

## CHAPTER 11

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# CARE AND MANAGED CARE: PSYCHOLOGICAL FACTORS RELEVANT TO HEALTHCARE AND ITS DELIVERY<sup>1</sup>

## 1. CARING

What is the essence of clinical caring, how can its value be determined, and what are its origins? Caring for a patient is a bit like loving someone. In both cases, the well-being of the person who is loved or the patient who is cared for is felt to be overwhelmingly important. Good clinical care goes beyond the diagnostic services, prescriptions or operations that the patient is billed for. It includes services done free of charge for the satisfaction of easing the patients' distress or enhancing their sense of security or optimism while they cope with illness. Love and clinical caring are not commodities to which market values have relevance. They have value without price. Whereas a person in the business of selling services is motivated by the prospect of making a profit, the altruistic clinician is motivated by the desire to help the patient. He or she is paid to be sustained, albeit comfortably, not to be made rich (Thomas, 1983, pp. 1-18).

Patients' satisfaction and compliance with medical prescriptions are dependent on the quality of the doctor-patient relationship (Hall, Roter & Katz, 1988; Roter & Hall, 1992, pp. 3-20; Linn, Brook, Clark et al., 1985; Like & Zyzanski, 1987). That quality is determined by the abilities of the participants in that relationship to give and receive caring. In a paper entitled "The Patient-Provider Relationship: Attachment theory and adherence to treatment in diabetes," Ciechanowski et al. showed that poor control of the disease was related to a dismissing style of interpersonal attachment (Ciechanowski, Katon, Russo & Walker, 2001). The authors cited the work of John Bowlby, the British psychiatrist who originated attachment theory. Bowlby found that attitudes about one's worthiness to receive care and the trustworthiness of others who might provide care are derived from one's experiences with caregiving during childhood. These attitudes influence the interaction adults have with others in patterns referred to as attachment styles. There are four styles of attachment in adults: secure, dismissing, preoccupied and fearful (Ciechanowski et al., 2001). Adults capable of secure attachments received consistently responsive caregiving as children. As adults, they are comfortable

depending on others, being comforted by others and working in doctor-patient relationships. Adults whose attachment style is dismissing received emotionally unresponsive care during childhood; they adapted by becoming compulsively self-reliant and they are uncomfortable with intimacy. Their dismissing attitude towards caregivers limited their ability to function well in a doctor-patient relationship and this limitation, it turned out, was associated with significantly poorer control of their diabetes and greater risks of blindness, kidney failure, and amputations. (Ciechanowski's series included a subgroup of patients with dismissing attachment styles who nevertheless maintained good control of their disease. The authors speculated that such favorable outcomes resulted from the ability of clinicians who were skillful in sustaining relationships with "difficult" patients.)

There are many conscious and unconscious factors that motivate individuals to become physicians (Ford, 1983, pp. 201-210). Given the ability to earn a comfortable living, the two most important incentives to work for at least 50% of clinicians are the inner satisfaction of knowing that one's efforts have genuinely improved the well-being of patients and the gratification experienced when patients express thanks (Maward, 1979; Gould, 1990). Obviously, to gain professional satisfaction, the clinician must be aware of what patients want and what they need. According to Mechanic & Schliesenger (1996), patients want their physicians to be competent, to assume control of their care (i.e., to take full responsibility and not inappropriately defer or delegate it to others), and to have the qualities of sensitivity, caring, genuineness, and respect for confidentiality.

It can be inferred from Ciechanowski's paper that physicians, too, have attachment styles. Twenty-five percent of the general population has a dismissing attachment style (Mikelson, Kessler & Shover, 1997), and it is likely that this 25% includes some physicians. And just as there are patients who feel little need for a personal physician, continuity of care or the reciprocal loyalty and trust characteristic of the "secure" doctor-patient relationship, so there are clinicians who feel no compelling desire to gain patients' trust or fulfill their needs (Green, 1969). The design of many systems of healthcare delivery seems to be based on the paradigm of the less-involved clinician, one whose professional satisfaction comes more from being a good "team player," vis-à-vis their colleagues and administrative bureaucracy, than from the experience of having personally improved the well-being of their patients. (Would physicians who are uncompromising champions of patient-centered care, e.g. Hippocrates or Maimonides in the past or Pellegrino (1979, p. 122) or Lown (1996) in the present, be comfortable working in through-put driven HMOs? Would such HMOs be comfortable having them on their staffs? My guess is, probably not.)

## 2. PSYCHOLOGIC CONTRADICTIONS INHERENT IN KEY TENETS OF MANAGED CARE

### 2.1. *The Shift from "Individual Provider" to "Team Provider"*

Medicine's growing complexity is being used to rationalize the shift from "individual provider" to "team provider" (Pellegrino, 1979). I fully agree that it is nearly impossible for a physician to stand alone as caregiver nowadays. In order to function well, he or she needs the help of technical specialists, for example, pharmacists, dietitians, and, yes, business managers. What I take issue with is the redefinition of a patient's medical visit as an encounter with a "team provider," rather than a personal physician. Granted, some patients might not object to, or even prefer, a "team of specialists." Nevertheless, patient satisfaction research indicates that the majority of patients are more satisfied when served by a caring personal physician (Hall, Roter & Katz, 1992; Linn, Brook, Clark et al., 1985; Like & Zyzanski, 1987; Mechanic & Schlesinger, 1996; Matthews, Suchman & Branch, 1993).

An "inter-professional team" can work well if its members understand the roles of *principal clinician* and *helper clinician*. The principal clinician is perceived by the patient as being the caregiver-in-charge, the doctor who knows the patient best, cares about him or her most, and remains available and accessible after the patient has left the hospital or clinic. (These characteristics define the term, "personal physician.") The other members of the healthcare team are perceived to be the physician's helpers and are valued by the patient according to how helpful they seem to be. When a patient who has enjoyed a satisfying doctor-patient relationship suspects that some other individual or team has taken control of his case away from his doctor, the patient may become angry and less compliant (Ley, 1982).

What motivated the paradigm shift from "individual provider" to "team provider?" I suspect that its purpose was to de-professionalize physicians by removing from them the ultimate responsibility for patients' care, thereby downgrading them to the status of biomedical knowledge technicians and members of teams (McKinlay & Stoeckle, 1990). Downgrading their role and level of responsibility would make them less important in the eyes of patients and less expensive to employ. However, most patients want a dyadic relationship with their doctor. Their expectations cannot be satisfied by a team of people (Mechanic & Schlesinger, 1996).

*Transference* is a psychological phenomenon inherent in the process by which a vulnerable person seeks help from a caregiver (Zinn, 1990). It is the largely unconscious patterns of feelings, thoughts, and behavior, originally experienced in relation to significant figures during childhood (e.g., a parent), displaced onto a person in the present (e.g. one's physician) (Moore & Fine, 1990, pp. 196-197). Transference of feelings such as warmth and trust facilitates rapport which, in turn, strengthens the diagnostic and therapeutic power of the doctor-patient relationship.

Transference is a person-to-person, not person-to-group phenomenon. When the principal caregiver shifts from the personal physician to a team, the transference may become so diluted that it no longer sustains the intimacy necessary for a working alliance (Usher, 1993, pp. 15-18). The weaker the working alliance, the lighter the caregivers' burden of responsibility for the success or failure of their healing efforts. Disappointing results can be attributed to poor compliance - the patient's, not the team's fault.

## 2.2. *The Shift from "The Health of the Individual" to "The Health of the Population" When Allocating Scarce Resources*

Managed care administrators exhort clinicians to change their goal from the health of individual patients to the "health of the population." ("Groups of doctors are becoming responsible for groups of patients" (Montague, 1994).) This sharply contrasts with their advertising copy. I've seen countless advertisements promoting one HMO or another, but I don't remember any that advertised their goal as "the health of the population." Rather, their slogans are phrases like, "We're here for you!" "Your health and the health of your family is our number one priority!"

One might say that it is now necessary for people to accept new limits on what they want. I would answer that, in order for any change to succeed, it must make sense not only as a logically consistent plan that ought to work, but also in terms of whether the changes are concordant with basic human needs and attitudes that haven't changed much in the past few thousand years.

An HMO psychiatrist/administrator wrote, "In planning treatment, the ideal HMO clinician first imagines the best that one could offer the patient, given unlimited resources, but then considers the needs of a total population that must in actual circumstances be served with finite resources" (Sabin, 1991). The clinician is then required to ration care according to his/her assessment of the availability of resources. At present, "available resources" seem to be estimates of *what's left over* after HMO executives, shareholders, entrepreneurial doctors, pharmaceutical companies, and hospitals are often lavishly compensated. "Scarcity" could be to some extent the creation of those who administer it.

I have two more objections to the psychiatrist's directive: it is unworkable and it is morally dangerous. It is unworkable because a physician engaged in practice can't possibly make an independent assessment of available resources. He or she would have to be an expert in economics, biotechnology, epidemiology and inventory & procurement. Instead, the clinician is forced to rely on the interpretations of experts in these non-clinical fields. However, administrative personnel are not caregivers and may not put patients' well-being first, especially if advancement in their own careers depends on the financial profitability of the businesses that employ them. So why should we trust them? Moreover, asking a doctor working with a suffering patient to stop and shift his concern to the comparatively abstract concept of "community resources" is like asking someone who has just discovered his house afire *not* to turn on his fire hose until he checks on



the level of water in his community's reservoir, and to open the nozzle only halfway if the reservoir is half-full. That's not the way human beings react to crises, nor can they be forced to react that way.

The drop in health insurance premiums during the early 1990s resulted in efficiencies that were squeezed out of the system. However, belt-tightening had its limits. "After that, pressures to increase costs would reappear as patients demanded ... their previous level of unconstrained access to the most expensive forms of medical care" (Sade, 2002). This statement begs two questions: 1) Was the rebound in costs after 1994 caused by patients' demands? 2) Is expense the basis upon which a treatment is determined to be warranted or unwarranted?

The notion that patients are to blame for spiraling medical costs can be used to justify the attitude that patients are therefore less entitled to expensive care. Was the price spiral of the 1960s-1970s caused by patients' insatiable demands for extravagant care, or by the tendency of entrepreneurial physicians and hospitals to milk the indemnity health insurance system? Are patients now to blame for the costs imposed by a pharmaceutical industry free to charge whatever the market will bear? What about the costs of marketing and extravagant expansions driven by the need of medical facilities to compete in the market place of managed competition? Patients are hardly to blame for the costly bureaucracies that have been created to review utilization and to check and outwit the utilization reviewers. "Among the nations of the world, the United States spends more of its gross domestic product on healthcare than any other nation," state Benjamin and Cluff. "Most of this expenditure helps create corporate and individual wealth; relatively little is devoted to the promotion of caring" (2001, p. 49).

The moral danger of shifting from care of the individual to care of the population has to do with betrayal of trust. The public expects us to put patients' well-being first. Patients trust us because they need us to be trustworthy and because physicians have advertised their profession as a trustworthy profession, at least since the fifth century BC. When an individual physician betrays a patient's trust, we are quick to condemn it as soon as it becomes apparent. But, when governmental policy obliges us to shift our allegiance away from the well-being of our patients, towards the advancement of a social cause or purpose, the public and physicians tend to go along. Why protest a change that is purported to be in the interest of society, especially if the shift doesn't immediately affect us, the currently healthy?

Robert Jay Lifton's book, *The Nazi Doctors--Medical Killing and the Psychology of Genocide*, describes history's most monstrous application of such a shift. Lifton interviewed 28 physicians who had worked for the Nazi regime. His report of their reasons for doing so is exemplified by the following excerpt:

The physician was to be concerned with the health of the *volk* even more than with the individual disease and was to teach them to overcome the old individualistic principle of "the right to one's body" and embrace instead the "duty to be healthy." Thus, Johann S. spoke to me with pride about the principle of being "doctor to the *volkskorper*" (national body or peoples' body) and of "our duty...to the collectivity" (Lifton, 1986, p. 30).

When German physicians made the switch from patients to the *volk*, emotionally and philosophically, they were ready to be enlisted in the program of eugenic “cleansing” of the German People. The shift was soon put to further use in the Holocaust, which was designed and implemented largely by physicians who even used medical students to assist them.

The above notwithstanding, physicians employed by government or private enterprises as researchers or administrators do laudable, morally sound work. However, there is peril in confusing the roles of scientific investigator or social agent with the role of personal physician. The role of personal physician precludes use of patients’ trust for purposes that might be inimical to their individual well-being. Devoted clinicians will never downgrade their fiduciary responsibility to their patients in favor of a social program or purpose, no matter how noble it may be. Put into psychological terms, the majority of patients and physicians have secure attachment styles. They want *their* doctor and *their* patients, not in a proprietary way (they don’t want to own each other), but in a way that affirms their commitment to *their* doctor-patient relationship. Any form of healthcare delivery that gets in the way of this emotionally powerful relationship will evoke strong protests, such as the recent backlash against managed care.

### 2.3. *The Need for “Bedside Rationing”*

Rationing is unavoidable when resources are scarce. However, the morality of rationing depends on the cause of the scarcity. When resources are depleted, individuals are morally obligated to submit to rationing. But when scarcity is caused by the withholding of plentiful resources for purposes of financial gain, rationing imposed on those who cannot pay is less morally defensible.

Bedside rationing based on monetary costs regardless of need is unacceptable to the public and to physicians. If a newer, more expensive treatment is clearly superior to an outmoded, less effective one, then the expensive treatment is warranted if the cheaper one is more likely to fail or cause unnecessary suffering (Asch & Ubel, 1997). The treatment of serious disease and the relief of suffering are, like the relief of starvation, issues to which property rights and market values can become irrelevant. Imposing property rights and entrepreneurial values in such circumstances is oppressive and could lead to social instability.

Dr. Dan English’s talk at the conference that gave rise to this volume, “Constricted Time: Losses to Patients and Professionals,” made painfully clear what happens when rationing of physicians’ time reaches the point at which there is a qualitative change in the purpose of the clinical encounter, from trying to solve a clinical problem to maximizing through-put. When that change occurs, it poisons patient satisfaction, diagnostic accuracy, therapeutic efficacy and physicians’ job satisfaction.

Karl Marx wrote, “To each according to his need, from each according to his ability.”

This was a beautiful idea that didn't work because it ignored the egocentricity and acquisitive drive inherent in human nature. Francis Peabody wrote, "The secret of the care of the patient is caring for the patient.... The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal" (Peabody, 1927). These are beautiful ideas that have always worked because they are syntonetic with what human beings need when they feel vulnerable to a disease: a person in a role of competence and authority who will devote him- or herself and whatever resources are needed to overcoming their illness. Financially motivated bedside rationing by physicians is an idea that simply won't work in a democracy because it conflicts with citizens' sense of decency.

### 3. THE FREE MARKET SOLUTION FOR THE PROVISION OF MEDICAL CARE

Dr. Robert Sade argued "...that fidelity to the patient's interest is best served by a free market which is both efficient and highly congenial to medical professionalism" (2002).

Is the free market driven by the profit motive the cure for the inefficiencies of managed competition and managed care? Goodman and Musgrave, advocates of free enterprise, wrote:

The market for medical care will never be exactly like the market for corn or wheat, but there is no reason why we cannot create a similar institutional framework. We can transfer the power to make important decisions from large institutions such as government, corporate employers, insurance companies, and hospitals to individuals. We can allow supply, demand and competition to allocate resources. Consumer preference and individual choice can determine the ultimate form of our healthcare system (Goodman & Musgrave, 1994, p. 17).

In contrast, Abraham Flexner, the individual who did so much to close down the entrepreneurs of medical education a century ago, wrote,

Medicine, curative and preventive, has indeed no analogy with business. Like the army, the police, or the social worker, the medical profession is supported for a benign, not a selfish, for a protective, not an exploiting, purpose (Flexner, 1910, p. 173).

Both statements have validity, yet they seem to contradict each other. Commodities are private assets and are best dealt with by a free market motivated by profit-seeking. By contrast, the services rendered by the army, the police, the social worker and physicians are not for profit. They are social, not private assets and their purposes are altruistic. Should the ability to pay for an asset be the sole determinant of whether it can be used? That is certainly true for private assets, but not necessarily for social assets. The structure and character of a society is shaped by what its members need in the pursuit of their individual self-interest. However, no one is an island. An individual's existence requires the support of society. Social supports are built by the transfer of private assets to the society's government. The

individual gives up some of his or her private assets and, in return, gains a social asset such as public roads. I am willing to pay taxes to build highways in places I will never visit because I want to live in a society that has a comprehensive system of roads.

Less obvious social assets are of a psychological/behavioral nature. For example, Milton Friedman wrote, "There is one and only one social responsibility of business – to use its resources and engage in activities designed to increase its profits *so long as it stays within the rules of the game*, which is to say, engages in free and open competition, without deception and fraud" (Friedman, 1962, italics added). The "rules" Friedman refers to are a splendid example of a social asset that individuals pay for by supporting the legislative, executive, and judicial apparatuses that codify and enforce them.

One might ask, "Why do we need rules? Why not act according to the rules of the jungle where acquisitive behaviors are governed only by the aggressive drives and survival skills of individuals, without regard for the well-being of others?" The answer is that it would be too psychologically painful to live that way. It would create so much hurt and hostility in others that one's own safety would diminish and fear would mount to the extent that all the riches in the world could not provide the happiness we pursue. We need the social asset of Friedman's rules because life would be too dangerous and too nerve-wracking without them.

I am no more in favor of "socialized medicine" than I am for *caveat emptor*, for-profit medicine. I support free market capitalism. I agree with Dr. Sade that both business and medical care require the practitioners of each to be honest and ethical. Nevertheless, I agree with Dr. Pellegrino's statement that the ethics of business and clinical medicine are fundamentally different. The purpose of business is to make a profit and profiting at another's expense is very much part of Friedman's "game." However, putting someone else at a disadvantage for the purpose of self-enrichment is entirely alien to the role of physician. Physicians kill pathogens, fight diseases, attempt to subdue dysfunction in favor of well-being. They should never exploit other human beings. When they do, they cease being good clinicians.

Entrepreneurs motivated by self-interest have enormous social value. It does not diminish the importance of financial assets to acknowledge that there are also individual assets (e.g., the love of another) and social assets (e.g., a system of adequate medical care for all children) whose value cannot be reckoned in terms of money.

#### 4. MEDICINE AND OTHER LEARNED, SERVICE-PROVIDING PROFESSIONS: SIMILARITIES AND DIFFERENCES

I support Pellegrino's contention that the role of physicians is different from that of other learned professions and that this difference is based on a covenant to be self-effacing in the task of giving altruistic, patient-centered care. A covenant is a solemn agreement based on mutual trust; a contract is legal agreement based on



mistrust (Li, 1996). The covenant that physicians enter into is far more substantial than any business contract. It begins with the medical school applicant's personal essay and its declarations of altruistic intent. Acceptance into the freshman class is based on trust; the Admissions Committee will not accept applicants whose stated good intentions seem insincere. The existence of the covenant is reaffirmed at graduation by the swearing of an oath. Thereafter, every time the physician applies for a license to practice, for the right to prescribe, or for admission to hospital staff, he or she must sign a promise to obey the laws and customs that substantiate the covenant. Do all physicians uphold the covenant? No, but those who break it and, as a result, are disciplined, are not likely to view the experience as an encounter with an inconsequential vapor.

What practical evidence is there to indicate that the role of physician is different from that of other professions? The medical profession tends to view itself, and be viewed by society, as humanitarian. Webster's dictionary defines "humanitarian" as "devoted to promoting the welfare of humanity, especially through the elimination of pain and suffering." In general, the professions of law or accountancy don't see themselves, and aren't viewed by society as being humanitarian in quite the same way. These professions certainly provide services indispensable to the well-being of society and they have codes of ethics that are as exacting as medicine's. But in general, they help us in our encounters with man-made contingencies of law and finance, whereas clinicians help us in our encounters with Nature in all of its implacable mercilessness. Night and weekend call is not a prominent feature in lives of most lawyers or accountants. Physicians' fees are not calculated as a percentage of the economic value they create in restoring a patient to productivity. The tax accountant assumes no responsibility for the accuracy of the data the client provides, whereas the physician is responsible for getting all the data necessary for appropriate management, even if the patient doesn't present it in his complaints.

The differences between medicine and other learned professions notwithstanding, there are no absolute categorical distinctions. There are doctors who put their self-interest ahead of their patients' and there are doctors who provide altruistic care. Similarly, there are lawyers whose principle goal is to get rich and lawyers whose principle goals include protecting the disadvantaged against injustice and advancing social betterment, even though this may result in less income. Some politicians are motivated by self-interest, others by the desire to improve our lives and institutions. There are teachers who live for the 3 o'clock bell and those who live for the student with hidden potential to whom they give extra time and interest without pay. I doubt that many physicians consider themselves morally superior or more socially valuable than altruistic lawyers or teachers.

## 5. CONCLUSION

I end this essay with the words of Jerome Kassirer, Editor Emeritus of the *New England Journal of Medicine*.

If we capitulate to an ethic of the group rather than the individual, and if we allow market forces to distort our ethical standards, we risk becoming economic agents instead of healthcare professionals. Inevitably, patients will suffer, and so will a noble profession (Kassirer, 1998).

These eloquent words deeply resonate with the attitudes of countless clinicians. Any scheme that requires physicians to abandon these attitudes will result in a fight. I can't imagine anything useful coming out of such conflict.

## NOTE

1. I am a practicing pediatrician who attended the conference on "The Ethics of Managed Care" in May, 2001, in Kansas City, Missouri. I was prompted to write this critical review by my sense that not enough attention was given to the psychological and emotional factors relevant to healthcare delivery. This essay has four parts: 1) an examination of caring; 2) a critique of some key tenets of managed care; 3) the limitations of the free market solution to problems of healthcare delivery; and 4) the similarities and differences between medicine and other learned, service-providing professions.

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