Resolving Disagreements in the Patient-Physician Relationship
Tools for Improving Communication in Managed Care

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DR JONES IS A PRIMARY CARE physician in a multispecialty group practice. Recently his colleagues decided to work with a group of ophthalmologists (group B) to provide vision care services for their patients. Advantages of this arrangement include facilitated communication between the primary care physicians and the ophthalmologists, the opportunity to develop quality improvement programs for high-risk patients, and a better financial agreement. For patients, ophthalmologists in group B are able to provide comparable quality eye care, and possibly improved screening and education programs. The problem is that several of the patients in the practice have long-standing relationships with ophthalmologists in another group (group A). How does Dr Jones ask his patients to refrain from using the services of ophthalmologists in group A, and begin using those in group B? How should Dr Jones explain the reasons for the switch in referral pattern?

The crux of the problem for Dr Jones is how to explain to patients the complex reasons for advocating the services of ophthalmologists in group B. While Dr Jones feels that he is on ethically firm ground for recommending the switch, he anticipates the potential for disagreement with patients. Foremost, he wants to maintain the ongoing trusting relationship he has en-

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joyed with his patients. He recognizes that changing ophthalmologists is more than inconvenient for the patients because it severs a long-term relationship between the specialist and patient. On the other hand, as an integral part of the primary care group he wants to do his share to help the group thrive. The group will do better financially if most patients switch; however, Dr Jones believes that this does not significantly influence his decision about referrals for individual patients since the financial incentive is shared by the entire group and has little direct effect on his compensation. He envisions his patients benefiting from the services of ophthalmologists in group B since they plan to implement tailored programs for high-risk patients. Furthermore, he resents explaining the referral change to patients because he believes this should be the responsibility of the health plan.

This kind of dilemma is now commonplace in the daily practice of medicine. Managed care uses financial incentives and restrictions on costly tests and procedures to shape physician decision making and limit costs.1-5 The public understandably questions whether physicians are making decisions based on patients’ welfare or whether they are unduly influenced by factors other than patients’ best interests.6,7 Policymakers, ethicists, and health care administrators have suggested the following mechanisms to protect the patients’ well-being and safeguard public trust:6-12 ethical guidelines,11-17 enhanced professionalism,16-21 realignment of the proper relationship between commutative and distributive justice,22 disclosure of financial arrangements,23-25 review boards, and limiting the links between decisions for individual patients and physician reimbursement.26 While these mechanisms address organizational ways to protect patient welfare, they offer no guidelines for physicians in their daily routine visits.

Such an economic environment presents a heightened potential for disagreements and conflicts between physicians and patients. These disagreements have significant consequences for the patient including diminished trust in the physician,27-33 dissatisfaction with the visit,34 disenrollment from the plan,35 and litigation.36-39 For physicians, conflicts with patients can result in feelings of frustration, anger, loss of control,40 and career dissatisfaction.41 Yet physicians find little guidance from the literature on ways to discuss these potentially contentious issues. The medical encounter thus becomes fertile ground for the unraveling of patients’ unfulfilled expectations, frustrations, and loss of trust and control. The challenge for physicians is to recognize these latent attitudes of patients, and engage them in a discussion with the goal of mitigating these barriers and building a trusting relationship.42-44 A set of specific communication skills tailored to particular situations can be invaluable to the physician.

We convened a group of stakeholders with a variety of perspectives to articulate the specific types of disagreements emerging in the patient-physician relationship as a result of managed care, suggest communication strategies that physicians can use in these situations, and suggest organizational strategies to decrease the potential for these disagreements. This article provides practical communication strategies to decrease disagreement and enhance the relationship between patient and physician.

**DISCUSSION GROUP**

The discussion group met in October 1998 and was composed of 12 participants representing the following 6 distinct constituencies considered stakeholders in the patient-physician relationship: 2 patient/consumer representatives, 4 leaders in health care organizations with a demonstrated commitment to communication skills training for physicians, 2 practicing physicians, 2 communication experts, a health policy analyst, and a health care ethicist. Before the meeting, participants were asked to list the types of disagreements they considered most frequent and most difficult in their settings. During the meeting, the group articulated the most common types of disagreements, which were allocation of resources, access to care, and financial arrangements of the health plan (TABLE), and selected a hypothetical example of each type to illustrate potential communication strategies. For each example, the participants articulated the perspectives of the patient, physician, and health plan director, and suggested strategies to help resolve the disagreement and identified organizational strategies that could either prevent or resolve conflicts. The suggestions stem from clinical experience.

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**Table. Types of Disagreements and Examples**

<table>
<thead>
<tr>
<th>Category and Type of Disagreements</th>
<th>Example</th>
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<tbody>
<tr>
<td>Allocation of resources</td>
<td>Patient expects that the physician should allow longer stay than guidelines recommend for the condition.</td>
</tr>
<tr>
<td>Length of stay in hospital</td>
<td>Patient expects to obtain referral that is not medically essential.</td>
</tr>
<tr>
<td>Specialty referral</td>
<td>Patient wants to see specialist who is not preferred provider for the primary care group.</td>
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<tr>
<td>Request for tests or treatment</td>
<td>Patient requests expensive tests to “rule out” disease. Patient requests nonformulary drugs. Patient requests the physician “bend the rules” to authorize uncovered services.</td>
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<tr>
<td>Access to care</td>
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<tr>
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<tr>
<td>What the physician charges</td>
<td>Patients worry that financial incentives influence decisions.</td>
</tr>
<tr>
<td>Disclosure of incentives</td>
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group consensus, and analogy to research on patient-physician communication.

**GENERAL PRINCIPLES**

The group noted 2 general principles that should apply to all potential solutions for resolution of disagreement. First, in each situation of conflict it is essential that the physician believe he/she is on ethically firm ground in recommending a course of action to the patient. The medical literature and the American Medical Association have offered guidelines to help physicians assess the appropriateness of particular managed care arrangements.5-10,14 It is only when this condition is met that the physician can initiate the conversations we are recommending. In other words, the group is not advocating methods to lead patients to trust physicians when in fact trust is not warranted. Physicians must believe they can pass the “red-faced test” and can honestly discuss the reasons for their medical decisions without feeling embarrassed.14 If physicians do not pass this test, then it is more appropriate for them to resolve the issues through discussions with plan administrators or medical directors rather than with patients. Typically these situations would lead physicians to advocate on behalf of patients’ requests, even if a rule of the health care organization needed modification. Physicians must decide if they can deliver high-quality care in a particular health plan and make choices not to participate in plans that do not protect patients’ best interests.

Second, there are communication skills that physicians should use to resolve communication challenges.45,46 These skills include (1) understanding patients’ worries and concerns,47,48 (2) expressing empathy,49-53 (3) encouraging patients to take an active role in discussing options in care,54,55 and (4) negotiating differences of opinion when necessary.56-58 Discussion of differences of opinion in a context of mutual respect can go a long way toward resolving conflict.59 The purpose of the communication strategies is not to convince the patient to do what the physician desires, but rather to understand the patients’ concerns and make decisions that are acceptable to the patient and physician.

Physicians may be concerned that use of specific communication strategies may require increased time in already pressured visits. Further, they may feel frustrated that they are allocating precious time to discussion of financial or logistic aspects of health care rather than focusing exclusively on medical concerns. Based on our experience and limited available research, the group participants believe that effective communication strategies do not necessarily decrease efficiency and may actually save time in the long run by avoiding patient dissatisfaction. Research is needed to assess the most efficient ways to incorporate discussion of difficult topics into routine visits.

**TYPES OF PATIENT-PHYSICIAN DISAGREEMENT**

**Case 1: Allocation of Resources**

In the example above about the arrangement for Dr Jones and his multispecialty group practice, Dr Jones must persuade his patients to switch to ophthalmologists in group B from ophthalmologists group A.

**Patient.** The patient is eager to stay with ophthalmologist A whom he trusts and who has provided good care for several years. He is comfortable with the office staff and routines of the practice. He wants to please his primary care provider but he sees little to gain in the change. In fact, he fears that the quality of care may be diminished with the new ophthalmologist, and the transition could lead to miscommunication. The patient may suspect that the change is primarily for financial reasons that are unlikely to be disclosed.

**Physician.** As described earlier, Dr Jones feels torn between his concern for disrupting a long-standing patient-physician relationship and his desire for the patient to make the switch. He worries that patients’ unspoken concerns may be related to thinking that money is the motivation for the change.

**Medical Director.** Overall it is financially important for primary care physicians in the group to refer as many patients as possible to the new ophthalmologists. While the health plan can inform patients about the transition by letter, ultimately physicians must explain it to patients on an individual basis. A good physician is a “team player.” Under exceptional circumstances the primary care physician could allow a patient to stay with ophthalmologist A.

**Strategies for Resolution.** The key strategies for resolution suggested for physicians to use in this situation include (1) empathize with how the upset patient feels about the switch, (2) express commitment to the patient’s best interest, and (3) offer options so the patient does not feel coerced and without any choice. The dialogue that follows illustrates these strategies.

“[s] I wonder how you are feeling about switching ophthalmologists [allow patient to express feelings]. I can understand why this is difficult for you. I am committed to ensuring that you receive the best possible care. We have contracted with ophthalmologists in group B because we believe they can provide the highest quality care for our patients in many ways. I would like to suggest that you give the new ophthalmologist a try and if it does not work out well, we can modify the situation. Does that seem reasonable?”

Options can be presented to patients in the following manner. “I would like you to try this new physician but there are some options. Perhaps you could try the services and reevaluate them with me. Alternatively, you could consider changing health plans, if that is possible.”

The responsibility of the primary care physician should go beyond the communication about the change to taking an active role in the transition by helping the patient establish care. The physician can say, “I’ll communicate with Dr B regarding your case to help make sure this transition is as easy as possible for you.” This ensures that the transition process is shared by the physician recommending the change.

**Discussion Group.** The discussion group recommended that physicians avoid a frequently used strategy called ...
the “common enemy” approach in which physicians generally blame the health system for not allowing them to maintain the old relationship. They say something like, “While I would like to refer you to your prior ophthalmologist, our plan doesn’t allow me to do that anymore. So we both have to make the switch despite the inconvenience.” While this approach may be acceptable to many patients, we believe it does not enhance long-term trust between the physician and patient, nor does it set the stage to negotiate future difficulties because it implicitly supports the idea that the health plan cannot be trusted, and that the administrators make financially motivated decisions rather than supporting what is best for both physicians and patients.

Finally, the health care organization can help by establishing guidelines for high-quality ophthalmology care and selecting ophthalmologists based on these criteria. The health care organization must communicate the reasons for the transition to patients in the group, particularly when the reason for change is exclusively for financial benefits. While the communication from the health plan may not be read or understood by all patients, it allows the primary care physician to make reference to the material. Furthermore, it is imperative that the managed care medical director gives the primary care physician flexibility in allowing individual patients to stay with an ophthalmologist in group A, although this exception must be only for unusual circumstances.

Case 2: Access to Care
Managed care organizations are hiring a variety of clinical professionals including nurse specialists, behavioral health counselors, and health educators who offer the advantage of providing care in focused clinical areas, while protecting physician time for more complicated patient needs. However, when patients expect that physicians are the sole providers of high-quality care, then clinical support personnel are seen as offering lower-quality service, and are perceived as barriers to the physician. Thus, change in the model of care from one centered on the physician to a model designed around a team concept leads to potential conflict, with the essence of the disagreement related to which provider should be seen and when.

For example, a 58-year-old man with long-standing diabetes calls the physician’s office regarding his blood sugar, which is consistently higher than usual, and says “I want to see my doctor.” The triage nurse responds that he could be seen by the diabetes nurse specialist today, or have an appointment with the physician in 2 weeks. The patient insists on seeing the physician that same day and eventually is slotted as an overflow appointment. Because the physician’s schedule is already fully booked, the patient waits an hour to be seen, and is frustrated and angry by the time he finally gets into the examination room.

Patient. The patient is comfortable with his own physician, and uncertain about whether the nurse responding to his call is adequately trained to assess his problem. If he comes in to see the nurse and the problem is not addressed correctly, he will need to return to see the physician resulting in the added inconvenience of 2 visits. He is concerned that this new team concept is just a method for the health care organization to save money. If he is assertive, he probably can get to see his own physician.

Physician. The physician is under pressure by the fully booked schedule. He is frustrated with the triage nurse for putting this nonurgent patient in as a same-day appointment. He is already late with his schedule and now he has to deal with another patient. Furthermore, he realizes that patients are completing a patient satisfaction form at the end of their visit, and these satisfaction scores are being incorporated into his performance evaluation. Overall, he feels that the health care organization has put physicians in a bind by increasing enrollment, advertising to the public that patients receive same-day access to providers, and yet not increasing the physician workforce to meet these demands.

Medical Director. The health plan wants to ensure that patients receive good care, and believes that midlevel providers can deliver these services more cost-effectively than physicians. Since the public has a choice of health plans and convenience is an important factor for them, the health care organization can use access to the physician as a vehicle to promote a good public image if they use their personnel efficiently through the team concept, which should satisfy patients and providers, who will see the appropriate types of patients.

Strategies for Resolution. The types of dialogue physicians should use for resolving such disagreements with patients include (1) acknowledging the patient’s frustration, (2) affirming a commitment to work out the snags in the system to meet the patient’s needs, and (3) educating the patient about the team concept. It is essential that physicians express concern for patients’ feelings before explaining the team concept. Often physicians omit this first step and start explaining the system of care to patients only to find patients uninterested and increasingly angry. While taking the time to explain the reasons for the change of care may feel burdensome, or may seem to be the responsibility of the health plan, investing this time with the patient may help alleviate the patient’s misperceptions. In the long-term it may result in timesaving and efficiency for the overall health plan. Furthermore, since patients trust their physicians, they may be more receptive to an explanation of the team concept coming from the physician than from the health plan.

Before physicians begin to talk with patients, they may need to reflect briefly on their own feelings of anger at the health care system. If the physician is angry and expresses this feeling directly or indirectly, it is likely to escalate negative feelings for both parties. The dialogue that follows illustrates the strategies enumerated above. “You sound frustrated and angry about the difficulty in getting an appointment today [allow patient to respond]. I’m sorry that you had this experience. Now that...
we are together, I want to give my full attention to your diabetes [address the medical issue]. May I share with you some information about how our diabetes team works? We believe we can actually improve care for diabetic patients by using the team model. The nurses are experts and can often help patients with their diet in more effective ways than I can. I want to assure you that even though other staff may be involved in working with you to care for your diabetes, I will talk regularly with them about your care. We believe we can actually improve care for patients with diabetes using the team model. Of course, I am available to you when you need my services."

Discussion Group. A number of system strategies may also be used to decrease this type of disagreement. Through the use of written communication and photographs of team members in the office, the health plan can introduce the members and their roles in patients' medical care. Staff can reinforce the goals and roles of the team in each encounter with patients, including telephone contacts. We suggest that staff who communicate with patients use set protocols so that the message is clear and consistent. In addition, statements by staff should emphasize the physician's role in the team, including the availability of the physician when needed so that the linkage of care is clear. Advertising that toutst early access should support the concept of a team model of care so that patients expect a variety of providers and do not perceive the team model as another cost-containment measure.

Case 3: Financial Arrangements of the Health Plan
Some patients are likely to come to physicians' offices with worries that financial incentives may adversely affect their care. Most often this is an unspoken concern that patients feel uncomfortable bringing up with physicians. However, patients are starting to initiate these conversations. We think that it is prudent for physicians to anticipate this situation, and give thought to how they might answer these questions. In the absence of direct or subtle clues that the patient is concerned about financial incentives, we are not certain whether it is useful, or perhaps harmful to the relationship, for physicians to initiate this conversation. One of the patient representatives in the group believed that any discussion of this nature would be very uncomfortable and would potentially undermine trust. In fact, one study demonstrates that patients who do not know how their physician is paid are more trusting than patients who do know the financial arrangements. In contrast, some physicians in the group thought that discussions related to financial issues should occur in the first visit and physicians should use these discussions to establish the ground rules of the relationship, and develop a sense of honest discussion about difficult topics. We left these questions unresolved.

We unanimously agreed that physicians should not enter into financial arrangements in which there is risk of patient decisions being influenced by financial compensation for the physician. Physicians should be able to describe their arrangements to patients without becoming “red faced.” Beyond passing this test, physicians need to use language that clearly explains financial arrangements that support rather than undermine trust.

For example, a 45-year-old man, who runs long distances, developed a painful and swollen right knee and visited the physician expecting a magnetic resonance imaging (MRI) scan to determine what was anatomically wrong. He recently read a newspaper article about managed care organizations limiting the use of expensive tests to save money. The article warns patients that physicians are working for the health plan rather than for the patient.

Patient. The patient feels nervous about discussing finances and does not want to alienate the physician, who is the expert and his access route to services. However, if his condition would improve with an MRI, he wants it. He just wants to make sure he gets the best care possible.

Physician. The physician feels comfortable on medical grounds that the MRI is not necessary, but is worried that the patient may misinterpret his motives for recommending a conservative course. While the finances of any 1 case do not affect his compensation, there are pressures to limit expensive tests. The health plan gives him feedback about his utilization patterns compared with other physicians, and also gives him feedback about patient satisfaction. In fact, he had a prior patient complain to customer service when he did not order a test the patient wanted.

Medical Director. The goal of the plan is to provide appropriate care to patients. While physicians should be judicious in their use of expensive tests, the use of a particular test is a judgment made by the physician. If physicians do not order tests when they are appropriate, it may be more costly for the plan in the long run. It is the aggregate use of resources that will determine the plan’s economic health.

Strategies for Resolution. The discussion group suggested that when the patient directly or indirectly expresses worries about the financial arrangements, the physician should (1) empathize with the patient’s concern about conflict of interest and welcome more discussion, (2) affirm commitment to the care of the patient, (3) discuss the essence of the financial arrangements in sufficient detail so that patients can understand and judge their potential impact, (4) provide options so the patient does not feel powerless, and (5) address the issue again at the close of the interview to reinforce willingness to discuss difficult issues and underscore the collaborative nature of the relationship. The dialogue that follows illustrates these strategies.

“I’m glad you brought this up. There is so much in the newspaper about managed care these days and patients naturally worry that they will not get needed care. Have you had experience in a managed care plan that makes you worry about this [allow patient to describe]? I am committed to good pa-
tient care and to a good outcome for you specifically. Discussing the choices we make will never trouble me. The most important thing is that you and I make the best decisions we can together.”

There are several ways to make disclosure statements to patients. One way is to say the following, “The physicians here are in a group practice and depending on how the whole group makes decisions about the use of tests and expensive procedures, our compensation can be affected. While theoretically my decisions about tests could be influenced, the effect of any 1 test like an MRI is not of significant consequence.”

Another way is to state the following, “The system is arranged so that physicians share in the responsibility of how and when money is spent. It is in our best interest to provide high-quality care. Sometimes if we do the expensive test first and get the results quickly, it is less expensive. We have incentives to provide good care, be cost-sensitive, and to make patients satisfied with the care they receive. I can give you more information about this if you would like it.”

Physicians should then present options for care. “We have several options in addition to the MRI. These include using the measures I have suggested and rechecking your knee in 3 weeks, a second opinion from a colleague now or possibly later if you don’t improve, and while I don’t think this necessary, you could choose to obtain the MRI privately.”

To end the conversation, physicians could say the following, “We have had a discussion that was difficult for both of us. How are you feeling about this? My perspective is that trust is crucial to our relationship and I hope that we can continue to work together even when we may feel uncomfortable or under difficult circumstances.”

Discussion Group. The discussion group had the greatest difficulty coming to a consensus about how to address issues related to financial conflict of interest that could affect clinical decision making. The Health Care Financing Administration, the Advisory Committee on Consumer Protection and Quality in the Health Care Industry, and a number of individual states have called for disclosure about the financial arrangements between providers and health plans to inform patients fully. Theoretically, this allows the patients to understand the potential influences on physicians and to make informed choices about which plan to use. However, disclosure of this information, especially when inserted in the fine print of a health plan brochure, is unlikely to be communicated adequately. Physicians could address financial conflicts of interest with their patients during their initial visits but patients may be alarmed instead of comforted by physicians’ straightforwardness.

The discussion group thought that the health plans could help to avoid disagreements by providing clear information to new and prospective patients. Opportunities for members to discuss risk arrangements and ask questions about the impact of these arrangements on care are important. Further, the plan might seek ways to identify patients most likely to have these concerns, for example, those with chronic disease, and invite discussion with them. While many physicians may believe that the primary responsibility for informing patients falls on the health plan, we underscore that most patients have limited interest in these arrangements when they are healthy or signing up for the plan. Their interest increases when they need services and hence they are likely to seek information from the physician at the time of medical need, rather than from the plan administrators.

CONCLUSION
While the strategies described above have focused on what the physicians can do to resolve disagreements, the discussion group believes that it is imperative for health care organizations to build a culture that supports the importance of excellent communication. The health care organizations represented in this discussion group include those who have invested significant resources to develop communication skills training for physicians and other personnel to enhance their ability to deal with these challenging situations. Large health maintenance organizations have provided half-day and full-day workshops for physicians on a variety of communication topics. Studies demonstrate that providing intensive communication skills training for physicians can improve dialogue between the patient and the physician, decrease physician frustration in dealing with challenging situations, and potentially improve patient satisfaction and outcomes.

Furthermore, successful health care organizations are likely to involve physician leadership in building an environment that values communication, provides feedback and incentives for physicians, and actively educates patients about the process of care. Health care organizations need to develop innovative methods to inform patients prospectively about models of care that may be different from their expectations.

A trusting relationship between physician and patient is the bedrock of medical care. In this era of managed care, the relationship is potentially strained by changes in the health care system and a decrease in public trust. These conflicts are unavoidable as the health care system evolves and patients and physicians experience changes in the process of care. Learning effective communication skills can help prepare physicians to preserve the patient-physician relationship. Furthermore, as demonstrated by the collaboration of the members of the discussion group, cooperation between patients, physicians, health care administrators, and policymakers will be necessary to find innovative approaches to coping with, and thriving in, these difficult situations.

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