional support all worsen the functional capacity of older people. Contextual concerns like isolation and related social psychological problems also can affect morbidity and mortality. For instance, there is now a large literature showing that social isolation and psychological distress are associated with higher rates of adverse cardiac events after myocardial infarction, and that these effects may be equal or greater in magnitude than previously established cardiac risk factors. Current productivity standards in managed care are leading to tighter...
scheduling of shorter appointments, which do not encourage the exploration of contextual concerns. When constraints of time and costs require prioritization, existing evidence about the importance of specific contextual problems for health outcomes can help guide physicians and patients in targeting contextual issues for discussion and intervention. Likewise, a reasonable hypothesis for future research is that the marginalization of contextual issues may be inversely related to patient satisfaction, an important outcome of care, and that for many patients more explicit attention to contextual problems would enhance satisfaction.

As a fourth criterion, practitioners should consider referral to social workers, psychologists, or psychiatrists but also should evaluate whether specific patients would benefit more from dealing with contextual issues exclusively in the primary care setting. In managed care, the primary care practitioner usually initiates such referrals, but administrative reviewers, often through utilization review committees, must approve the referrals for reimbursement. For some patients, experiences with mental health professionals prove unsatisfactory or financially prohibitive. In addition, mental health professionals’ role in mediating socially caused distress has received criticism both outside and inside the psychiatric profession (for example, Laing, 1964; Kupers, 1981; Davis, 1986; Davis, 1988). Even aside from utilization review, because many patients do not feel comfortable in seeking help from mental health professionals, primary care practitioners rather than psychiatrists probably will continue to see the majority of patients with emotional problems who present to physicians for care (Depression Guideline Panel, 1993). Although referrals to mental health professionals sometimes may prove necessary or appropriate, a broad mandate encouraging such care for people suffering from contextually based distress is not a solution.

As a fifth criterion, physicians and MCOs should try to avoid the medicalization of social problems that require long-term reforms in social policy, and medicalization itself requires further critical attention. At the individual level, medicalization can become a subtle process. For instance, there is a fine line between physicians’ discussing contextual interventions and assuming professional control over broad arenas of patients’ lives. At this point it is important that physicians not imply that the solution of contextual difficulties ultimately becomes the individual’s responsibility.

Even from the standpoint of utilization and cost, it can be argued that attention to contextual concerns in many instances can improve functional status, decrease unnecessary utilization, and possibly reduce the costs of care, especially for at-risk people like older patients and those affected by poverty. Aiming toward a more supportive and humanistic encounter, one that can address contextual concerns rather than simply marginalizing them, then may emerge as a goal that even some enlightened MCOs could support.

Clearly, it would be helpful if patients and doctors could turn to more readily available forms of assistance outside the medical arena to help in the solution of social problems, and current conditions do not evoke optimism about broader changes in medicine’s social context. Such changes will require time and financial resources, although not necessarily more than those now consumed in inefficient conversations that marginalize contextual issues. From our studies, it is clear that contextual problems warrant social policies to address unmet needs like those expressed in the encounters that we have studied. Of course, these suggestions are not new. Yet it is evident that meaningful improvements in medical discourse between doctors and patients will depend partly on wider reforms that go beyond the changes inherent in managed care.

BARRIERS TO INFORMATION SHARING

The need for information on health and illness does not decrease with age. On the contrary, information seeking has been found to be an important behavior of elderly patients. Beisecker and Beisecker identified an increase in these behaviors with increasing age. They argue that older patients have more chronic problems and therefore may have more questions to ask during the visit to their doctor. Important to note is that the increase in information-seeking in their study was associated with increased length of the visit.

Although organizational and financial conflicts of interest are changing the fabric of patient-doctor communication and relationships, several research projects including our own have documented many barriers to communication between patients and physicians even before the ascendance of managed care. These barriers derive from differences in social class, education, gender, ethnicity, cultural
background, language, and age. In particular, physicians have tended to perform poorly in responding to patients' desire for information about their medical problems, diagnostic testing, treatments, and other aspects of care.\[35\]

Our own research group constructed a random sample of practicing internists in Massachusetts and California and tape-recorded 336 encounters in several clinical settings, including private practice and hospital outpatient departments.\[41\] \[42\] Regarding information giving and withholding, we asked the doctors to rate each patient's desire for information and the helpfulness of giving the information; patients completed a self-rating based on the same seven-point scale. According to their responses, patients wanted to know almost everything and thought that the information would be helpful, but doctors underestimated the patients' desire for information and, when compared with the patients', underrated the clinical usefulness of information giving. In 65% of the encounters, doctors underestimated their patients' desire for information; in 6%, they overestimated; and in 29%, they estimated correctly.

One way that we looked at the transmittal of information was simply the amount of time devoted to the process. We found that doctors spent very little time giving information to their patients—a mean time of 1 minute and 18 seconds, in encounters lasting a mean time of 16.5 minutes. After the recorded encounters, we asked the doctors how much time they thought they devoted to information giving, and then we compared this perception to the actual time that we measured from the tape recordings. On the average, doctors overestimated the time they spent giving information by a factor of nine. Doctors thought that they spent much more time informing their patients than they actually did.

INFORMATION WITHHOLDING IN MANAGED CARE

Beyond such barriers to communication under prior practice arrangements, a new source of information withholding by doctors now pertains to the structure of managed care. This barrier to the sharing of information adds to the other barriers already considered. Doctors participating in managed care rarely, if ever, explain to patients that doctors' own financial earnings under capitated arrangements improve to the extent that they can limit services such as diagnostic tests, expensive treatments, and specialty consultations. In other words, doctors tend not to reveal the financial conflict of interest inherent in managed care.

Of course, MCOs also do not communicate this conflict of interest explicitly to patients whom they seek to enroll. In fact, an increasing source of contention involves gag rules that many MCOs have required their physician employees to follow. These rules explicitly prohibit physicians under contract from disclosing a range of diagnostic or treatment options to patients when they are different from those approved by the administrators of the organization.\[32\] \[48\] The gag rules that restrict physicians in managed care from sharing information that they believe may prove important for patients' health and well-being imposes a basic conflict with doctors' responsibilities under the Hippocratic oath and current ethical norms, which call for prioritization of the patient's welfare over all other concerns.\[2\]

Whereas physicians find themselves in an ethical bind from the imposition of these gag rules, patients are caught in an even more precarious situation. Seen from patients' viewpoint, contracts that forbid a physician to reveal the full range of treatment options or diagnostic techniques to patients violate patients' rights, particularly the right to informed consent.\[7\] \[34\] The legal doctrine of informed consent requires that physicians explain to patients the choices available, the risks and benefits of the proposed treatment, and any alternatives. \[84\] Because a patient's access to this information is restricted as a result of managed care gag rules, informed consent is not achieved, and subsequently, the patient is put at risk. Most often, patients are unaware that such a gag rule exists, and therefore falsely assume that they are receiving all relevant information to give informed consent for the procedure chosen. Not recognizing physicians' conflict of interest, patients predictably assume that they can trust physicians' advice and recommendations because of the ethical responsibility to act in patients' best interests. In such a scenario, informed consent may not be obtained because the patient is in essence not given all necessary information to make a consensual decision. In addition, the consent is obtained under false pretenses: the patient believes that the physician has given all necessary information because it is the physician's responsibility to do so.

In recognition of the ethical dilemmas that gag rules impose, many consumer rights organizations have advocated their abolition. As a response, the Federal government has banned explicit gag rules for MCOs participating in the national Medicare and Medicaid programs. In addition, patients' rights laws
passed by some state legislatures have extended this ban to private managed care plans. Even when formal gag clauses are eliminated from physicians’ contracts with MCOs, however, the financial risk that MCOs frequently impose on physicians to limit their services maintains a more subtle pressure that restricts the communication of diagnostic and therapeutic options. Under these circumstances, although formal gag clauses may appear less frequently in MCOs’ contracts with physicians, the financial conditions that encourage less than full communication continue.

MEDICO-POLITICAL STRUGGLE

As managed care works its transformation of the patient-doctor relationship, the questions of consent and acquiescence present themselves. Why do patients and doctors acquiesce to such a fundamental shift in the historical basis of their relationships? Do patients see little ability to resist a new system of care in which physicians—the professionals with whom they previously valued close and trusting relationships (even if those relationships sometimes became flawed)—have become double agents, gatekeepers who purportedly represent the interests of both patients and corporations, whose revenues depend in large part on restricting services? Have physicians’ quest to maintain their livelihoods really become so desperate that they have become, as some have argued whimsically, like lemmings marching into the ocean of managed care?

An important exception to passivity in the community of US physicians involves an organization that has worked to achieve a national health program for the United States. Physicians for a National Health Program (PNHP), with chapters in all 50 states, initiated a series of proposals between 1989 and 1994 that called for a national health policy based on a single-payer national approach. Modeled on the Canadian system but advocating policies to correct problems that have arisen in Canada, PNHP’s proposals led to the most widely supported alternative to the managed care oriented proposal of the Clinton administration. Although Congressional legislative measures based on the single-payer model failed along with those of the Clinton plan, PNHP has continued to work actively at the national and state levels to maintain the vision of a well organized national program as a viable policy option.

One component of PNHP’s work since the failure of the Clinton proposal has involved a continuing, sharp critique of managed care’s impact on the patient-doctor relationship. PNHP leaders have called attention in many forums to the deleterious effects of gag rules and other restrictions on free communication between patients and doctors. These efforts have contributed to movement in state legislatures and gradually in the national Congress toward reforms that will modify such practices. Further, PNHP has emphasized the adverse impact of corporate policies on access to appropriate care.

A major part of this critical work has focused on administrative waste and the erroneous view that physicians’ practice patterns account for much of the problem of high costs in health care. Although uncontrolled costs comprise a multifaceted problem, administrative waste deserves special emphasis from this viewpoint. Many of the structural problems that affect the patient-physician relationship under managed care, analyzed earlier in this article, are connected to intensive administrative practices that encourage micromanagement of clinical decisions by nonclinical managers within MCOs.

Part of the savings achieved through a national health program could be used to address problems in the patient-physician relationship, such as the development of systems to confront the contextual issues that impinge on medical encounters, as described in the last section of the article. Yet because managed care is administratively intensive, it tends to increase the proportion of health care expenditures devoted to administrative activities as opposed to clinical services well beyond the prior 24% figure. Administrative practices that curtail services and constrain communication in the patient-physician relationship under managed care themselves are costly. The evidence that these added administrative costs can be justified by appropriate reductions in clinical costs has been limited.

CONCLUSION

This article has spelled out some of the troubling contradictions that managed care has created in day-to-day encounters and relationships between doctors and patients, with a focus on elderly patients. Under the constraints of managed care, practitioners’ role as double agents and the financial structures that constrain open communication have thoroughly changed the nature of patient-physician interactions.
Managed care has created enduring legal and ethical dilemmas in interpersonal relationships that warrant attention in health policy.

To this end, the article has touched on the unresolved question of what kind of patient-physician encounter we should be striving to create and has outlined some of the struggles that have emerged and continue to emerge as managed care proliferates. In these struggles, the very future of the patient-physician relationship as we have known it is at stake. The era that preceded managed care obviously was not free of problems in this relationship, but the conflicts of interest and mixed loyalties inherent in managed care arrangements have further clouded patients' and health professionals' relationships with one another. A loss of trust and open communication, linked to the structure of managed care, will continue to generate conflict and policy debate. Without such conflict and debate, medicine will lose some of its most basic qualities of interpersonal caring and compassion.

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