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Patient Doctor Relationship: Changing Paradigm, Challenges and Strategies

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ABSTRACT

The patient doctor relationship is a vital concept in health care. A good relationship increases adherence to treatment recommendations, enhances continuing care and promotes patient satisfaction. It has been researched in terms of communication, interpersonal skill of the doctor, mutual trust, ethics, health literacy. Doctor has always held disproportionate power over patient, particularly in India. Classic paternalism in their behavior is rule rather than exception. The low doctor-population ratio in India puts a tremendous strain on the available medical facilities and restricts the time available for doctors to interact with patients. There are reasons why doctors do not explain in detail to the patient about diagnosis, treatment planned or expected prognosis. Not providing information to patients is a clear violation of their rights. Rights of patient must be complimented with their responsibilities. There is need to formulate patient charter in all health care facilities.

Keywords*: Patient doctor relationship, ethics, patient rights and duties, patient charter*

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INTRODUCTION

The patient doctor relationship has been and remains a keystone of care. It is a medium in which medical data is collected, diagnosis and plans of treatment are made, compliance is ensured, patient activation and rehabilitation support is provided.[1] The relationship between doctors and patients has received philosophical, sociological and literary attention since the times of Hippocratus, Caraka and Susruta and other sages.[2] A congenial relationship increases adherence to treatment recommendations, enhances continuing care and promotes patient satisfaction with health care and self-reported health.[3, 4] This relationship, however is not balanced. The patient's attitude is a complex of trust, which comes from perceived competence and integrity of doctor, and paradoxically, also that of distrust, which comes from the state of uncertainty and vulnerability.

The relationship between patient and doctor is fiduciary, i.e., physicians are expected to act in their patient's interests, even when those interests may conflict with their own. In addition, the doctor patient relationship is remarkable for its centrality during life-altering and meaningful times in person's life, time of birth and death and during severe illness. An incompetent doctor is judged not merely to be a poor businessman, but also morally blameworthy, as having not lived up to the expectations of patients and having violated the trust that is essential and moral feature of doctor patient relationship. Trust is a fragile state. Deception or even minor betrayals are given weight disproportionate to their occurrence, probably because of their vulnerability of the trusting party.

Modern medicine has come to rely on a battery of tests to come to a diagnosis even for the basic clinical condition. Sub specialization produces a breed of doctors whose aim is to know more and more about less and less. A patient comes to a doctor with a hope that he will be treated holistically and not as an organ or system. Modern patient assumes two identities, one as health consumer and other as active participant 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 to an increasing preoccupation with cost, quality and access to health care.

HISTORICAL PERSPECTIVE: CHANGING PARADIGM

In the earlier age, the physician's role was paramount, consisting of comfort and healing.[5] Care was substituted for cure, as physician had little else to offer. A strong bonding relationship existed between physician and patient, based upon trust and faith. Oliver Wendell Holmes rightly commented, "Choose a physician, as you would a friend." Majority of doctor-patient meeting took place in patient's home and not in an office or hospital.[6] This admittedly idyllic state reflected a relationship characterized by paternalism and dependency. Patients were often considered to be too ignorant to make decisions on their own.

Role of the doctor, as friend, mentor and fount of medical counsel, has declined over the ages. Patients sought information elsewhere, with the result that the physician is no longer the sole, authoritative gatekeeper of medical information. They have become consumers and have turned to other information sources. The medical profession, increasingly isolated and alienated from patients, complains of neurotic and overly demanding patients who make lists of irritating questions.[7] Low doctor-population ratio in India puts tremendous strain on available medical services and constrains the time available for doctors to interact with patients.[8] However, not providing information to patients about their diagnosis, course of treatment and prognosis is clear violation of their rights.

Physicians, in India, have always held disproportionate power over their patients. Classical paternalism in doctor's behavior is rule rather than an exception.[9] Datyeet al[10] conducted a survey on patient-physician communication around HIV testing, and identified a number of gaps between practice and guidelines. They attributed it to the existing social and legal contexts of the physician-patient interaction in India.

MEDICAL INTERVIEW- A LOST ART

The medical interview is a major medium of the health care. It is major interface between care provider and care seeker. It has three functions and fourteen structural elements, as elucidated in **Table 1**. The three functions are gathering information, developing and maintaining therapeutic relationship and communicating information.[11] It is a major influence on doctor and patient satisfaction and is a major determinant of compliance to treatment plan. Increasing data suggests that patients who are encouraged to ask question during medical interview tend to participate in their care which eventually results in better patient satisfaction.

Effective use of the structural elements of the interview gives patient a sense that they have been heard and allowed to express their major concerns[12] respect, caring[13] and understanding. It also allows patients to express and reflect their feelings and relate their stories in their own words.[14]

Table 1 Function and elements of medical interview

Functions
1. Determine and monitor the nature of problem
2. Develop, maintain and conclude the therapeutic relationship
3. Carry out patient education and implementation of treatment plans
Structural elements
1. Prepare the environment
2. Prepare onself
3. Observe the patient
4. Greet the patient
5. Begin the interview
6. Detect and overcome barrier of communication
7. Survey problems
8. Negotiate priorities
9. Develop a narrative thread
10. Establish the life context of the patient
11. Establish a safety net
12. Present findings and options
13. Negotiate plans
14. Close the interview.

MODELS OF PATIENT DOCTOR RELATIONSHIP

In North America and Europe, there are four models that define doctor patient relationship.[15] These are as follows:-

(a) Paternalistic model
(b) Informative model
(c) Interpretive model
(d) Deliberative model

In Paternalistic model, best interests of patient, as judged by clinical expert, are valued above the provision of comprehensive information and decision-making power to patient. The informative model, by contrast, sees patient as consumer who is in best position to decide for him/herself. It views the doctor mainly as provider of information. The interpretive model has shared decision making mechanism. Physician helps the patient to interpret complex medical evidence and its relevance to patient's illness. The deliberative model is one where both the physician and patient deliberate on the best course of action.[16] There is obviously some overlap among interpretive and deliberative models. Their relationship can be classified as shown in **Table 2** with scores for its components.[17]

Table 2 Models of Patient doctor relationship with its scoring

Model	Level of patient autonomy	Level of physician's decision	Level of moral Deliberation
Classical paternalist	Low score	High score	Low score
Modern paternalist	Low score	High score	High score
Autonomist	High score	Low score	Low score
Deliberationist	High score	Low score	High score

Vaisman[18] suggested that the deliberative model is most suitable model on the basis of the three key principles of ethics, viz., autonomy, beneficence and justice.

INFORMED CONSENT, PATIENT DECISION MAKING: A CRITICAL REVIEW

Failure to obtain consent constitutes refusal by physician to respect the autonomy of patient. However, in order to be consent to be truly relevant and for patient to be autonomous, consumers must first achieve a reasonable level of understanding through education, information, and explanation.

There are two models for integrating informed consent into the clinical practice of medicine.[19] The "event model" of informed consent treats medical decision making as an isolated act that takes place at one point of time, usually before treatment. The "process model" integrates informed consent at all stages of medical decision making, requiring continuous care by the physician and active participation by the patient. 'Event model' is ubiquitous in clinical practice but 'Process model' reflects a recognition that medical decisions are rarely made at one point in time and active participation of patients is required in decision making process, with their physicians. Many a times, obtaining consent is viewed only as a necessary formality to avoid a malpractice suit. Green[20] argues that introducing consent forms just before treatment and well after making decisions, undermines the role of the form in the shared decision making process and perpetuates adversity.

Critics have labelled informed consent as charade.[21] Explanation is given readily but it fails to provide the basis for an intelligent choice of available options to patient. Katz[21] believes that patients "hear in doctors' recommendations and not reflections of their own wishes, but the physician's wishes and hopes". 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.

FACTORS AFFECTING DOCTOR PATIENT RELATIONSHIP

A series of organizational factors affect the doctor patient relationship. The accessibility of personnel, both administrative and clinical, and their courtesy level provides a sense to patient that they are important and respected, as do the reasonable waiting times and attention to personal comfort. The availability of courteous staff, nurses and doctors instill a sense of security. User friendly education materials create an atmosphere of caring and concern.

Standardization of practice, sometimes relying on 'evidence based medicine,' is often used to minimize costs or maximize or ensure quality of care. It is often touted as promoting fairness by treating the individuals in like manner. Both standardization and application of evidence based principles in choosing care standards however rely

on value judgements about what counts as good evidence and how it should be interpreted and applied. The danger to the doctor patient relationship in these movements is that individual patient with their individual needs and preferences may be considered secondary to following practice guidelines, thus leading to a situation where patient may be compelled to feel being treated like an inanimate participant. Such a scenario has potential to spoil doctor patient relationship.

PATIENT RIGHTS IN INDIA: AN ANALYSIS

Patient doctor relations can be defined by the amalgam of rights of patients, their responsibilities and Code of Ethics Regulations (COER) as enunciated by MCI in 2002.[22] Disease management association of India (www.dmai.org.in) have drafted a document which entails patient rights and their responsibilities.[23] This draft document is validated by NABH. It is an open secret that there is hardly any intrinsic respect for patients' rights in India. If they are violated, the only recourse for patients is to approach the consumer courts. Prominent features of patient rights, responsibilities and code of ethics are given in **Table 3**.

Table 3 Salient features of Patient rights, responsibilities and COER 2002

Patient rights	**Patient responsibility**	**COER, 2002/ Doctor's code of practice**
I deserve respectful care from my doctor	I will maintain healthy habits and take responsibility for my health	I will provide a printed schedule of my fees for office visits, procedures, testing and surgery. (Para 1.8, 3.7 COER, 2002)
I would like to be heard to my satisfaction	I will be respectful to doctors and medical staff	I will schedule appointments to allow the necessary time to see you with minimal waiting time and listen to you without interruption. (Para 3.3 COER, 2002)
I would like to get complete information about my medical problem	I will be honest with my doctor and disclose my family/medical history	I will encourage you to bring a friend or relative into the examining room with you
I would like to be educated, so I can provide informed consent	I will do my best to comply with my doctor's treatment plan	I will facilitate in getting you medical records. (Para 1.3, 7.2 of COER, 2002)
I would like my privacy to be respected	If I am not happy, I will inform my doctor	I will explain your prognosis and further diagnostic activity and treatment. (Para 2.3 COER, 2002)
I want confidentiality to be maintained	I will do my homework so that I can participate intelligently	I will prescribe information therapy and discuss your diagnostic, treatment and medication options,to allow you to make a well-informed decision. (Para 7.16 COER,2002)
I would like my doctor to provide me with options, so that I can select	I will not ask for padded bills and false certificates	I will inform you of my qualifications to performthe proposed diagnostic measures or treatment. (Para 1.4.2,7.20 COER, 2002)
I expect my doctor to write prescription legibly and explain me the dosage, dos and don'ts and genericoptions for drugs	I will understand my medicines	I will inform you of organizations, support groups, websites and publications that can assist you
I would like to be informed of hospital rules and regulations	I will be punctual for my appointment	I will not proceed until you are satisfied that you understand the benefits and risks of each alternative and I have your agreement on a particular course of action. (Para 7.16 COER,2002)
I would like information on whom to contact in case of an emergency	I will pay my bills on time	I will display the patient charter prominently in my facility

Patient rights	Patient responsibility	COER, 2002/ Doctor's code of practice
I would like information about fees	I will abide by the hospital/facility rules	
I would like a copy of my medical records	I will have realistic expectations from my doctor and his treatment	

TOWARDS A NEW DOCTOR PATIENT RELATIONSHIP

There exists a dilemma among the health care providers whether patients are to be treated as consumers or they are still to be treated with the sense of altruism and paternal attitude. Patients are definitely consumers and they have to be treated like one. Dynamics of patient doctor relationship must also be viewed through the prism of economics. 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.[24] 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 patient's physiologic and psychological response to therapy.[25, 26]

The doctor patient interview is the foundation of clinical process. Two distinct narrative emerge out of it i.e, the patient's story, which is the original motivating account that the sick person narrates to physician and medical account (metastory), constructed by physician from selected, augmented parts of the patient's narrative. These two versions of the same story can warp mutual understanding and impede communication.[27] A new alliance between physicians and patients, based on co-operation rather than confrontation, must be universally adopted. Patient centered care has to replace a one sided, physician dominated relationship. Such an alliance must take into account not only the application of technical knowledge, but also dissemination of information to assist the patient to understand, control, and cope with overpowering emotions and anxiety. Mutual participation, respect, and shared decision making must replace passive submission.

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