
Communication in the physician-patient relationship*

By Alan M. Rees
Professor Emeritus

Case Western Reserve University
Cleveland, Ohio 44106

Political, legal, ethical, social, economic, and technological changes in the twentieth century have produced a profound effect on the health care and health status of Americans and the way in which physicians and patients communicate. In the latter half of this century, the responsibility for individual health care has shifted from a physician-oriented, paternalistic approach to a patient-centered one. Patients now assume two identities: health consumers and active participants in the medical decision-making process. This phenomenon has created an environment where consumer demand for information has shifted from a single focus on symptoms, diagnosis, and treatment of diseases to an increasing preoccupation with cost, quality, and access to health care. This shift emphasizes the critical role played by medical librarians in the dissemination of needed information, and it challenges librarians to take a leadership role in opening newer channels of communication between physicians and patients. The 1992 Janet Doe Lecture analyzes the evolutionary change in the physician-patient relationship and its modes of communication, projects future roles for medical librarians, and provides an extensive list of references for further reading.

THE CHANGING PHYSICIAN-PATIENT RELATIONSHIP

On the American agenda, health has a high social priority. Ever greater amounts of political, legal, and social energy are invested in health concerns. But the great promise offered by our advanced medical technology threatens to elude us in that no simple, positive relationship exists between the growing national financial investment in health care and the health status of the American populace. In 1992, the adequacy of the U.S. health care system has become an election issue, and candidates are debating the ideological, economic, political, ethical, and social ramifications of health care reform. The optimal allocation of increasingly scarce national resources to health care remains to be determined, creating controversy and frustration.

This is far removed from a past and placid age in which expensive, high-technology medicine had yet to be invented. In that earlier age, the physician's

role was paramount, consisting of comfort and healing. Care was substituted for cure, in that the physician had little else to offer. A strong bonding relationship existed between physician and patient, based upon trust and faith. "Choose a physician," declared Oliver Wendell Holmes, "as you would a friend." The great majority of doctor-patient encounters took place in the patient's home and not in an office or hospital [1].

To attract and hold patients, physicians had to be sensitive, caring, and responsive. This was not sanctity, but good marketing. The critical elements in building a practice were not degrees or specialty certification, but intimacy and involvement with the patient in his own environment. Peabody, a distinguished professor at Harvard Medical School, regretted as late as 1930 that "hospitals are apt to deteriorate into dehumanized machines" that give the physician little time to cultivate more than a superficial contact with patients [2]. When the general physician went into the home of a patient, Peabody argued, he was able to comprehend the total background of the patient's life. "What is spoken of as a clinical picture is not just the photograph of a man sick in bed; it is an impressionistic painting of the

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patient surrounded by his home, his work, his relatives, his friends, his joys, sorrows, hopes and fears." Every visit was "an occasion for warm conversation in addition to medical treatments." In this manner, conversation with a patient was inseparable from diagnosis and treatment.

The patient's role as narrator in the drama of illness was crucial. In the absence of diagnostic tests, the physician relied essentially on the case history and depended upon the patient to tell him what was wrong. Office records were seldom kept, in that the physician had little difficulty in remembering the patient and his family. Medical care consisted of the human touch. Many still lament the passing of the old family physician from the medical scene.

This admittedly idyllic state reflected a relationship characterized by paternalism and dependency. Holmes told medical students that "your patients have no more right to all the truth you know than he has to all the medicine in your saddlebags . . . he should only get so much as is good for him" [3]. Patients were most often considered to be too ignorant to make decisions on their own behalf. Informing patients about the uncertainties and limitations of medical interventions served only to undermine the faith that was so essential to therapeutic success. Physicians felt comfortable in making decisions for their patients. Patients' rights did not exist, and it was assumed that the physician acted in the patient's best interests.

By the middle of this century, the world that intimately intertwined physician and patient had almost vanished. Physicians became separated from their patients politically, economically, and socially. The distance between doctor and patient widened. Little social mingling remained, and the physician-patient relationship became impersonal and remote, based upon a negotiated and structured financial transaction. Communication was highly formal, limited, and strained [4].

As the role of the physician as friend, mentor, and fount of medical counsel declined, patients sought information elsewhere, with the result that the physician is no longer the sole, authoritative gatekeeper of medical information. Patients have become consumers and turn to other information sources such as friends, relatives, doctors on call, Ask-A-Nurse, chiropractors, and even quacks.

The medical profession, increasingly isolated and alienated from patients, complains of neurotic and overly demanding patients who make lists of irritating questions—*la maladie du petit papier* (scrap of paper sickness) [5]. Physicians avoid excessive demands on their time and pinpoint "heartsink patients"—those who create the "feelings felt in the pit of your stomach when their names are seen on the morning's ap-

pointment list." Such individuals are otherwise described as "hateful patients," "dependent clingers," "entitled demanders," and "manipulative help rejectors" [6]. A physician's equivalent of the National Practitioners' Data Bank has been suggested to keep track of patients who have sued their doctors. Even those patients who conform to accepted relationship norms are increasingly denied extensive personal interaction with their physicians and are consequently forced to seek information elsewhere. Unlisted phone numbers and protective office staff shield physicians from unwanted and uncompensated questioning and discussion.

To cope with what has so often become an adversarial relationship with their physicians, consumers feel a compelling need to seek information in order to understand, amplify, confirm, or contradict what has been learned in their fleeting encounters with providers. To compensate for their perceived abandonment by the medical community, libraries are considered by consumers to be a nonthreatening, neutral, and inexpensive source of health-related information.

CONSUMER HEALTH INFORMATION NEEDS

Individual responsibility for the preservation of health and the prudent use of expensive medical treatment cannot be delegated. The health care system is complex and requires considerable personal decision making. Increasingly, consumers are forced to contend with the spiraling cost of health insurance, choices between alternative treatments, nagging doubts about the quality of care received, qualifications of their health care providers, and conflicting evidence concerning efficacy and safety of many products and procedures. What is the "truth" concerning silicone breast implants and the safety of Halcion and Prozac? Why is the cost of coronary artery bypass surgery 50% more at Harrisburg Hospital in Pennsylvania than at Lancaster General Hospital, only thirty-eight miles away? [7] Consumer empowerment is propelled by the perceived need on the part of consumers to protect their own interests. Katz argues that "the idea that doctors know what is in their patient's best interests and can therefore act on their behalf is so patently untrue that one can only marvel at the fervor with which the notion has been defended" [8]. The advocacy of informed consent, patients' rights, living wills, advance directives, and access to medical records is in large measure a response to the need felt by consumers to defend themselves from predatory health care providers whose interests do not necessarily coincide with their own. A large number of malpractice claims spring from a

breakdown in the trust that physicians are acting in the patient's best interests.

The alienation felt by the consumer is particularly apparent in the hospital environment. The hospital is viewed as increasing the powerlessness of the sick patient, maintaining his uncertainty, and diminishing his image of self. The oppressive and counter-therapeutic attributes of the hospital environment are seen to emanate from the professional ideology of physicians and the hierarchical relationship they establish with patients [9]. The profusion of patient advocates, patient representatives, and ombudsmen stems from the need for protection against the system.

The need for information is most often expressed with reference to signs and symptoms of diseases, medical tests, drugs, alternative treatment options, qualifications of medical providers, and coping strategies. A suggested typology of health-related information needs includes access information (availability and quality of care); disease information (symptoms, diagnosis, treatment, and prognosis); coping information (management of chronic diseases and conditions); and medical ethics information (conflicting issues related to issues such as genetic testing and extraordinary means of prolonging life) [10]. Basically, patients wish to know what is wrong, what it is called, whether it is serious enough to require expensive professional care, what alternative treatments exist, and how they can cope.

Illness is experienced in strange, terrifying surroundings. Confronted with pain, discomfort, feelings of fright and despair, patients seek information to retain customary control over their bodies and to restore normalcy in their lives. The active search for health information, notes Lenz, is "one mechanism for coping cognitively with change, uncertainty, disability, and crisis, and for gaining control over health-related events" [11]. At a most vulnerable point in their lives, patients urgently need vital life-sustaining information. Withholding such information can make the therapeutic relationship counter-productive, in that the physician's silence intensifies the patient's fears and fantasies. Cousins notes that every patient who comes to a physician presents two diseases, not one: "In addition to the disease being diagnosed and treated, there is the disease that goes by the name 'panic.' If we treat one disease and not the other, we may be treating half the patient" [12].

Eliciting what the patient wants in terms of information is undertaken too rarely. Explanation and education are not reimbursable procedures within the structure of the delivery system. Too often, a rigid dichotomy is maintained between a patient and a patient's illness. For fifty years the only thing physicians wanted to hear from their patients was "an accounting of their symptoms, as concise as possible

and chronological" [13]. Osler's admonition that "it is more important to know what sort of patient has the disease than to know what sort of disease the patient has" was forgotten.

Physician-patient communication may be related to two domains of medical practice—the technical domain, concerned with establishing the proper diagnosis and prescribing proper therapy, and the Samaritan (humanitarian) domain, involving supportive care. Patients express a distinct need for both technical and supportive information. Inui and Carter suggest that "the modality of communication for the 'caring' aspect of medical practice may also differ somewhat from communication for the pursuit of the technical medical agenda, placing greater emphasis on nonverbal modes of communication (touching, listening, posturing, facial expressions, tonal changes)" [14].

The disinclination or inability to communicate information to patients is attributed by Freidson to a view of the patient as incompetent to comprehend or cope emotionally with medical information and to the belief that an informed patient constitutes a threat to the physician's professional status [15]. "In any profession, one working definition of success is the attainment of such prestige that one need not deal with anyone who does not come in as a humble supplicant eager to obey" [16]. Consistent failure to see patients at the designated appointment time constitutes a controlling mechanism and a devaluation of patients' dignity and time [17].

In a study at a Michigan health maintenance organization, 90% of complaints stemmed from the ways that members of the medical staff communicated with their patients [18]. Patients objected to the highly controlling approach to the medical interview. Sixty-nine percent of patients were interrupted by their physicians within the first eighteen seconds of being asked to explain what was wrong with them [19].

INFORMED CONSENT AND PATIENT DECISION MAKING

Communication between physician and patient is strongly governed by the doctrine of informed consent. This doctrine now determines both the legal and ethical regulation of American medicine. Legally, it may be defined as the procedure whereby patients consent to or refuse a medical intervention based upon information provided by a health care professional regarding the nature and potential consequences of the proposed intervention [20]. The ethical foundation of informed consent is based upon the promotion of personal well-being and self-determination. Patients collaborate with their physicians to identify and evaluate treatment options but retain a veto over

any proposed treatment. Failure to obtain informed consent constitutes a refusal by the physician to respect the autonomy of the patient. The three essential ingredients of autonomy are the ability to understand, the ability to make rational choices, and the ability to act on these choices. In order to be autonomous, consumers must first achieve a reasonable level of understanding through education, information, and explanation [21].

The President's Commission for the Study of Ethical Problems in Medicine recognized that shared decision making is the appropriate ideal for patient-professional relationships that a sound doctrine of informed consent should support [22]. "Ethically valid consent," the commission noted, "is a process of shared decision making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of particular treatments."

Two models for integrating informed consent into the clinical practice of medicine have been identified [23]. The "event model" of informed consent treats medical decision making as a discrete act that takes place at a circumscribed point in time, usually before treatment. This emphasizes the disclosure of information and invites patients to decide whether to accept the physician's recommendations. The "process model" integrates informed consent into the physician-patient relationship at all stages of medical decision making, requiring continuous care by the physician and active participation by the patient. Although the event model fits most easily into the organization of hospital or clinic practice, the process model reflects a recognition that medical decisions are rarely made at one point in time and that active participation by patients in an ongoing interaction with their physicians is required.

Some critics have suggested that informed consent is a "charade" [24]. Explanation is given readily but fails to provide the basis for an intelligent choice of available options. One single authoritative voice emerges—that of the physician. Katz believes that patients "hear in doctors' recommendations not reflections of their own wishes, but the physician's wishes and hopes" [25]. What passes as disclosure and consent is so often an attempt by physicians to shape the disclosure process so that patients will comply with their recommendations. In this manner, informed consent represents a legitimization by the patient of the doctor's unilateral professional decision. Dialogue with patients is not always conducted in the spirit of inviting patients to share with their physicians the burden of decision and is viewed only as a necessary formality to avoid a malpractice suit. "Introducing consent forms just before treatment, and well after decisions have been made," argues Green, "undermines the role of the form in the shared de-

cision-making process and perpetuates adversity in the physician-patient relationship" [26].

A sharp distinction can be made between patients' desire for information and their willingness to participate in decision making. Haugh and Lavin distinguish between two types of medical rights—the right to medical information and the right to make medical decisions [27]. Although evidence exists that patients wish to be better informed, many do not want to participate more in decision making. One study determined that 41% of patients preferred receiving additional information about their hypertension, but, in actual decision making, they played a relatively passive role, leaving the decision entirely up to their physicians in 63% of cases [28].

QUALITY OF CARE AND INFORMED CONSENT

Consumer demand for information is now shifting from a single focus on symptoms, diagnosis, and treatment of diseases to an increasing preoccupation with cost, quality, and access to health care. In this connection, *Quality of Medical Care: Information for Consumers*, a report of the Office of Technology Assessment, investigated whether information could be developed and distributed to assist the public in its choice of medical providers [29]. The report offered three rationales for producing better-informed medical consumers: more information enables people to avoid poor-quality providers; information on specific providers educates the public about the quality of care and injects greater price competition into the medical marketplace; dissemination of information on quality stimulates the medical community to improve the level of current practice. The report identified basic categories of quality care information that should be made more readily available to consumers. These included hospital mortality rates, adverse events such as nosocomial infections in hospitals, volume of services provided, formal disciplinary actions, and patients' assessments of their care.

The report concluded that "people will require skills and social support to undertake what for many is new behavior, namely interacting with physicians and raising questions about quality" [30].

Another significant source of quality information for consumers lies in outcomes management research, which links medical management decisions to new, systematic information about outcomes. Outcomes analysis endeavors to determine which medical and surgical procedures work and which do not. The intention is not only to identify those treatments that can best relieve symptoms and disease, but also to relate success to patients' satisfaction with long-term results. Such research offers dual benefits: helping insurers control costs by avoiding diagnostic tests, drugs, and surgery that are unnecessary and ineffec-

tive and empowering patients to make informed choices about their treatment options [31].

Elwood, a leading proponent of outcomes analysis, points out that "patients are still forced to judge medical care on the basis of the quality of the amenities (the physician's manner, the waiting time, and so forth) because they rarely have the knowledge or suitable information to base it on anything else. . . . patients claim that they are told what kind of care they will receive, rather than being given real choices" [32]. The present patient experience so often results in uninformed patients, skeptical payers, frustrated physicians, besieged health care executives, and a beleaguered government. Elwood concludes that outcomes management will "help patients, payers, and providers make more rational choices, based upon a better insight into the effect of these choices on the patient's life."

The Agency for Health Care Policy and Research supports a number of Patient Outcomes Research Team (PORT) projects through its Medical Treatment Effectiveness Program (MEDTEP) [33]. MEDTEP coordinates activities related to outcomes research, development of clinical practice guidelines, and dissemination of the recommendations of guidelines panels. A basic objective is to increase the involvement of patients and consumers in decision making regarding health care. Current PORT projects include comparative analysis of the effectiveness of treatments involving back pain, total knee replacement, gallbladder disease, caesarean section, and cataracts. These research projects should contribute significantly to informed consent and decision making, and may also result in more judicious use of expensive medical treatments and surgical procedures. Relman states that "the Era of Assessment and Accountability is dawning at last" [34].

The release of hospital mortality data by the Health Care Financing Administration (HCFA) should also support informed consent. *Medicare Hospital Mortality Information (1987, 1988, 1989)*, made available in May 1991, is a 25-volume publication that provides selected mortality rates in nearly 6,000 hospitals [35]. Actual and predicted rates are given by hospital for nine surgical procedures and eight medical conditions. Revealing the risks of hospitalization and various procedures has significant implications in relation to consumer decision making. Knowledge of the relationship between volume and patient outcomes is clearly of interest to consumers in evaluating the quality of care.

The data published by HCFA in the massive 93-volume *Medicare/Medicaid Nursing Home Report* are also relevant to consumer concerns [36], as are the accreditation data of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Yet another valuable data source is records of phy-

sician performance. The New York State Health Department has released the death statistics for each heart surgeon in the state [37]. "Surgical scorecards" now exist for consumers to pinpoint "bad apple surgeons." However, no one has yet solved the problem of how to make such data available and meaningful to the public.

The National Practitioner Data Bank, covering disciplinary actions of state medical boards, payments made in malpractice claims, and restrictions on hospital privileges, unfortunately remains closed to consumers. Limited, aggregate data released for the first year reveal, according to Sidney Wolfe of the Public Citizens Health Research Group, "a shocking degree of inaction by hospitals in protecting patients from incompetent medical care" [38]. Wolfe argues that the value of the data bank is undermined by Congress's refusal to allow consumers access to doctor-specific data. "Knowing about a doctor's disciplinary record and performance," says Wolfe, "is critical to a consumer's ability to make informed decisions when choosing health care providers."

THE LIBRARY ROLE IN PHYSICIAN-PATIENT COMMUNICATION

The library role in responding to the health information needs of the American public has become more definitive in recent years. This sharpening of focus was initiated some fifteen years ago by a small cadre of pioneering medical librarians who perceived, in the late 1970s, the need to disseminate medical information to the community at large [39]. While health professionals had ready access to multiple health information services, laypersons with critical information needs were forced to accept what little trickled down through their local libraries. Access to the literature of medicine should not remain the exclusive privilege of health care professionals. This radical notion reflected the belief that a democratization of access to health information was urgently needed. Despite significant progress, many medical libraries still have a policy of restricted access.

The early proponents of consumer health information services recognized that medical librarians, as specialists in the retrieval and dissemination of health information, have an obligation to serve the public, in addition to their traditional constituency of health professionals. It has, however, required considerable time and perseverance to overcome the long-established view that the role of the medical librarian is to serve only health professionals. The formal recognition by the Medical Library Association (MLA) of the Consumer and Patient Health Information Section crystallized an expanded definition of health sciences librarianship and moved what was regarded as

a peripheral activity into the mainstream of medical librarianship.

Library Services and Construction Act (LSCA) funded projects have led to a significant improvement in the capability of both medical and public libraries to respond to consumers' health information needs. The funding resulted in the development of model collections, increase in staff skills through training, formulation of reference guidelines, networking, multitype library cooperation, and the creation of linkages with community health organizations. LSCA demonstration projects defined and legitimized a new library role in providing health information to the community [40]. With public libraries now clearly designated as the principal service agent, five types of medical libraries are actively involved in delivering health information to the public: academic medical center libraries; medical society libraries such as the New York Academy of Medicine; hospital libraries; Veterans Administration libraries; and special libraries, such as Planetree.

A number of academic medical centers, especially those supported by state funds, have initiated consumer health information services as a community service, in some instances on a statewide basis. By providing educational, consultative, and backup support to both public and hospital libraries, the delivery of library services has been enhanced at the local level.

In the hospital setting, libraries are increasingly involved in providing information services to patients and their families. Libraries are called upon to provide information in support of patient education programs related to specific illnesses, diagnostic procedures, and treatment methods. Many hospital libraries are also active in organizing community health education programs designed to enhance the image of the hospital as a caring institution [41].

The interface between hospital libraries and patient education has not been explored adequately, beyond the broad differentiation that libraries provide information with no interpretative opinion or tutorial support, while patient education influences patient behavior to produce changes in health knowledge, attitudes, or practices. Consequently, while patient education has defined and measurable behavioral objectives, such as smoking cessation or weight loss, library-based services lack such defined objectives. It is entirely possible that library-based information services create awareness, stimulate interest, and reinforce existing health practices, whereas the interpersonal relationships established by patient education induce change. Clearly, a close and supportive relationship between librarians and patient educators is required. No uniform pattern of cooperation in hospitals has emerged.

The services provided to consumers by libraries in these various settings range from browsing to book circulation, supply of pamphlet materials, construction of information packages on demand, sale of books, telephone response to questions, database searching, photocopying of articles, viewing of films and videocassettes, and referral to voluntary health associations and community health agencies. Some libraries make CD-ROM databases, such as Health Reference Center and MEDLINE, available for consumer use.

The present-day library can draw upon an unprecedented amount of informational materials in both print and electronic form. More than 800 popular medical books are published annually, including bestsellers such as Kowalski's *Eight Week Cholesterol Cure* and Siegel's *Love, Medicine and Miracles*. The *Mayo Clinic's Family Health Book* and the *Columbia University College of Physicians and Surgeons Home Medical Guide* are now accepted as standard reference works. Newsletters published by medical centers such as Harvard and Johns Hopkins have been highly successful in disseminating authoritative and understandable medical information. Magazines such as *American Health* have circulation in the millions. *Good Housekeeping* and similar publications also contain much health-related content, primarily focused on women's health concerns, skin and beauty care, food and nutrition, and health problems of children [42].

Although the popular literature contains some original material, much of the content consists of information recycled from the professional literature. Articles published in the *New England Journal of Medicine* and *JAMA* are regularly scanned, digested, and translated into lay terms for popular reading. It is quite common to find a research paper digested in a dozen or more popular medical magazines and newsletters. The dissemination of medical information to the consumer reflects, in this manner, a two-stage process in which medical journalists act as intermediaries to filter, metabolize and digest technical and scientific information for popular consumption.

Access to the popular health literature is facilitated by a number of indexing and abstracting services. *The Consumer Health and Nutrition Index* (Oryx Press) covers some fifty popular health magazines and newsletters together with articles of consumer interest in a number of professional journals such as the *New England Journal of Medicine* and *JAMA*. On CD-ROM, Information Access Company's *Health Reference Center* indexes popular magazines and newsletters and supplies full text of a select number of publications.

TOWARDS A NEW PHYSICIAN-PATIENT RELATIONSHIP

The right to health must be accompanied by the moral obligation to preserve one's own health. The most

promising approach to the present health care crisis lies in educating consumers to improve their self-care practices and reduce health risk factors. More support must be given to individual initiatives in the form of stress management, improved nutrition, exercise, control of hypertension, and cessation of smoking—all of which can lead to both an improvement in health status and a reduction in costs. It bears repeating that educated, well-informed, and empowered consumers can do more for improving the health of the U.S. populace than a massive investment in buildings and expensive medical technology. As Illich iconoclastically notes in *Medical Nemesis*, "That society which can reduce professional intervention to the minimum will provide the best conditions for health" [43].

Satisfactory treatment outcomes are dependent on patient consent and cooperation. A positive correlation exists between information and satisfaction, and between satisfaction and compliance. Patients who are encouraged to participate in their own health care are more likely to volunteer information, elicit the best in a practitioner, receive better care, and get better faster with less treatment [44]. Benefits that can result from the improved flow of information include enhancing the accuracy of medical history taking, facilitating patient compliance with therapeutic regimens, increasing patient satisfaction, and improving patients' physiologic and psychological response to therapy [45-46]. The transmission of information affects both the quality of care and the course of treatment. The need is clearly for a better-informed and more participatory patient.

The physician-patient encounter is the foundation of the clinical process of primary care. Kathryn Hunter points out that a patient's story provides the chronologic events of an illness and sketches out a common-sense etiology [47]. The physician takes this story (voice of the life world) and transforms it into a medical narrative (the voice of medicine) and subsequently returns it to the patient. Two distinct narratives are involved: the patient's story, or the original motivating account that the sick person relates to the physician; and the medical account (metastory), constructed by the physician from selected, augmented parts of the patient's narrative and from the signs of illness in the body. These two versions of the same story can warp mutual understanding and impede communication [48]. The physician's narrative has to be interpreted, replotted, and returned to the patient with respect to diagnosis, prognosis, and recommendations for treatment. Much of the tension in modern medical encounters stems from a poorly defined narration to patients. Physicians too often regard the medical version as the reality and neglect the retelling of the story to the patients in meaningful terms.

A new alliance between physicians and patients, based on cooperation rather than confrontation, must be universally adopted. Patient-centered care has to replace a one-sided, physician-dominated relationship in which the exercise of power distorts the decision-making process for both parties. Such an alliance must take into account not only the application of technical knowledge, but also the communication of information calculated to assist the patient to understand, control, and cope with overpowering emotions and anxiety. Physicians must accept responsibility for both a technical expert and a supportive, interpersonal role. The polarization produced by the conflict between medical paternalism and patient sovereignty is counter-productive. Mutual participation, respect, and shared decision making must replace passive submission. Dispensing information in a manner that maximizes understanding is a prerequisite for more equal participation.

THE FUTURE

Successful therapeutic intervention requires mutual trust, nurtured by effective communication. The therapeutic partnership between patient and physician can be strengthened by improved information transfer. Better-informed patients bring more to the partnership and gain more from the interaction. If patients ask clear and forthright questions, they are more likely to receive better care with more successful outcomes. An investment in time and energy is, however, required to clarify one's concerns, establish priorities, and present them concisely and convincingly. The acquisition of a solid information base is a prerequisite for initiating a successful dialogue in the physician-patient encounter. Libraries can assist patients in constructing a medical agenda that defines the reasons for the visit and in formulating a list of questions to be asked. Construction of such an agenda would enable patients to make more effective use of the very limited time involved in typical medical encounters.

Oppenheim recommends that a patient should at least ask for the name of the problem, what caused it, what should I do about it, when should I get better, and what should I do if I'm not, and do you want to see me again for this problem [49]? He offers the following examples of uninformed, misinformed, partially informed, and informed dialogue:

Question: You say you were hospitalized for three weeks in 1982. What for?

Answers: "For tests" (useless); "For a heart condition" (not much better); "For heart failure" (useful but not specific enough); "Heart failure from a leaky valve" (pretty good); "Heart failure from a leaky mitral valve. The doctor said I probably had rheumatic fever when I was young" (ideal).

Libraries should provide enhanced information services in support of improved physician-patient encounters. A significant contribution can be made towards narrowing the knowledge gap that divides physicians and patients and correcting what is at present an asymmetrical physician-patient relationship. One can reasonably expect improved patient-physician dialogue to result from a more equalized knowledge base. Improved consumer competence and responsibility can also lead to more judicious and prudent utilization of expansive health care services. Higher rates of breast-conserving surgery have been found in those states that have informed consent laws requiring physicians to give patients with breast cancer information about treatment options [50].

Better-quality informational materials are urgently required. The present publication trend in the consumer health literature reflects a multiplication of nutrition books, home medical guides, and books on specific disease such as cancer, diabetes, and arthritis. Relatively few publications provide consumers with information useful for personal decision making. Basic issues related to costs, quality, access, outcomes and the economics of health care are rarely addressed. Less encyclopedic medical knowledge and more information to help consumers solve typical problems is required.

The range of information available to consumers needs to be broadened. Consumers have a right to know more about the appropriateness and the quality of health care they are receiving. In this connection, consumer decision making would be greatly improved if data accumulated by HCFA and other federal agencies were made more readily available. To achieve informed medical consumers capable of truly informed consent and effective decision making, a concerted effort must be made to make crucial information available to the public in a meaningful form. Freedom of access must mean more than the publication of a deluge of undigested and unformatted data beyond the comprehension of most consumers. An investment has to be made in digesting, compacting, and interpreting hospital mortality rates, outcomes analysis, practice guidelines, nursing home accreditation reports, and other relevant data. Patient choice guidelines should be developed to create a more medically literate population [51]. HCFA should examine the success achieved by the National Cancer Institute in disseminating vital health information to the public.

The Agency for Health Care Policy and Research is actively disseminating findings related to outcomes research and clinical practice guidelines. As each practice guideline is completed, separate patient and physician guides will be published in both English and Spanish. The patient guides will summarize the essential findings in terms that consumers can un-

derstand. Guides are already available on acute pain management and urinary incontinence in adults, and will be published in the next few months on the diagnosis and treatment of benign prostate hyperplasia, depression, pressure ulcers, and cataracts. Within the next year, consumers will have authoritative information as to which procedures work and which do not, and will be able to draw upon this information in making decisions regarding their health care.

The newly formed Foundation for Improved Medical Decision Making has announced ambitious plans to produce a series of video programs designed to help patients choose treatments for four common ailments—benign prostate disease, low back pain, hypertension, and early-stage breast cancer. The goal is to educate patients and encourage their participation in treatment. Dr. John Wennberg, professor of family medicine at Dartmouth, who devised the interactive video project, states that “We’re beginning to democratize the doctor-patient relationship.” The initiators believe that providing such information to consumers should introduce into a health care market dominated by physicians and other providers the kind of consumer power that drives other industries [52].

The development of decision-making software for use by consumers on their home computers should be undertaken. The informatics research funded by the National Library of Medicine may prove to have applications for consumer health information processing. Automated decision support systems for physicians based upon expert systems technology may very well be adaptable to the development of decision support software for consumers.

The existing mandate of the National Library of Medicine to provide informational support only to the professional community should be reconsidered in the light of the increasing need for consumers to be more actively involved in decisions regarding their health care, the therapeutic significance of better physician-patient communication, the expanding role of health professionals in health education, and the emerging role of consumers in efforts to improve health care quality and control costs. The recommendation in the 1987 *Long Range Plan* of the National Library of Medicine—that the library should examine its role in the dissemination of popular health information—should be implemented [53]. Goal 2.4 of the plan noted that “given the current emphasis on individuals assuming a stronger role in their own health care, and the shift in emphasis from disease treatment to prevention, the lay public’s need for and access to health information should be reviewed.”

If we as a nation are truly committed to preventive medicine and market competition, consumers should be educated and encouraged to play a more active role. A significant improvement in health status can

be achieved by better-informed and empowered consumers. Medical librarians can take a leadership role in opening up channels of better communication between physicians and patients and in gaining access to relevant information. No one other than the medical librarian is better able to bridge the gap between the world of medicine and that of the general community.

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