

A Caring Partnership: Can We Gain Control?

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Abstract

Background: The health care system in the United States is in trouble. Patients and physicians are becoming increasingly unhappy with the system. There has been a progressive deterioration in trust in the system and in patient-doctor interactions.

Methods and Results: The history of the evolution of medicine as a profession over the past 350 years is briefly reviewed. The forces that have changed a paternalistic, but caring, system into one that is no longer paternalistic, but also less caring, are discussed. It is suggested that the current market-driven, industrial model is failing both patients and physicians, and that it is too costly.

Conclusion: The case is presented for patients and physician to join forces to work for reforms of the system, to encourage more physicians to take up careers in primary care, to fund health insurance for the uninsured, and to subsidize the education of future physicians. These approaches should help restore trust and a caring partnership between patients and their physicians. This partnership is necessary for attaining the reforms suggested.

Key Words: Patient-physician relationship, health care system, health care reform.

Introduction

Over the past 20 years or more dissatisfaction with health care in the United States has been increasing, among both patients and physicians (1, 2). Patients are frustrated by the conflict between the promise of the new technology and its increasingly high cost (1). They also note the change in the physician-patient interaction, which they perceive as being less personal and increasingly brief (2). Physicians have a similar sense of frustration with a health care system that they feel forces them to be “double agents,” always asked to balance patient needs against societal and financial priorities, as represented by insurance carriers (3, 4). While these issues have become more sharply defined over the past ten years, concerns about changes in

the patient-doctor relationship have been voiced by physicians for more than two generations (5, 6). In this essay I will review the evolution of our present malaise and suggest a way out of our troubles.

Where We Were

Medicine as a scientific discipline began to evolve some 350 years ago with the publication of William Harvey's *De Motu Cordis*. This was followed by the remarkable success of Herman Boerhaave as a professor of medicine at the University of Leiden in Holland from 1701–1738 (7). His teaching style attracted students from Britain and Europe. His influence was thus widespread. At about the same time, Thomas Sydenham (1624–1689) established the crucial importance of bedside observation as the basis of clinical diagnosis and, therefore, of case management. It was based on Sydenham's precepts that the great physicians of the 19th century, such as Laennec, Bright, Addison and others, described the disorders which still carry their names.

The 19th century saw the evolution of microbiology by such great men as Koch. A century earlier Jenner had established vaccination for the prevention of smallpox, and Lind had demonstrated

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that fresh fruit juice prevented scurvy. In 1847 Withering recognized the value of digitalis in treating heart failure. These were the first demonstrations that it was possible to prevent disease or moderate its ill effects. The first medical organization to set out a code of medical ethics was the American Medical Association (AMA), in 1849. The end of the 19th century saw the establishment of the Johns Hopkins University and School of Medicine, with William Osler and W.S. Halstead as chairs of the medicine and surgery departments, respectively. This marked the start of the movement towards academic health science centers in the US, which was followed by European and British universities. The high standards set by such institutions and the steady evolution of the scientific basis of medical care established the conditions for growing public trust in the work of physicians.

The relationship of patients to physicians was based on this trust. For more than half a century patients accepted the paternalistic model of the patient-physician interaction handed down over the centuries from the time of Hippocrates and Plato (4). The evolution of clinical and basic science since the time of Harvey had laid the foundation of medicine as a true profession. With a definable scientific basis, a body of clinical knowledge and the establishment of accredited educational institutions, society accepted the right of the medical profession to govern itself. In return for this right the members of the medical profession were expected to provide care for all comers to the best of their ability. Thus, a social contract evolved which patients and physicians accepted. Yet although medical science was advancing, effective treatments were slower to develop. Thus, while our ability to make diagnoses improved and we were able to offer prognoses and sometimes (most often in surgery) cures, patient care based on good supportive relationships between physicians and patients remained the basis of the care of the patient (6).

Where Are We Now?

After World War II we saw a dramatic growth in the science and technology of medicine. There was the discovery of antimicrobial agents that replaced sulfonamides, automated analysis for blood chemistries, cardiac catheterization, fiberoptic endoscopy, computed tomography (CT) scanners, magnetic resonance imaging (MRI) and minimally invasive surgery. The advances in pharmaceutical science brought a plethora of new treatments, with new drugs that were often curative. Now, new genetic analysis and perhaps genetic therapy are on the horizon. These developments have spurred the

growth of subspecialties in all the major branches of medicine, promising more prestige and higher incomes for specialists. At the same time physicians began to work in larger practices in medical offices, and no longer as solo practitioners seeing patients in consulting rooms that were in their own homes (5). Indeed physicians, as their incomes grew, moved into the suburbs, away from many of their patients. This specialization and geographic separation have contributed to a gradual loosening of the patient-physician relationship (5).

During this same period, society was also changing, under the influence of social forces such as the civil rights movement and the women's rights movement. These and other rights movements led to increasing emphasis on individual autonomy for other social groups, including medical patients. And patient autonomy was stimulated by other factors, such as the failure of clinical investigators, in an era of rapidly developing science and technology, to ensure that subjects of investigation were fully informed of the risks and benefits of interventions (8). This in turn led to commissions appointed by the President or Congress and the courts to examine how the profession conducted itself (8). These examinations resulted in commission reports and court judgments requiring the development of national standards for informed consent for clinical investigations (8). In addition the problem of medical error was highlighted by the Harvard Study in the early 1980s. And the quality of hospital care in New York State was the subject of an investigation undertaken at the request of Dr. David Axelrod, the New York State Commissioner of Health. These developments added to the erosion of trust by patients in the health care system as a whole.

These societal and professional developments occurred during a period when the rising costs of health care greatly exceeded the inflation rate in the general economy. In the late 1970s and early 1980's general inflation was 8–10% annually while health care costs rose by 14–16%. Physician incomes were also rising, as were health insurance rates. This led in turn to attempts to develop both not-for-profit and for-profit health maintenance organizations (HMO) and managed care organizations (MCO) as a way of controlling costs. While these interventions helped for a while, they were soon overtaken by events. Despite efforts to make health care a market commodity and encourage privatization, cost pressures continued. By 2004, health care expenditures accounted for 14–15% of gross domestic product (up from 6–7% in 1980) and amounted to \$1.55 trillion annually, which represents \$5,400.00 per person annually. Further-

more, while the national inflation rate is now about 2.5–3%, health care inflation increases are 10–12% (9). Yet we now have about 45 million uninsured, 15–20 million temporarily without insurance, and a further 20 million who are underinsured (10–14). Our health care costs are more than twice as high as those of any other industrialized nation. However, measured by World Health Organization standards, we rank 32nd in health outcomes in the world, including life expectancy at birth, infant mortality and immunization rate, among other measures of health.

We have allowed our profession and our health care system to become an industry that is market driven. Many patients and physicians are unhappy. The societal problems of the uninsured are huge, in terms of increased suffering and increased cost. Efforts at cost control lead to covert rationing, because insurers disallow certain treatments or investigational interventions, or impose time-consuming prior certification requirements to discourage their use. This leads to increasing stress on patients and physicians. A consequence of these influences may be an increase in malpractice litigation.

Where Do We Go from Here?

It seems to me that the present system of health care is failing its beneficiaries, i.e., the patients, as well as the professionals, physicians, nurses and others working in it. This failure demonstrates that health care does not flourish as a market commodity, since it excludes millions from enjoying its remarkable potential benefits. Even those with access to services find it impersonal and frustrating. It is, therefore, time for a change. But physicians, even with the support of other health care professionals, cannot achieve significant change without the help of our patients—numbers really count. We need to form an alliance with our patients to attain that goal (4). This will require restoring an effective, educated trusting relationship between patients and physicians (4).

The foundations of such a caring partnership are the well-established ethical principles on which good medical practice has been based for centuries:

- Beneficence: caring for the patient, altruism, guidance and advocacy.
- Non-maleficence: do no harm, ask, “What should we do?” not just “What can we do?”
- Justice: provide needed care for all; health care as a communal good.
- Respect for person: regardless of status, culture, religion or race.

The first requirement for ensuring that these principles guide our practice is that we must ensure understanding of the fundamentals of good patient-physician relationships that will truly foster a caring partnership. Over the past 50 years a number of authors, including Szasz and Hollender, Siegler, Pellegrino and Thomasma, Engel, Emmanuel and Michael Balint, have described various models of this relationship. All emphasize mutual trust, understanding and partnership. These models have been previously reviewed (2, 4). They are in striking contrast to the model offered by Engelhardt and Rie, which is based on a libertarian and market-based system (14), which in my view has clearly failed. The model described by my father, Michael Balint, based on research and training seminars with general practitioners in the UK, is the one that most clearly describes the dynamics of the patient-physician relationship (15). I believe it is a model that points the way forward. This model identifies four basic features of the relationship. The first reinforces the old saying “Physician know thyself,” so important for understanding how we react to different persons. The second requires that the physician establish the “deeper diagnosis,” that is, the medical, social and personal issues of the patient. This is very much along the same lines as described by Jonsen, Siegler and Winslade in their book *Clinical Ethics* as the “four boxes” (16). The third is the physician’s “apostolic function” (15), which calls for the education of the patient about his/her illness, and how to deal with it. This must be accompanied by the fourth component of mutual education leading to the “mutual investment company” or caring partnership. This in turn allows patient and physician to address management issues founded on evidence-based medicine and thus more prudent use of health care resources. A trusting partnership is the fundamental basis for such discussions. Arriving at a trusting partnership takes time. The physician and patient need to learn how to use multiple, relatively brief visits to build the understanding that is the essential basis for attaining this goal.

To bolster the evolution of a caring and trusting partnership, physicians, their professional societies and the health care system must take steps to address the problem of medical errors. Physician leadership in this area is critical to restoring trust in the system as a whole while developing the partnership between individual patients and their physician. Physicians will also need to influence their professional societies to take up public advocacy for better patient access to affordable health care and drugs. Too often at the present time, our professional societies lobby for the benefit of their

members only. A few, such as the American College of Physicians, have been a strong lobby for patient needs. We need others to join them for our profession to regain the societal respect it must have to succeed in restoring the caring partnership on a broad basis.

To attain a health care system that measures up to the standards noted above, we will need to increase the number of physicians providing primary care, whether as internists, family physicians or other primary care specialists (17–22). This will require cooperation among current rivals (19), changing residency education programs (22) and reforming payment for primary care (21), as was recently suggested by the Society for General Internal Medicine (23). In order to change the ratio of generalists to subspecialists (as suggested above) and provide insurance coverage for those currently uninsured so that they can gain access to care calls for fundamental changes in our present system. Currently the administrative costs in the US health care system are about 25 cents on the dollar compared to Canada or Europe, where it is 7–10%. Medicare's administrative costs are similar to those in Canada. If we could cut the administrative overhead in the US by half we could save about \$180–190 billion annually, based on current reported costs (9). The estimated cost of providing basic health insurance to the uninsured is \$75–85 billion, so the savings in administrative costs could readily cover these expenses and leave resources available for other improvements in the system. These could be used to make careers in primary care more readily attainable for new graduates of our medical schools, as I will discuss below.

If we are to achieve the changes outlined above, we will need to work in a caring partnership with our patients to change the national view of health care from that of a market-driven industry to one that recognizes health care as a social good and obligation, like public education, sewage systems and national defense. Acceptance of this view will not come easily, but that major change can be achieved has been shown in Oregon (24) and Maine (25). In both of these states the process involved extensive public discussion. To allow new graduates to pursue careers in primary care medicine, which so many applicants to medical school would like to be able to do, we will need to remove several economic barriers. The average level of debt carried by medical school graduates is well in excess of \$100,000. The US is the only industrialized democracy that does not subsidize medical education. If we were to apply the savings realized by reduction of administrative overheads in health insurance costs, discussed above, to paying for the

education of future physicians, the economic barriers could be removed. In return, we may wish to consider some form of salaried health service. Several good models exist in Europe, as well as in the US, such as the VA Medical System, the time-honored academic medicine system and such staff model HMOs as Health Care of Puget Sound or the Kaiser Permanente System. At the same time we should examine ways of rewarding good, cost-effective care by innovative approaches such as the new program adopted by the National Health Service in the UK (26, 27). Any such system must ensure transparency, so that all participants recognize the rationale for particular management decisions (28). "The mutual investment company" concept discussed above would allow physicians to discuss such decisions more readily with their patients. Based on all those discussions between patient and physician, the physician may have to be willing to advocate for a deviation from the usual treatment, based on the special needs of a particular patient.

Can these goals be achieved? Maybe that will only happen if we have a catastrophic crisis in health care. I hope that that can be avoided if we as a profession can, even within current constraints, work towards a caring partnership with our patients and towards the acceptance of the principle of health as a societal good. That is a goal worth striving for. We will, as noted, need allies in order to succeed. Those allies are our patients. Our guide in this endeavor should be Osler's injunction, "You are in this profession as a calling, not as a business, as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow man" (29).

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