Rising Pressure on the Doctor-Patient Relationship in the United States

An STS Research Paper
presented to the faculty of the
School of Engineering and Applied Science
University of Virginia

by

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March 27, 2020

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Although the United States is a world leader in medical technology, large studies of healthcare delivery reveal that "only about half (55%) of US citizens receive necessary care and fewer than half of physician practices incorporate recommended processes of care" (Doebbeling & Flanagan, 2011). The healthcare system faces challenges such as "major gaps between evidence and practice, suboptimal quality, inequitable patterns of utilization, poor safety, and unsustainable cost increases" (NAE, 2005). The doctor-patient relationship (DPR), already controversial, is threatened by rising distrust of healthcare providers. This skepticism is due in part to the increasing influence of pharmaceutical companies. Keller et al. (2016) found that about 80% of physicians have a financial relationship with the pharmaceutical industry, and even though "61% of physicians reported that financial incentive did not influence their own practice, only 16% believed that the same was true for their colleagues." If medical professionals distrust their own colleagues, patient distrust is unsurprising. In addition to pharmaceutical companies, other factors such as patient satisfaction reports, regulations, and ethically controversial cases contribute to increased distrust. Medical professionals are therefore actively seeking to improve and protect the DPR.

Importance of the DPR

A healthy relationship between a doctor and a patient is key in effective medical care, as "it is within the interactions that constitute this relationship that information is shared, that choices get determined, that reassurances are provided, that decisions are made and, ultimately, that care is given" (Dunn, 2019). Chipidza et al. (2015) found that better DPRs were associated

with better patient outcomes. Impaired DPRs, documented by patient reports of feeling unheard or disrespected, were associated with poorer outcomes. Shrivastava et al. (2014) concluded that a poor DPR is associated with low patient compliance; such patients also change their doctor more often. Kerse et al. (2004) assessed the relationship between four aspects of the DPR and medication compliance. They found that consultations with greater levels of "patient-reported physician-patient concordance were associated with one-third greater medication compliance." The Healthcare Administrators Association (HCAA) claims that good DPRs helps healthcare administrators stay at the "forefront of industry and business issues while enjoying an open exchange of ideas" and considers the DPR an important to the success of healthcare centers (HCAA, 1980). With the DPR as such a delicate yet powerful aspect of healthcare, clinicians should inherently want to uphold quality relationships with their patients, though rising distrust suggests suspicion that they are succumbing under the pressures that threaten the DPR.

Review of Research

Pharmaceutical Companies

The pharmaceutical industry, nicknamed "Big Pharma", views collaboration with physicians as essential to research, but many doctors are considering cutting ties with drug companies to protect their professional integrity. According to D'Arcy & Moynihan (2009), "both the pharmaceutical industry and health care professionals must focus on the goal of improving health." Pharmaceutical companies pose a threat to trust in doctors because of their history of bribing medical professionals and they complicate the DPR through direct-to-consumer advertising for prescription pharmaceuticals.

Ornstein et al. (2019) found that "2,500 physicians have received at least half a million dollars apiece from drug makers and medical device companies in the past five years alone." Although some physicians may argue it bribery from companies does not influence their medical decision-making, Ornstein et al. also emphasizes that there are strong links between payments from companies and products that those doctors chose. Lazarus et al. (2019) further outlined the far-reaching effects of money paid to doctors by pharmaceutical companies by stating that "physician researchers double as clinicians and teachers, so their treatment choices and teaching content could reflect a bias toward a company's product or hypothesized mechanism of action" and that "the very science base for the practice of medicine could be jeopardized, given that some editors of medical journals have significant undeclared conflicts with industry." Lazarus et al.'s attributed the main difficulty in halting the influence of pharmaceutical marketing altogether to "key opinion leaders who conduct important research". This is because academic medical centers tend to "turn a blind eye to these high-profile doctors as speakers and advisers to industry because they rake in big research dollars." Typically, these physicians "claim they are not influenced by pharmaceutical companies, even though abundant research has proved them wrong" (Lazarus et al., 2019).

Increased frequency of commercials that include phrases such as "ask your doctor about" or "talk to your doctor to see if this is right for you" change the dynamic of the DPR. Instead of the standard doctor's visit where patients list their symptoms and concerns and wait for the clinician's recommendation for care, patients that visit the doctor for consultation with specific pharmaceutical advertising in mind alter the decision-making process of clinicians and pose them with the desire to comply to requests out of patient satisfaction. Robbins (2015) concluded that "patients who reported being most satisfied with their doctors had higher healthcare and prescription costs and were more likely to be hospitalized than patients who were not as

satisfied", highlighting the complications as a result of direct-to-consumer advertising. She infers that the higher cost of prescriptions and healthcare indicates that these "more satisfied" patients are likely asking for expensive brand name medications that they probably heard of through advertising, further muddying the DPR. She emphasizes that "focusing on what patients want—a certain test, a specific drug—may mean they get less of what they actually need" and that healthcare providers unintentionally might not be looking out for their best interests by attempting to satisfy patients."

Patient Satisfaction

The consumerism mentality has infiltrated contemporary medical practices, thus posing a major internal conflict for clinicians. Dr. Rada Jones (2018) highlights the shift towards customer satisfaction in healthcare and how this "measure of how products and services supplied by a company meet customer expectations" has turned the emergency room she works into a place where she feels like her role as an ER doctor is "provide products that [her] patients can't wait to buy". Beyond just the ER, patients are increasingly self-diagnosing before even arriving at the doctor's office through the use of tools such as WebMD. Further adding the blurred dynamic between the doctor and patient since patients are arriving with a list of diagnoses rather than placing total trust into their healthcare provider's hands.

Monetary incentives based on patient satisfaction ratings are dominating healthcare. William P. Sullivan, an emergency room doctor, warns that "By creating a monetary incentive to increase patient satisfaction, the government is not only increasing its expenses but promoting a metric that significantly increases death rates" (Falkenberg 2013). He expresses the sad reality that "money drives professional behavior for doctors, as it does for virtually everyone else, and

the soaring insurance premiums that come with a malpractice suit have surely affected decision making."

O'Rourke (2014) spoke on behalf of the general patient role in a DPR, "they want a doctor who is able to slow down, aware of the dividends not just for patients but for [his or] herself and for the system", suggesting that this is the key to patient satisfaction. Though O'Rourke demonstrates that at least some of the patient pool is aware that the patient can't always be right, she admits that "few of us want to hear that".

Regulations

Legislation, healthcare administration policies, and insurance company policies make up the majority of regulations that increase pressure on the DPR. Five physician organizations, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the American College of Surgeons (ACS), have together criticized four types of laws that have degraded the DPR and called for putting patients' interests first (Weinberger et al., 2012). The physicians in these organizations view the DPR as vital and threatened. Upon recognition of complaints filed by these organization, America's Health Insurance Plans (AHIP), an insurance industry trade group, issued a statement on improving the prior-authorization process, one of their many efforts to mitigate the pressure of insurance companies on the DPR (Robeznieks, 2018). However, the effects of insurance companies on the healthcare extend far beyond the efforts of AHIP. According to O'Rourke (2014), insurance companies rein in costs by lowering fees. Because of this, many doctors seek to be in a network where they receive higher reimbursement rates and end up working for "groups that require them to cram in a set number of patients a day." In turn, shortened appointments and the flustered

appearance of an overrun doctor can lead to greater patient dissatisfaction, lower patient compliance, and a weakened relationship.

O'Rourke also described the burden placed on doctors' time as a result the of tasks they are mandated to complete in order to comply with the plethora of regulations placed on them by a variety of groups such as healthcare administrators, insurance providers, electronic health record systems (EHRs), and the Health Insurance Portability and Accountability Act (HIPPA). He stated *that "*medical practitioners who do most of their work in hospitals spend just 12 to 17 percent of their day with patients." He explained that the "rest of the time is devoted to processing forms, reviewing lab results, maintaining electronic medical records, dealing with other staff". He highlighted the effect of regulations on non-hospital medical practices in US through mention that they "spend ten times as many hours on nonclinical administrative duties as their Canadian counterparts do" (O'Rourke, 2014).

Government regulations make it even more difficult to balance quality healthcare and patient satisfaction because, according to Falkenberg (2013) "they have fully embraced the 'patient is always right' model" over the past decade. He added that widely used Press Ganey surveys that measure patient satisfaction by metrics such as waiting times, pain management and communication skills are important to the government because of the ideology that "increased customer satisfaction will improve the quality of care and reduce costs." A statement Robbins (2015) disproves. Falkenberg also stated that an $850 million ObamaCare initiative put in place to aide in focusing on patient satisfaction reduced Medicare reimbursement fees for hospitals that had low patient satisfaction scores. Along the same lines, some hospitals have started "tying physicians' compensation to their ratings" (Falkenberg 2013).

Medical Ethics

People are living longer and advancing technology is allowing us to sustain a life longer, which has resulted in a continuous rise in quantity and complexity of ethically controversial cases that doctors face. Dunn (2019) stated that one kind of "asymmetry" in the DPR is "the doctor's ability, often enshrined within the law, to opt out of providing or offering certain kinds of intervention on grounds of conscience." Doctors are often under quick and harsh criticism by patients and their advocates if they exercise this right to not comply with patient and advocate requests, thus jeopardizing a healthy DPR. However, doctors are aiming to prevent conflict in these situations by calling for ethics consults in hospitals and "reorganizing practices to meet the needs of patients who require more time, a broad array of resources, and closer follow-up" (IOM, 2001).

The National Patient Advocate Foundation (NPAF) and its affiliate, the Patient Advocate Foundation (PAF), aim to represent the patient and "work at the local, regional, and national level to promote access to affordable, quality healthcare for people with chronic, debilitating or life threatening illnesses", adding additional participants that intervene with aspects that contribute to DPRs (NPAF, 1994; PAF, 1994). Patient advocacies become largely involved with ethically controversial cases, whether it be a family member, friend, or professional advocate. Schwartz (2002) considered "whether advocates are necessary since not only can they be dangerously paternalistic, but the salutary values advocacy embodies are already part of good professional health care." He concluded that advocacies place two different tensions on the DPR. First, there may be "conflict between what can reasonably be an expected duty of health care practitioners, and what might be beyond reasonable expectations". Second, it can be difficult for any trained professional to "distinguishing between what is actual representation of patients' wishes, and what is an assertion of what the advocate believes to be in the best interests of the

patient" (Schwartz, 2002). I had a first-hand experience with a rather common ethics consult call while working in the Cardiac Care Unit (CCU) at the University of Virginia Health System this past summer. An elderly woman was placed on end of life care and her family refused the withdrawal of such care after a few days. Doctors exercised their right to call for further help from ethicists in order to best maintain and professional and healthy DPR.

Combatting Threats

Efforts to Improve the DPR

In addition to previously mentioned efforts by clinicians to maintain healthy relationships with their patients, dedicated and humble doctors are making the greatest effort for improvement in the DPR stigma as a whole via the First Amendment of the United States Constitution; freedom of speech. Thousands of clinicians are writing articles and conducting research to better inform the general public of ways in which a healthy DPR can be upheld. They also beg of their fellow physicians to have integrity in their profession and feel determined to be a part of the morally "good" group of physicians. Dr. Arthur Lazarus is one of these individuals and he proposes five ways in which doctors can and should continue to eliminate threats to the DPR (Lazarus, 2019):

> First, they need to own up to their conflicts of interest with the industry, whether real, perceived, potential, or otherwise… . Second, doctors should proactively consult with their corporate compliance officers or legal counsel and seek their advice about thorny ethical issues. Institutional compliance officers are unable to mediate conflicts if they remain purposely hidden…Third, physicians, including those in the industry, need to dial up their moral compasses. It's imperative that they be up front about who they're taking money from, and why. Doctors have the right to make as much money (legally) as they can, but they must be true to themselves and ask whether these payments and business relationships are affecting their teaching methods, selection of drugs or devices, and care they give their patients. Fourth, when questioned by patients about their relationships with industry, doctors should engage and answer honestly without becoming defensive. Let patients decide whether payments pose a threat to their

> care. Fifth, doctors can report questionable marketing practices to the FDA by emailing BadAd@fda.gov or calling 855-RX-BADAD — the so-called "Bad Ad Program."

Ancell & Sinott-Armstrong (2017) also offer their professional advice to fellow medical practitioners on "how to allow conscientious objection in medicine while protecting patient rights." Many clinicians follow a similar initiative, in hopes to mitigate any conflicts between doctor and patient without completely disregarding the importance and power in patient satisfaction. With publications in widely dispersed medical journals, such as *Forbes*, *New England Journal of Medicine*, and *Journal of General Internal Medicine*, suggestions and changes doctors are writing about are reaching the eyes of the entire medical community. Doctors are using tactics that do not compromise the quality of healthcare, but do increase patient satisfaction. One of the ways in which they are achieving this is seeking the opportunity for more frequent patient-doctor interactions, which has been proven to increase patients' perceived quality of care (Dugdale et al., 1999).

Efforts to Protect the DPR

Much like the efforts to improve the doctor patient relationship and lift some of the threats, clinicians are also taking to journalism to protect the rights they have in the DPR as a medical provider by voicing the consequences that would occur if they did not hold their ground. Clinicians like Dr. Drummond are using their voice to outline the pressures they face in the workplace and why one-hundred percent patient satisfaction is extremely dangerous. He implored that there are countless situations in which it is crucial to deny a patient's request: drug seekers that could die or kill others behind the wheel of a car if given the oxycontin they request, inappropriate antibiotic requests that could lead to multi-drug resistant bacterial infections or allergic drug reactions, inappropriate Tests like expensive CT Scans for low back pain without radicular symptoms, and pushing the limits on radiation dosing which is "causing the wrongful termination of good

doctors" (Drummond, 2014). Falkenberg (2013) expanded on this topic as well, explaining the term "overdiagnosis" as the "detection of abnormalities that are not destined to ever bother us" because "almost any unnecessary or discretionary test has a good chance of detecting an abnormality." He, among many other medical professionals that are writing about this topic, warn that while "more tests and stronger drugs equal more satisfied patients, and more satisfied patients equal more pay", "the biggest loser is the patient, who may not receive appropriate care".

The Future of the DPR

It takes two to tango. While efforts are being made by clinicians to uphold quality DPRs, good medical practice "demands of both doctors and patients" (Dunn, 2019). There are ways in which patients can improve and protect their DPRs. Beck (2015) concludes that just as doctors are "sometimes guilty of not listening to patients", patients can also jeopardize the DPR by objectifying the doctor as "less than a person" and solely there to meet their needs. As in most relationships, care and patience should be exercised by both parties. Dunn (2019) emphasizes that in the midst of threats to the DPR, it is essential that both parties understand that some situations "involve pushing back and protecting those elements of the doctor– patient relationship that have fundamental value, regardless of context, changing social values, or technological advancement" and others warrant "revisiting, refining and potentially adapting the moral foundations" of the DPR.

In light of the recent COVID-19 outbreak and declaration of a global pandemic, it is important for all aspects of healthcare to be strong in case disaster strikes. Both the efforts clinicians have made thus far to combat threats to the DPR and their selfless dedication to caring for COVID-19 infected patients demonstrate that there are many medical professionals that take integrity in societal role they committed to upon taking the Hippocratic Oath.

References

Ancell, A., & Sinnott-Armstrong, W. (2017) How to Allow Conscientious Objection in Medicine While Protecting Patient Rights. *Cambridge Quarterly of Healthcare Ethics,* 26(1), 120-131.

Beck, J. (2015, September 24). Doctors Have Feelings, Too. https://www.theatlantic.com/health/archive/2015/09/when-patients-ignore-doctors-emotions/407032/

Chipidza, F. E., Wallwork, R. S., & Stern, T. A. (2015). Impact of the Doctor-Patient Relationship. *The Primary Care Companion for CNS Disorders*, *17*(5).

D'Arcy, E., & Moynihan, R. (2009). Can the Relationship between Doctors and Drug Companies Ever Be a Healthy One? *PLoS Medicine*, *6*(7).

Dugdale, D. C., Epstein, R., & Pantilat, S. Z. (1999). Time and the patient-physician relationship. *Journal of General Internal Medicine*, *14*(1), S34–S40.

Dunn, M. (2019, March) At the moral margins of the doctor–patient relationship. *Journal of Medical Ethics,* 45(3), 149-150.

Doebbeling, B., & Flanagan, M. (2011). Emerging Perspectives on Transforming the Healthcare System: Key Conceptual Issues. *Medical Care, 49*(12), S3-S5.

Drummond, D. (2014) Patient Satisfaction Should Never Be 100 Percent. *The Happy MD*. www.thehappymd.com/blog/patient-satisfaction-should-never-be-100

Falkenberg, K. (2013, January 1). Why Rating Your Doctor Is Bad for Your Health. *Forbes.* www.forbes.com/sites/kaifalkenberg/2013/01/02/why-rating- your-doctor-is-bad-for-your-health/#5c47648c33c5

HCAA (1980). Health Care Administrators Association. https://www.hcaa.org/page/aboutus

IOM. Institute of Medicine (US) Committee on Quality of Health Care in America. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. http://www.ncbi.nlm.nih.gov/books/NBK222274/

Jones, R. (2018, August 2). Death by Patient Satisfaction in the ER. *Doximity.* opmed.doximity.com/articles/death-by-patient-satisfaction-in-the-er

Keller, F., Marczewski, K., & Pavlović, D. (2016). The relationship between the physician and pharmaceutical industry: background ethics and regulation proposals. *Croatian Medical Journal*, *57*(4), 398–401.

Kerse, N., Buetow, S., Mainous, A. G., Young, G., Coster, G., & Arroll, B. (2004). Physician-Patient Relationship and Medication Compliance: A Primary Care Investigation. *Annals of Family Medicine*, *2*(5), 455–461.

Lazarus, A., Hussain, M. S., Bach, J., Saklecha, A., & Radvansky, B. (2019, November 22). It's Time to Stop the Pharmaceutical Marketing Money Machine. https://opmed.doximity.com/articles/it-s-time-to-stop-the-pharmaceutical-marketing-money-machine

NAE. National Academy of Engineering (US) and Institute of Medicine (US) Committee on Engineering and the Health Care System. (2005). *Building a Better Delivery System: A New Engineering/Health Care Partnership* (P. P. Reid, W. D. Compton, J. H. Grossman, & G. Fanjiang, Eds.). http://www.ncbi.nlm.nih.gov/books/NBK22832/

NPAF (1994). National Patient Advocate Foundation. https://www.npaf.org/

O'Rourke, M. (2014, October 15). Doctors Tell All-and It's Bad. https://www.theatlantic.com/magazine/archive/2014/11/doctors-tell-all-and-its-bad/380785/

Ornstein, C., Weber, T., & Jones, R. G. (2019, October 21). Across the U.S., over 700 doctors were paid more than a million dollars by drug and medical-device companies since 2014. https://www.inquirer.com/health/dollars-for-docs-propublica-doctors-drugmakers-devicemakers-20191021.html

PAF (1994). Patient Advocate Foundation. https://www.patientadvocate.org/

Robeznieks, A. (2018, March 30). How insurance companies' red tape can delay patient care. https://www.ama-assn.org/practice-management/sustainability/how-insurance-companies-red-tape-can-delay-patient-care

Robbins, A. (2015, April 17). The Problem With Satisfied Patients. *The Atlantic.* www.theatlantic.com/health/archive/2015/04/the-problem-with-satisfied-patients/390684

Schwartz, L. (2002, February 1) Is there an advocate in the house? The role of health care professionals in patient advocacy, *Journal of Medical Ethics,* 28(1), 37-40.

Shrivastava, S. R., Shrivastava, P. S., & Ramasamy, J. (2014). Exploring the dimensions of doctor-patient relationship in clinical practice in hospital settings. *International Journal of Health Policy and Management*, *2*(4), 159–160.

Wagner, Edward H., Brian T.Austin, and Michael Von Korff. Organizing Care for Patients with Chronic Illness. *Milbank Quarterly*, 74(4):511–42,1996.

Weinberger, S. E., Lawrence, H. C., Henley, D. E., Alden, E. R., & Hoyt, D. B. (2012). Legislative Interference with the Patient–Physician Relationship. *New England Journal of Medicine*, *367*(16), 1557–1559.