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The enduring and evolving nature of the patient–physician relationship

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Abstract

Just as the molecular and chemistry oriented sciences were adopted as the 20th century medical paradigm, incorporation of the patient's perspective into a relationship-centered medical paradigm has been suggested as appropriate for the 21st century. It is the medical dialogue that provides the fundamental vehicle through which the paradigmatic battle of perspectives is waged and the therapeutic relationship is defined.

In many regards, the primary challenge to the field is the development of operationally defined and measurable indicators of medical communication that will provide a valid representation of the conceptual models of the therapeutic relationship. The purpose of this essay is to explore the implications of a relationship-centered medical paradigm on the nature of the patient–physician relationship and its expression in the communication of routine medical practice.

An organizing framework for distinguishing commonly measured communication elements into conceptually distinct components is suggested. Application of this framework is illustrated through an empirical study of communication in primary care practice. The results of the study demonstrate the usefulness of this approach in linking communication to models of therapeutic relationships.

The importance of medical communication is further explored in a summary of studies that establish its association to outcomes and in an overview of future challenges to the field. © 2000 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Patient–physician relationship; Therapeutic relationship; Doctor–patient communication

1. Introduction

In one manner or another, the construct of the doctor–patient relationship and its expression through the medical dialogue, has been described or alluded to in the history of medicine since the time

of the Greeks [1], and in the modern medical and social sciences literature for the past 50 years [2–7]. Nevertheless, historians of modern medicine have tracked an undeniable decline in the centrality of communication to the care process [8].

In his study of the history of doctors and patients, Shorter attributes the denigration of communication to the ascendancy of the molecular and chemistry-oriented sciences as the predominant 20th century

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medical paradigm [8]. This change was fundamental in directing medical inquiry away from the person of the patient to the biochemical and pathophysiology of the patient. It was not coincidental that the practice of interviewing patients from a written outline designed around a series of yes–no hypothesis testing questions replaced unstructured medical histories [8].

The resulting loss of focus on the patient as person was well captured in Kerr White's lament that physicians failed to recognize that 'apples are red and sweet as well as being composed of cells and molecules' [9]. Lacking a pathway to collaboration and partnership, many see the need for fundamental reform in medicine's vision [9–12]. Just as the molecular and chemistry oriented sciences were adopted as the 20th century medical paradigm, incorporation of the patient's perspective into medicine's definition of patient need has been suggested as the medical paradigm of the 21st century [10].

The medical dialogue is the fundamental instrument through which the paradigmatic battle is waged; the patient's problem will be anchored in either a biomedical and disease context or a broader and more integrated illness context that incorporates the patient perspective [12]. Based on this anchor, the nature of the patient's problem will be established and the visit's agenda and therapeutic course will be determined.

The purpose of this review is fourfold: (1) to explore the theoretical conceptualizations of the therapeutic relationship as it relates to the patient–physician communication; (2) to explore the expres-

sion of the therapeutic relationship in actual practice based on empirical study of patient–physician communication; (3) to review the links between communication and health outcomes; and finally, (4) to provide an overview of the challenges and directions to future research in patient–physician communication.

2. The theoretical and philosophic basis defining the therapeutic relationship

Bioethicists Emanuel and Emanuel [13] suggest that power relations in medical visits are expressed through several key elements, including: (1) who sets the agenda and goals of the visit (the physician, the physician and patient in negotiation, the patient); (2) the role of patients' values (assumed by the physician to be consistent with their own, jointly explored by the patient and physician, or unexamined); and, (3) the functional role assumed by the physician (guardian, advisor, or consultant).

Application of these core elements can be useful in recognizing the variety of power relations expressed in models of the doctor–patient relationship (Table 1).

The upper left quadrant, demonstrating mutuality, reflects the strengths and resources of each participant on a relatively even footing. Inasmuch as power in the relationship is balanced, the goals, agenda and decisions related to the visit are the result of negotiation between partners; both the patient and the physician become part of a joint venture. The medical dialogue is the vehicle through which patient

Table 1
Prototypes of the doctor–patient relationship

| Patient power | Physician power | |
|--------------------|----------------------|----------------------|
| | High physician power | Low physician power |
| High patient power | Mutuality | Consumerism |
| Goals and agenda | Negotiated | Patient set |
| Patient values | Jointly examined | Unexamined |
| Physician's role | Advisor | Technical consultant |
| Low patient power | Paternalism | Default |
| Goals and agenda | Physician set | Unclear |
| Patient values | Assumed | Unclear |
| Physician's role | Guardian | Unclear |

values are explicitly articulated and explored. Throughout this process the physician acts as a counselor or advisor.

Most prevalent, but not necessarily most efficient or desirable, the prototype of paternalism is shown in the lower left quadrant. In this model of relations, physicians dominate agenda setting, goals, and decision-making in regard to both information and services; the medical condition is defined in biomedical terms and the patient's voice is largely absent. The physicians' obligation is to act in the patient's 'best interest'. The determination of best interest, however, is largely based on the assumption that patient values and preferences are the same as that of the physician. The guiding model is that of physician as guardian, acting in the patient's best interest regardless of patient preferences.

The top right of the table represents consumerism. Here the more typical power relationship between doctors and patients may be reversed. Patients set the goal and agenda of the visit and take sole responsibility for decision-making. Patient demands for information and technical services are accommodated by a cooperating physician. Patient values are defined and fixed by the patient and unexamined by the physician. This type of relationship redefines the medical encounter as a marketplace transaction. Caveat emptor, 'let the buyer beware', rules the transaction with power resting in the buyer (patient) who can make the decision to buy (seek care) or not, as seen fit [14]. The physician role is limited to technical consultant with the obligation to provide information and services contingent on patient preferences (and within professional norms).

When patient and physician expectations are at odds or when the need for change in the relationship cannot be negotiated, the relationship may come to a dysfunctional standstill, a kind of relationship default, as represented in the lower right of the table. Default can be seen as characterized by unclear or contested common goals; obscured or unclear examination of patient values, and an uncertain physician role. It is here where medical management may be least effective with neither the patient nor the physician sensing progress or direction. A frustrated and angry patient may make inappropriate time and service demands and ultimately drop out of care completely because of failed expectations. For physi-

cians, these visits represent the most frustrating aspects of medicine reflecting 'the difficult and hateful patient'. Unless recalibration of the relationship is undertaken with direct intervention, the relationship is likely to continue to unravel and ultimately fail [15].

3. Characteristics of relationship-centered care

It can be argued that patient demand and satisfaction should drive the relationship model adopted by patients and their physicians inasmuch as each form of relationship brings some benefit [14,16]. A different perspective, however, can be taken. Even when patients and physicians have mutually agreed upon a paternalistic relationship, questions regarding the appropriateness of the relationship may still be raised. Patients and doctors are often on so unequal a footing that few patients can really play an equal role with physicians in shaping the relationship. The possibility exists, then, that patients may adopt a passive patient role, not fully aware of alternatives or able to negotiate a more active stance [17].

Just as the paternalistic model can be criticized for its narrow exclusion of the patient's perspective, fault can also be found with the consumerist model as too narrowly limiting the physician's role. Patients may limit physician participation in decision making without appreciating the full benefit in terms of both decision-making and coping that could be added by the inclusion of the physician's perspective [18,19].

The optimal relationship model, then, appears to be that of mutuality. Cognizant of the semantic dilemma presented by the term patient-centered, the Pew-Fetzer Task Force on Advancing Psychosocial Health Education [20] suggests the more encompassing term of 'relationship-centered medicine' as recognizing the role of relational reciprocity to optimal integration and synthesis of both the biomedical and lifeworld perspectives.

Semantics can have a powerful role in shaping and focusing debate; it is more than just the simple use of words, it can guide how social reality is interpreted, understood, and acted upon [21]. For this reason, relationship-centered care will be used in the remainder of this paper to connote the optimal form of patient-physician relationship.

Relationship-centered visits can be characterized as: medically functional, informative, facilitative, responsive, and participatory [18,20,22–25]. The relative importance of each of these characteristics may vary depending on the care setting, health status of the patient, nature and extent of prior relationship, as well as other exigencies. Nevertheless, each contributes in some manner in all visits.

The first of these is the extent to which the relationship fulfils the medical management functions of the visit within the constraints of a given health delivery system. Provision of quality care demands accomplishment of basic medical tasks. If the relationship model inhibits performance of these tasks, it fails both patients and physicians in a primary way. Included among these tasks are structuring the visit, efficient use of time and resources, smooth organization and sequencing of the visit, and team-building among health professionals [24,25], as well as technical tasks related to physical exam, diagnosis and treatment.

Secondly, the relationship must be facilitative in eliciting the patients' full spectrum of concerns and visit agenda. Within this context the patient's ability to tell the story of his/her illness holds the key to the establishment and integration of the patient's perspective in all subsequent care. Telling of the story is the method by which the meaning of the illness and the meaning of the disease are integrated and interpreted by both doctor and patient. Particularly critical is elicitation in the psychosocial realm of experience. A patient's experience of illness is often reflected in how it effects one's quality of life and daily function, one's family, social and professional functioning and relations, and one's own feelings and emotions. Awareness of how these coping challenges are faced is critical to the finding of common ground and establishment of authentic dialogue [22–25].

Thirdly, the visit must be responsive to the patient's emotional state and concerns. Physicians are not simply expert consultants, they are also someone to whom people go when they are particularly vulnerable. Use of support, empathy, concern, and legitimation, as well explicit probes regarding feelings and emotions are important elements of rapport building and key to a patient feeling known and understood [22–26].

Fourthly, the relationship must be informative, providing both technical information and expertise and behavioral recommendations in a manner which is understandable, useful, and motivating. A singularly consistent finding in studies of doctors and patients conducted over the past 25 years has been that patients want as much information as possible from their physicians. The importance of this information appears as critical to the patient's capacity to cope with the overwhelming uncertainty and anxieties of illness as in its substantive contribution to directing patient actions [18].

Finally, the fifth element of the relationship is that it must be participatory. Physicians have a responsibility and obligation to help patients assume an authentic and responsible role in the medical dialogue and in decision making. The first definition for 'doctor' in the Webster's Dictionary is 'teacher'. The word 'teacher' implies helping, but this help is not limited to the usual clinical sense of providing correct diagnosis and treatment, or empathy and reassurance. A teacher helps by equipping learners (patients) with what they need to help themselves; this includes not just information but also confidence in the value of their own contributions. The educator model is more egalitarian and collaborative than the traditional doctor–patient model, and as such is core to the building of a mutual partnership [27].

4. Communication elements as indicators of relationship-centered care

In many regards, the primary methodological challenge to the field is the transition from the conceptual underpinnings of relationship-centered care to operational indicators that are observable and measurable elements of communication. Indeed, there are a number of measurement systems which address at least some component of relationship-centered care consistent with the characteristics listed above [24]. While none of the systems are explicitly contradictory or suggest exclusivity in their measurement, there has been little attempt to find common measurement ground. This is problematic; no single magic measurement bullet is evident or likely to soon emerge.

A flexible accommodation to many of the varying

systems could be the use of common communication elements or building blocks. This has already been done to some extent. A 1988 meta-analysis of communication studies [28] found that the 250 or so different elements of communication measured in the reviewed studies could be reduced to five broad and subsuming categories, as displayed in Table 2.

The first of the large communication categories is information giving. The content of the informative exchange is most often distinguished as primarily biomedical (related directly to medical symptoms or history) or psychosocial (related to the broader social, psychological, or emotional context of the medical problem or symptoms). In individual studies further content refinement was also evident. For instance, some studies distinguished biomedical topics as those related to history and symptoms from those related to the therapeutic regimen, tests, and treatment. Other studies distinguished psychosocial topics related to lifestyle and health promotion discussion or specific health or social issues (such as genetic testing or domestic violence).

Irrespective of the content of information, the manner of informational delivery was specified in

several studies. Some forms of information delivery can be considered more directive than other forms. Giving specific instructions is an example of the more directive form, while proposing or suggesting alternatives is less imposing. This distinction is consistent with Labov and Fanshel's [29] conceptualization of 'aggravated' and 'mitigated' forms of address, a concept used in both qualitative and quantitative studies of medical communication [30,31].

The second broad category of exchange is information seeking which includes question asking across several categories (general, biomedical, psychosocial), although again, additional content categories were also evident. For instance, biomedical topics were sub-categorized into those relating to medical history and symptoms, therapeutic regimen and treatment, (further refined in some studies to compliance-specific related questions), and lifestyle and health promotion questions. Several different question-asking formats were also evident. Most commonly, open and closed questions were identified, but sometimes, leading, grab bag, or rhetorical questions were coded.

The third subsuming category of exchange relates to partnership building. Partnership building can be seen to occur when the physician actively facilitates patient participation in the medical visit and/or attempts to equalize status by assuming a less dominating stance within the relationship. The two classes of partnering behavior can be distinguished as reflecting 'enlistment', the active facilitation of patient input, and 'lowered dominance', the assuming of a less controlling or dominant role. The former was much more often coded than the latter, although both appear to play very important facilitative roles.

The fourth category relates to rapport-building behaviors that explicitly convey emotional content, both verbally and nonverbally. It is distinguished from psychosocial exchange, which puts a medical problem or symptom within a broad psychosocial context, as the explicit expression of feelings and emotions. This broad category of talk includes statements of worry and concern, reassurance, empathy, legitimation and positive regard. Emotional talk is also communicated implicitly through body language, facial expression, and voice quality.

Table 2
Conceptual groupings of physician communication categories

| | |
|------|-----------------------------|
| I. | Information giving |
| | A. Information content |
| | 1. Biomedical |
| | 2. Psychosocial |
| | B. Information manner |
| | 1. Aggravated |
| | 2. Mitigated |
| II. | Question asking |
| | A. Question content |
| | 1. Biomedical |
| | 2. Psychosocial |
| | 3. Compliance-related |
| | B. Question format |
| | 1. Closed |
| | 2. Open |
| III. | Partnership-building |
| | A. Active enlistment |
| | B. Lowered dominance |
| IV. | Rapport-building |
| | Emotionally-responsive talk |
| V. | Socioemotional talk |
| | A. Positive |
| | B. Negative |
| | C. Social conversation |

A fifth category, relates broadly to socioemotional behaviors of several kinds. Included here is positive, negative and social talk. Positive talk captures the general positive atmosphere created in the visit through verbal behaviors such as agreements, approvals, and compliments. Positive non-verbal communication include nods, smiles, eye contact, forward and open body lean, and vocal qualities of friendliness, sincerity and interest. Negative verbal expressions of criticism or disapproval, as well as vocal qualities of irritation, dominance and disinterest and non-verbal indicators through frowns, closed and distant body language, avoidance of eye contact, also convey emotionally charged communication. Social conversation is not as emotionally charged as positive or negative talk, but does convey friendliness and personal regard. Social conversation is defined as non-medical exchanges largely social pleasantries and greetings, usually a linguistic bridge from the social opening or closing of the visit to the business of the visit.

5. Communication elements as indicators of relationship-centered care

Our study of the patterns of communication in primary care visits [32] illustrates the usefulness of the building-block approach to combining communication elements. Through cluster analysis of key communication elements (patient and physician question asking, psychosocial talk, and biomedical talk), we were able to find empirical support for the theoretical prototypes of the patient–physician relationships described earlier and presented in Table 1. Furthermore, several communication indices were constructed to validate the cluster analysis and provide greater depth to our understanding of communication dynamics in its varied relationship forms. A measure of verbal dominance during the medical visit was derived by calculating a ratio of the total count of physician statements divided by a total count of patient statements. A communication control score was calculated relating patient control (patients' questions and physicians' information giving and counseling, both biomedical and psychosocial), to physician control (physicians' questions, orientations, and patients' biomedical information).

In this way, we explored the construct validity of the patterns by devising a measure similar to one used by Greenfield et al. [33] to effectively discriminate the communication patterns of patients who had been given an activation intervention and those who had not.

The five patterns of relationship evident in the analyzed visits were: narrowly biomedical, biomedical (in-transition), biopsychosocial, psychosocial, and consumerist. The first two could be considered reflections of the paternalistic model described earlier, the third and fourth patterns represent variations on relationship-centered models, while the last represents consumerism.

The variations on physician-dominated visits were the two most common patterns evident in the visits. Each represented about one-third of the analyzed visits. The first of these, the narrowly biomedical pattern reflects the essential elements of the paternalistic model. The patient's voice is absent in these visits as reflected in the minimal psychosocial exchange and low patient communication control of the visit. High levels of physician question asking, and physician verbal dominance overall further distinguish these visits as being physician directed and guided. A second characteristically biomedical and physician controlled pattern was identified, but with slightly more allowance for patient input in the psychosocial arena than its restricted counterpart. Although still a physician controlled model of exchange, and dominated by high physician question-asking, the allowance of greater psychosocial dialogue may mark an intermediate pattern in which a transition to a fuller expression of the patient's perspective is possible.

A third pattern, biopsychosocial, was identified which balances the psychosocial and biomedical focus of the visit while simultaneously lowering the physician's verbal dominance of the visit. Comprising about 20% of the visits analyzed, this pattern appears as a mutual and collaborative model of exchange reflecting relationship-centered visits. Patients' health values and preferences were likely to be jointly negotiated and explored within these exchanges, with implication for patient autonomy self-understanding and self-discovery.

A fourth pattern, primarily psychosocial in character, also reflects relationship-centered visits, but more

intensely than in the biopsychosocial pattern. This was identified in 8% of the visits analyzed. With a preponderance of talk in the psychosocial domain, an almost equal ratio of patient and physician talk in the visit and high patient control of communication, this pattern provides an opportunity for in-depth dialogue about the social and emotional implications of the patient's condition. The physician's role may be friend or therapist, engaging the patient in dialogue about life issues that go well beyond the biomedical circumstances.

Finally, the last identified was a consumerist pattern characterized by few physicians' questions, but a relatively high number of patient questions, and little psychosocial exploration. Moreover, the physician provided a great deal of biomedical information in response to the patients' questions. This form of visit comprised about 8% of the studied visits. The physician can be seen as acting as a competent technical expert who provides relevant factual information.

Communication control was significantly related to the five communication patterns in a direct linear fashion; the biomedical exchanges showed dramatically less patient control of the communication process than the more participatory models. A similar linear relationship was found for verbal domination with the biomedical exchanges showing much less patient input into the medical dialogue than the more participatory models. We found that these patterns were associated with a variety of patient and physician outcomes; both patient and physician satisfaction was lowest in the biomedically-restricted models and highest in the more participatory ones.

The utility of the building blocks to capture relationship-centered care in a very different clinical setting, an inner-city pediatric emergency room, is also illustrative [34]. In this study, we found that pediatricians' relationship-centered style was best defined as above the 50th percentile for three categories of talk: partnership, information-giving, and rapport-building. In that study about one-third (32%) of the physicians met the relationship-centered criteria based on their talk with parents; a slightly higher proportion of physicians (36%) (with many of them different than those just mentioned) met the criteria based on their talk directed toward children. In each instance, relationship-centered care

was associated with more parent and child input into the medical dialogue both to the physician as well as to one another. Parents rated relationship-centered physicians (based on talk directed toward them) as being more informative and displaying more partnership than other physicians in the study; they rated relationship-centered physicians (based on talk directed toward their child) as doing a better job than other physicians.

Finally, in our study associating routine communication with physicians' malpractice experience [35] we found that partnership building behaviors — checking patients understanding, eliciting expectations and opinions, encouraging patients to talk, as well as providing orientation statements which help patients anticipate what will happen next in the visit were associated with a history of fewer malpractice suits. Socioemotional exchanges, especially positive exchanges including humor and laughter also appeared associated with a history of fewer malpractice suits.

6. The evidence linking communication skills to broad health and quality of life outcomes

In her comprehensive review of the literature, Stewart [36] found strong evidence linking physician–patient communication to a variety of patient health outcomes, including emotional health, symptom resolution, functional status, physiologic measures (i.e. blood pressure and blood sugar level), and pain control. While the review was organized by fitting the effective communication elements in the studies to two phases of the visit (history taking and discussion of the management plan) the communication elements can also be placed within the relationship-centered values and objectives framework proposed earlier.

As displayed in Table 3, informativeness is a powerful communication function clearly linked to health outcomes. When the physician gives clear information, especially when coupled with emotional support, psychological distress is reduced [26], symptom resolution enhanced [37] and blood pressure reduced [38]. When physician informativeness was coupled with the provision of informational packages and programs (particularly for patients

Table 3
Relationship-centered care objectives and supportive communication elements

| | |
|---|---|
| Informative | |
| Physician gives information (with emotional support) | Reduction in distress [26] Symptom resolution [37] Blood pressure control [38] Pain reduction [39] |
| Patient is given information (with informational packages and programs) | Improvement in mood [40] Improvement in function [41] Reduction in anxiety [40] |
| Participatory | |
| Physician asks about patients' understanding, concerns, and expectations. Physician asks for impact of the problem on functioning | Symptom resolution [37] Reduction in anxiety [45] |
| Physician encourages patients to ask questions | Reduction in anxiety [45] Reduction in role limitations [45] Reduction in physical limitation [45,47] Symptom resolution [46] |
| Patients perceive a full and open discussion of the problem | |
| Physician is willing to share decision making | Reduction in anxiety [45] |
| Physician and patient agree on the nature of the problem and the need for follow-up | Problem resolution [47] Symptom resolution [49] |
| Responsive | |
| Physician probes explicitly about feelings and emotions | Reduction in distress [25] |
| Physician expression of support and empathy | Symptom resolution [37] |
| Facilitative | |
| Full patient expression of feelings, opinions, and information | Physical and social role limitations [42,43] Health status, functional status and blood pressure control [38,42] Improvement in physiologic status [39,44] Improvement in function [39,43] |
| Patient is successful at obtaining information | |

undergoing radiation or surgery), pain was reduced [39], function improved [40], and mood and anxiety improved [41].

Visits that are participatory and contribute to the development and expression of active partnerships, also produced better health outcomes. Asking questions about patients' understanding of the problem, concerns and expectations, and perception of the impact of the problem on the patient's functioning facilitated symptom resolution [37] and reductions in patient anxiety [42]. When physicians encouraged patients to ask questions, patient anxiety was reduced in gynecology patients [43], as were role and physical limitations in chronic disease patients [33,44,45]. In visits in which the patient perceives a full and

open discussion of the problem has taken place, symptom resolution is facilitated [46] and when the doctor and patient agree about the nature of the problem and the need for follow-up, both problem [47] and symptom resolution [48] is enhanced. Finally, physician willingness to share decision making by giving patients the opportunity to choose among treatment options are associated with reductions in anxiety and depression, especially among cancer patients [49].

Visits that are responsive to the patients' emotional state are also associated with positive health outcomes in both the physical and emotional domain. Physician probing explicitly about feelings and emotions, led to reduction in psychological distress [26],

and physician expression of support and empathy was associated with reductions in both patients' psychologic distress [26], and symptom resolution [38].

Finally, visits that are facilitative in helping patients and effectively communicate their story, and express the full spectrum of concerns and questions, produce positive health outcomes. Specifically, when patient expression of feelings, opinions, and information was facilitated, there were improvements in physical and social role limitations [33], health status, functional status and blood pressure control [44,45]. When the patient took the initiative for obtaining information (and fulfilling their informational agenda) physiological status (improvements in blood pressure for hypertensive patients and hemoglobin A_{1c} for diabetic patients) [44,45] and functional status was enhanced [33,44].

Stewart concludes her review by suggesting improvements in communication requires a shift in the balance of power between physician and patient. However, she notes that this shift should not be a full pendulum swing to patient autonomy; autonomy in itself appears not to be the answer. When the medical dialogue is a shared process, outcomes are better. Neither physician dominance or total abdication of power was related to positive patient outcomes, rather engagement in a process that leads to agreement on problem and problem solving appears the optimum alternative.

7. Research challenges of the next decade

At the brink of the millenium, it is too seductive not to take the fortuneteller's globe and speculate on future directions and research challenges. Ten challenges appear immediately.

1. The field has been strengthened by a variety of communication assessment methods. Many of these systems, however, are complimentary and could potentially be combined in creative and powerful ways. Furthermore, measurement approaches must be subject to both construct and predictive tests of validity. I would encourage continued exploration of individual communica-

tion elements as common denominators to many of these systems. This approach can help promote creative ways of integration and synthesis, as well as replications and validation of findings.

2. The schism between qualitative and quantitative methods continues to stymie progress on both fronts. We need to develop new models of analysis that are integrative rather than parallel or competing. I am optimistic that we are already making some progress in bridging these two very different research traditions. New computer technologies, but even more so non-traditional thinking, may be the key to this needed breakthrough.
3. There needs to be greater attention to the long-term nature of the doctor–patient relationship and longitudinal data sets. While we suspect that continuity of care provides great advantages to the therapeutic relationship, we really know very little about continuity's black box. In fact, it may be that there are some negative aspects of continuity, such as the presumptuousness of familiarity, labeling, and simply the need for a fresh perspective.
4. The field needs more experience in analyzing relationships under stress. Most of what we know about patient–physician communication has been described within the context of routine primary care. There is a growing and important body of studies with cancer patients that will help us better understand non-routine care and the management of life threatening illness episodes.
5. Integration of psychotherapeutic techniques and theories into communication assessment and primary care training will help push forward the field in meeting the challenges of psychosomatic and psychosocial distress among so many primary care patients. In addition to the obvious adaptations of psychotherapy within the context of primary care, new approaches to defining the nature of the therapeutic alliance and the parameters for patient counseling need to be established.
6. Relationships outside of primary care — including emergency room visits and the care provided by subspecialties has been largely ignored. Insight into these areas are important not only as it directly relates to the care of large numbers of patients who will remain outside of the primary care system, but to improve coordination and

integrate care for the majority of patients straddling primary and specialty care.

7. Communication researchers must confront emerging ethical and philosophic issues. These include decision-making processes related to conditions of uncertainty such as end of life planning, enrolment in clinical trials, treatment of the cognitively impaired, and decisions regarding genetic testing and its consequences.
8. Insight is needed into the social context of the therapeutic relationship with attention to issues of gender, SES, and ethnicity, particularly as these characteristics relate to physicians. Of these social context variables, gender has received the most attention within communication studies, although the number of studies is still quite small, probably less than 20 [50,51]. Virtually unknown, are the effects of physician social class, ethnicity, and culture, on patients of the same or different backgrounds [18].
9. Knowledge of the basic social psychology of the therapeutic relationship continues to mature, but still show vulnerable gaps. We cannot yet consistently increase patient understanding and recall, improve participatory decision-making, or optimize adherence and commitment to therapeutic regimens. These are continuing and critical challenges for communication researchers.
10. We must embrace the challenge of new interactive computer technologies into all levels of our work. Use of interactive CD ROMs, web-based programming, and interactive videos foreshadow this tremendously exciting new frontier.

Finally, the tens of thousands of patients and their physicians who have participated in this research by opening their private worlds to us should be acknowledged. We cannot have confidence in any research agenda that is developed in isolation from those who are most directly affected by it. The many doctors and patients who have demonstrated their willingness to partner with us also deserve a voice in the development of the research agenda of the next millennium.

Our work is cumulative. Many of us have shared in the development and refinement of systems with our students and with one another. We have taken and continue to take inspiration from each other's

work. Our greatest reward will be our ability to model a truly collaborative and active partnership in our own social and professional relations.

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