Placebo Response, Sustained Partnership, and Emotional Resilience in Practice

In 1973 Herbert M. Adler coauthored a paper that marked a watershed in the literature on the placebo response.[1] Since 1945 others had commented upon the placebo effect as it was revealed in research settings through the use of double-blind studies. Adler and Hammett tied this new line of research to lessons taught in a few classic articles from an earlier era.[2] They showed, first, that cross-cultural studies could shed considerable light upon placebo phenomena; and second, that understood this way, the placebo response was a part of every healing encounter and thus required careful study by all clinicians, not only by investigators concerned about research design. Their work triggered an expanded appreciation of the placebo response, allowing others, for instance, to discern that the distinction between diagnosis and therapy in the typical encounter is artificial—that diagnostic investigation is an important part of the actual work of healing.[3,4]

Dr. Adler now returns with a detailed analysis of the history of the present illness as a form of therapeutics.[5] His work demands commentary on what he claims for the therapeutic nature of the medical interview, the implications for the structure of the clinical practice of primary care, and the emotional demands his model makes upon the practitioner.

Adler suggests that the right sort of narrative account of the patient's illness does more than lead to correct diagnosis; it also begins the process of healing. Moreover, the construction of this narrative need not be left to the patient alone; ideally, it is the product of coprocessing involving both patient and physician. A few years ago this suggestion might have seemed wildly improbable. Work within the past decade, however, has highlighted the importance of narrative for medicine and has demonstrated the manner in which narrative accounts can relieve suffering and promote healing actions.[6] For instance, the rate of functional recovery of elderly hip fracture patients can be correlated with the narratives they tell about their injuries and the extent to which the narratives suggest reintegration into daily life.[7]

The importance of narrative for healing can extend beyond the sick individual or the dyadic patient-physician relationship. Frank[8] has recently argued, especially in connection with chronic illness, that giving testimony of one's suffering is a critical part of the process of healing, and that the communal practice of listening empathically to such testimony is ultimately a healing practice for the community as a whole. If, as Frank suggests, there is an ethical obligation at the community level to give and to attend to such testimony, then the caring physician would seem to have a special obligation to study patient narratives of illness and to aid patients in finding words for their suffering when they feel overwhelmed.[9]

In today's practice environment, comments about the patient's story of illness might appear to be laughably naive. Even those physicians who have been successfully converted to a biopsychosocial model of medical science and practice might still object that the era when the physician had the time and resources to attend to the psychological and social aspects of illness has now receded into the distance. Instead, the growing emphasis on cost-containment through managed care has so shortened the typical primary care encounter, and so distorted the traditional physician-patient relationship into an assembly-line process, that it is a counsel of perfection to prescribe narrative sensitivity as part of the physician's daily work.

But this cynical view assumes that all managed care environments are equally detrimental to the physician-patient relationship, and that today's version of managed care represents its most mature developmental stage. It assumes further that primary care physicians, including academic physicians in primary care, have no influence upon the future of managed care systems. If there is hope for change, and if readers of this journal are among the possible agents of change, then we need to study especially where the interests of patients, of primary care providers dedicated to

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high-quality practice, and of fiscal managers might most overlap. There are already some data to support the proposition that the well-managed and solvent plan would promote continuity in the primary care relationship, as continuity of care with the primary provider is most likely to control costs while simultaneously enhancing patient satisfaction.[10]

Thus the notion of sustained partnership in primary care has become the focus of both clinical research and policy proposals.[11] Read in this light, Adler's analysis suggests some further dimensions of the primary care relationship that could be predicted to be cost-effective. Attending carefully to the history of the present illness, in the manner Adler describes, might extend the length of visits and drive up costs in the short run —as do most highly effective preventive interventions. If this approach reduces the number of patients who return for multiple visits for varied somatic complaints, because their underlying psychological distress was never recognized and treated,[12,13] then it will ultimately reduce costs at the same time that it increases both patient and physician morale.

A final objection to Adler's proposal might be the emotional demands it places upon the physician and its apparent violation of the accepted wisdom of detached concern as the ideal relationship with patients.[14] Adler points out that the physician who attends carefully to the patient's narrative will vicariously reexperience the illness and suffering to some degree. Ironically, the more fully and empathically the physician can experience the patient's distress, the better the patient will feel—for the patient is carefully monitoring the physician for signs of empathic receptiveness and feels most safe in telling the story and most relieved of the worst aspects of personal anguish, the more the physician appears to be in tune with the narrative. It seems highly doubtful the physician can fake this level of empathy or reduce it to a mechanical technique of interviewing that allows for maintaining a large emotional distance. But allowing that degree of empathic experience of the patient's suffering can be highly threatening to the physician's emotional equilibrium and, therefore, perhaps to the physician's objectivity and ability to treat effectively.

Some would submit that the flaw in this reasoning is not in Adler's advice, but rather in our having adopted detached concern as our ideal model of the relationship. That model presumes that the real danger to the physician's effectiveness lies in emotional overengagement, that emotional distance is, by contrast, by far the safer course. If we listen to the complaints of today's patients, however, they do not allege that they get poor care because the physician is reduced to a blubbering imbecile upon hearing of their distress. Instead they complain, virtually with one voice, that physicians don't seem to care and don't listen to them.[15]

In medicine, especially a male-dominated world of medicine, close relationships seem scary and potentially overwhelming, whereas isolation seems safe.[16] Our own sense of safety in emotional distance has probably led us to be overeager to hear the message of detached concern, with the emphasis on the detached rather than the concern. It might be time to explode the myth of getting too close to the patient as a serious danger of attending carefully to the patient's story and affect. I would propose that physicians who mistreat and exploit patients, because they get too close, are not attending empathically to the patient's narrative at all, nor are they coprocessing the patient's experience as Adler recommends. Instead, they are attending to their internally driven needs and fantasies and projecting those upon the patient.[17] Physicians who engage in sexual relationships with patients are probably the clearest example of this sort of abuse.[18]

The empathic physician who attends most carefully to the patient's narrative still runs a danger of emotional vulnerability, as Adler admits; indeed, it can be said that the virtue of compassion, which most would view as a desideratum of good practice, requires this degree of vulnerability.[17] As Adler suggests, this places a special demand upon medical educators to prepare future physicians to be suitably empathic and involved listeners without burning out as a result. Coulehan[19] has recently described emotional resilience as the quality we should aim to instill in our trainees and has suggested various ways in which this quality could be promoted.

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