CHAPTER

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Doctor-Patient Relationship

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INTRODUCTION

Doctors and patients interact; it demands respect, and if the doctor also displays compassion, sets the scene for the development of trust. Physicians must never forget that patients are individual human beings with problems that all too often transcend their physical complaints. They are not "cases" or "admissions" or "diseases." Patients do not fail treatments; treatments fail to benefit patients. Most patients are anxious and fearful. Physicians should instill confidence and offer reassurance but must never come across as arrogant or patronizing. The doctor–patient relationship is in itself therapeutic; a successful consultation with a trusted doctor will have beneficial effects irrespective of any other therapy given. The doctor–patient relationship is multilayered, dynamic and bilateral. On considering a relationship that is based on mutual participation of two individuals, the term "relationship" refers to neither structure nor function but rather an abstraction compassing the activities of two interacting systems or persons. The apparent, intrinsic quality of this unique doctor-patient relationship allows two people, previously unknown to each other, to feel at ease with variable degree of intimacy. This relationship, in time, may develop to allow the patient to convey highly personal and private matters in a safe and constructive environment. A professional attitude, coupled with warmth and openness, can do much to alleviate anxiety and to encourage patients to share all aspects of their medical history. Empathy and compassion are the essential features of a caring physician. The physician needs to consider the setting in which an illness occurs—in terms not only of patients themselves but also of their familial, social, and cultural backgrounds. The ideal patient-physician relationship is based on thorough knowledge of the patient, mutual trust, and the ability to communicate.

HISTORY OF DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship has been dependent on the medical and social scenes of following periods. These are: (a) Ancient Egypt (approximately 4000 to 1000 B.C.), (b) Greek enlightenment (approximately 600 to 100 B.C.), (c) Medieval Europe (approximately 1200 to 1600 A.D.), (d) The French revolution (late 18th century), (e) Doctor-patient relationship 1700-to present day. In ancient Egypt healers were as much magicians and priests as they were doctors and magic was an integral part of care. Treatment was largely limited to external. It seems likely that in ancient Egyptian medicine the activity-passivity type relationship existed. The Greeks developed a system of medicine based on an empirico-rational approach, such that they relied more on natural observation. The Hippocratic Oath established a code of ethics for the doctor, whilst also providing a 'Bill of Rights' for the patient. In Medieval Europe there was deterioration of the doctor-patient relationship. The magico-religious beliefs were revived and became widely accepted. The events that led to the French Revolution brought an end to an era in which the mentally ill and socially underprivileged were incarcerated in dungeons. There was change in the doctor-patient relationship from an activity-passivity approach to a guidance-co-operation model. During the 18th Century symptom-based model of illness ensured the preservation of patient dominance throughout the period. Later the hospitals emerged as places to treat patients who were underprivileged. Doctors provided treatment to those who were more passive. The hospital became the cornerstone of medical care and along with rapid growth of microbiology, surgical skills and pathology a new Medicine developed which required the examination of the patient's body to formulate a diagnosis resulting in an activity-passivity (paternalistic) model.

Table 1: Types of doctor–patient relationship

Patient control	Doctor control	Doctor control
	Low	High
Low	Default	Paternalism
High	Consumerist	Mutuality

TYPES OF DOCTOR–PATIENT RELATIONSHIP

Different forms of doctor-patient relationship arise from differences in the relative power and control exercised by doctors and patients (Table 1). In reality, these different models perhaps do not exist in pure form, but nevertheless most consultations tend towards one type.

PATERNALISTIC RELATIONSHIP

A paternalistic (or guidance–cooperation) relationship, involving high physician control and low patient control, where the doctor is dominant and acts as a 'parent' figure who decides what he or she believes to be in the patient's best interest. This form of relationship traditionally characterized medical consultations and, at some stages of illness, patients derive considerable comfort from being able to rely on the doctor in this way and being relieved of burdens of worry and decision making. However, medical consultations are now increasingly characterized

Table 2: Duties of a good doctor

Patients must trust doctors with their life and death. To justify that the Doctor must show respect for human life.

Knowledge, skills and performance

- Make the care of your patient the first concern.
- Provide a good standard of practice and care.

Safety and quality

- Protect and promote the health of patients.
- Take prompt action for patient safety, dignity.

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity.
- Respect patient's right to confidentiality.
- Work in partnership with patient
- Work with colleagues in the ways that best serve patient's interests

Maintaining trust

- Be honest and open and act with integrity
- Never discriminate unfairly against patients or colleagues
- Never abuse your patient's trust

by greater patient control and relationships based on mutuality.

MUTUALITY RELATIONSHIP

A relationship of mutuality is characterized by the active involvement of patients as more equal partners in the consultation and has been described as a 'meeting between experts', in which both parties participate as a joint venture and engage in an exchange of ideas and sharing of belief systems. The doctor brings his or her clinical skills and knowledge to the consultation in terms of diagnostic techniques, knowledge of the causes of disease, prognosis, treatment options and preventive strategies, and patients bring their own expertise in terms of their experiences and explanations of their illness, and knowledge of their particular social circumstances, attitudes to risk, values and preferences.

CONSUMERIST RELATIONSHIP

A consumerist relationship describes a situation in which power relationships are reversed; with the patient taking the active role and the doctor adopting a fairly passive role, acceding to the patient's requests for a second opinion, referral to hospital, a sick note, and so on.

DEFAULT RELATIONSHIP

A relationship of default can occur if patients continue to adopt a passive role even when the doctor reduces some of his or her control, with the consultation therefore lacking sufficient direction. This can arise if patients are not aware of alternatives to a passive patient role or are timid in adopting a more participative relationship.

Different types of relationship, and particularly those characterized by paternalism and mutuality, can be viewed as appropriate to different conditions and stages of illness. For example, in emergency situations it is generally necessary for the doctor to be dominant, whereas in other situations patients can be more actively involved in treatment choices and other decisions regarding their care.

DIFFICULTIES IN THE DOCTOR–PATIENT RELATIONSHIP

Regardless of experience and skill, it is inevitable that, at some point in a doctor's career, the doctor–patient relationship will break down. There can be many reasons for this; sometimes, these are beyond the control of the clinician, but often conflict arises when there is a genuine or perceived failure of the doctor to meet one or more of the duties outlined in (Table 2). It is important to recognize a breakdown in the relationship quickly and, whenever possible, identify the reason. If patients are unhappy with an aspect of their care, they are entitled to a prompt, open, constructive and honest response that includes an explanation and, if appropriate, an apology. It is also important to reassure the patient that the issues raised will not adversely affect their future care. Often, an acknowledgement that something is wrong and demonstration of a desire to put things right are sufficient to rectify any conflict. However, the longer one takes to address a problem, the more difficult it becomes to resolve. The patient may continue to be dissatisfied with the doctor and it may be most appropriate for another colleague to take over their care. It is important to reflect on such incidents, to identify whether one would approach a similar challenge differently next time.

DOCTOR-PATIENT COMMUNICATION

Effective communication between doctor and patient is a central clinical function that cannot be delegated. Most of the essential diagnostic information arises from the interview, and the doctor's interpersonal skills also largely determine the patient's satisfaction and positively influence health outcomes. Such skills, including active listening are qualities of a doctor most desired by patients. When a patient sees a doctor, he has some expectations and hopes. He expects the doctor to be interested in him as an individual. He wants to be listened, so that his fears can be expressed and his burdens shared. To be able to meet these expectations the doctor must develop certain skills. He should have the patience to listen to the patient's complaints and try to understand what is trying to convey. There is considerable healing power in the doctor-patient alliance. The bond of trust between the patient and the doctor is vital to the diagnostic and therapeutic process. It forms the basis for the doctor-patient relationship. In order for the doctor to make accurate diagnosis and provide optimal treatment recommendations, the patient must be able to communicate all relevant information about an illness. Doctors are obliged to refrain from divulging confidential information. This duty is based on accepted codes of professional ethics which recognize the special

Table 3: Some Barriers to Good Communication in Health Care

The Doctor
• Authoritarian or dismissive attitude
• Hurried approach
• Use of jargon
• Inability to speak first language of the patient
• No experience of patient's cultural background
The patient
• Anxiety
• Reluctance to discuss sensitive or trivial issues
• Misconceptions
• Conducting sources of information
• Cognitive impairment
• Hearing/speech/visual impairment

nature of these medical relationships. Some barriers to good communications in health care is given in Table 3.

CONTEMPORARY ISSUES

In India, the doctor-patient relationship has remained far more constant than in Western societies. A paternalistic approach still dominates, and doctors have a high status in society. Litigations rates of doctors are far lower in India in comparison to Western countries. Another contemporary effect on the doctor-patient relationship has been the exponential increase in the use of the internet by the patients. This means that the patients are better informed, especially in the more affluent society, and this has facilitated the patient-centered approach to health care that predominates today. While better patient education has obvious advantages for the doctor-patient relationship, there are concerns that information on the internet might not always be accurate and reliable. This poses a new challenge for the medical professional – that of revising any misinformation the patient has found him- or her-self. In some countries doctors have a poor reputation and inequity of care and un virtuous circle of referral and kickbacks may destroy any chance of a trusting relationship with their patients.

CONCLUSION

Previously, patients were most often considered to be too ignorant to make decisions on their own behalf. Doctors felt comfortable in making decisions on behalf of their patients. Later on doctors became separated from their patients politically, economically and socially. The distance between doctor and patient widened and the doctor-patient relationship became impersonal and remote. Today however there is a new alliance between the doctor and patient, based on co-operation rather than confrontation, in which the doctor must "understand the patient as a unique human being". Thus patient-centered care has replaced a one-sided, doctor-dominated relationship in which the exercise of power distorts the decision-making process for both parties. The primary objective of the doctor is to listen to the patient in order to identify what is the 'real' problem actually is instead of simply eliciting symptoms and signs. Shared decision making between the doctor and the patient will determine the most appropriate and best course of action for an individual patient. The doctor in this patient-centered model is ideally placed to bridge the gap between the world of medicine and the personal experiences and needs of his patients. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both the diagnosis and treatment are directly dependent on it. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.

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