

# Lecture VI: Doctor – patient relationship



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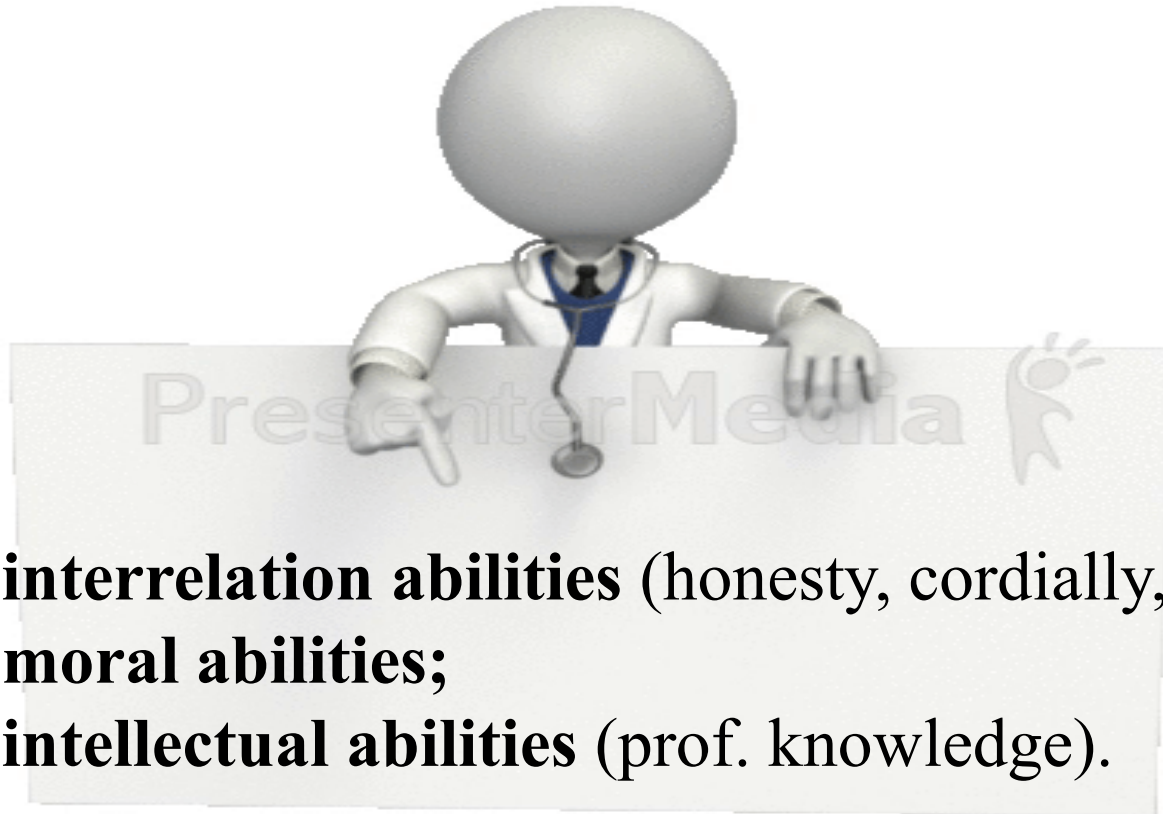
# STRUCTURE

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- 1. Doctor's main abilities and status**
- 2. Patient obligations and privileges**
- 3. D-p relationship from different models of disease explanation**
- 4. D-p relationship models. Specific phenomena in a D-P relationship**
- 5. Errors frequently encountered in a doctor-patient relationship**
- 6. Principles of communication skills developing**
- 7. Communication barriers and traps in a d-p relationship**

# Main doctor's qualities and professional traits

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# Professional status of a doctor imply:

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- **Technical competencies** verified by exams, ritualized and expressed by diplomas, titles, etc
- **Universalism** in offering medical assistance – equality for treatment.
- **Functional specificity** – using professional authority to build professional doctor-patient relationship.
- **Affective neutrality** – a doctor never judge, punish or have intimate relationships with his patient.
- **Altruism.**
- **The obligation to get the patient's consent.**

# Doctor's role imply:

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- Respecting doctor's obligations and be aware of professional rights.
- Respecting patient's rights.
- Communication abilities with the patient.
- Using an adequate language to be understood by the patient according to his educational level.
- Attitudinal adaptation according to patient's personality:
- Guide in chronic disorders, in prophylaxis.
- **Patience (a lot).**
- Professional and social doctor's prestige working as a placebo for the outcome of the patient.

## **Doctor is expected to:**

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- Apply a high degree of skill and knowledge to the problems of illness.**
  - Act for welfare of patient and community rather than for own self-interest, desire for money, advancement, etc.**
  - Be objective and emotionally detached (it should not judge patient's behavior in terms of personal value system or become emotionally involved with them.**
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- A solid green horizontal bar at the bottom of the slide.

# Doctor's Rights:

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- ❖ Granted rights to examine patients physically and to enquire into intimate areas of physical and personal life.
- ❖ Occupies position of authority in relation to the patient.
- ❖ Ask for a professional advice from colleagues
- ❖ Refuse to consult patient in case of....
- ❖ Not to respect the confidentiality in case of....
- ❖ .....

# Sources of conflicts in the doctor's role

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- **Conflicts** between doctors' own values and those of some of their patients. (ex: in relation to abortion, homosexuality, AIDS and other conditions or behaviors invested with moral evaluations).
- **Conflicting demands** placed on doctors in terms of their requirement to act in the best interests of their patients and their duty to serve the interests of the state. (ex: back pain is the major reason for time off work but it is often difficult to determine its cause or severity except by relying on patients' reports, which could present problems in evaluating the legitimacy of their claims to the sick role).



# Sources of conflicts in the doctor's role

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- The **competing interests** of individual patients and the wider patient population. (ex: doctors are often involved in rationing scarce resources of staff time, beds and medical equipment and might have to decide which patients should be given a transplant or undergo other medical procedures.
- Conflicts between **maintaining the confidentiality** of the doctor–patient relationship and disclosing information to a patient's parent or spouse.

# **Role conflicts in a doctor-patient relationship:**

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- **Psychological resistance of some patients to the doctor's authority.**
- **Affective ambivalence of the patient.**
- **Refusal or inability to communicate of certain patients.**
- **Personal nonconstructive peculiarities of certain doctors.**

## Patient's sick role is marked by:

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- The marginal situation (state) between the health and disease, which make the patient very sensitive, instable and conflicted.
- The situation of a sick person is seen as alarming and makes the patient to adopt any strategies for protection and adaptation to the new social role.
- The narrowing of an activity sphere.
- Egocentrism (the personal problems become more important than others).
- The anxiety increases if the disease become chronically.
- Reducing responsibilities (professional, social, familiar).

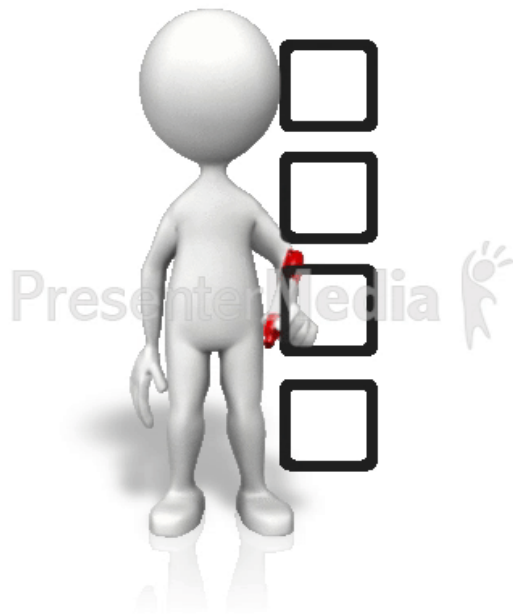
# Patient obligations and privileges:

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- Must want to get well as quickly as possible.
- Should seek professional medical advice and cooperate with the doctor.
- Allowed (and may be expected) to shed some normal activities and responsibilities.
- Regarded as being in need of care and unable to get better by his or her own decisions and will.

# Doctor-patient relationship from the perspective of the biological model of diseases explanation

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- Paternalistic model of relationship
- Physician is totally responsible for a patient wellbeing.
- Physician give diagnosis, recommend treatment and ask total compliance from patient
- Patient has passive role if being cared by therapists.

# Doctor-patient relationship from the perspective of the bio-psycho-social model of diseases explanation

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- Human beings are the product of hereditary and environmental factors.
- Diseases are seen in context with the patient and his environment.
- It should be construct of a genuine therapeutic relationship.
- Any doctor should have not only medical knowledge, but also some notions about individual psychology.

# Doctor-patient relationship peculiarities

- For most physicians, the establishment of good rapport with a patient is important.
- Some medical specialties, such as psychiatry and family medicine, emphasize the physician-patient relationship more than others, such as pathology or radiology, which have very little contact with patients.
- For a constructive relationship, patient must have confidence in the competence of their physician and must feel that they can confide in him or her.
- The doctor and patient's values and perspectives about disease, life, and time available play a role in building up this relationship.
- A positive relationship between the doctor and patient will lead to frequent, quality information about the patient's disease and better health care for the patient and their family.

# Doctor-patient relationship peculiarities

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**Poor D-P relationship compromise the physician's ability to make a full assessment and the patient is more likely to distrust the diagnosis and proposed treatment, causing decreased compliance to actually follow the medical advice which results in bad health outcomes.**



# Specific phenomena in a D-P relationship

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Compliance/noncompliance or  
therapeutic  
adherence/nonadherence

Transferring/contratransferring

Placebo/nocebo effect



**Good communication** between doctor and patient boils down to two things:

- **respect for each other, and**
- **the ability to manage expectations.**

# Models of the doctor–patient relationship

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**A paternalistic (or guidance–cooperation) relationship**, involving high physician control and low patient control, 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.

**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.

**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.

**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.

## Three main models of medical decision-making correspond with the three main types of doctor–patient relationship (described by Charles et al (1999))

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- **Paternalistic model of medical decision-making**
  - **Shared model of medical decision-making**  
(correspond to relationship of mutuality)
  - **Informed model of decision-making.** (may correspond to a consumerist relationship).
- 
- **!!! In reality, these different models and types, almost do not exist in pure form, but nevertheless most consultations tend towards one type.**

# Paternalistic model:



“If I’ve told you once I told you 1,000 times, stop smoking!!”

- The traditional **paternalist model** regards the doctor, as medical expert, as solely responsible for treatment decisions with the patient expected merely to cooperate with advice and treatment.
- The doctor decides what is in the patient’s best interest, based on the medical data at hand and on the clinical judgment.
- The shortcoming of this model is the fact that the doctor and the patient can have distinctive value systems.

!!! It is reserved for emergency medicine.

# Shared model of medical decision-making

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- Relationships of mutuality regard shared decision-making as the ideal.
- This requires that both parties are involved in the decision-making process, share information, take steps to build a consensus about the preferred treatment and reach agreement (consensus) on the treatment to implement.
- **When the patient either can not or will not do what the physician knows is the correct course of treatment, the patient becomes non-adherent.**

# Four Requirements for Shared Decision making

(based on Charles et al (1999))

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1. Both doctor and patient are involved in the decision-making process.
2. Both parties share information.
3. Both parties take steps to build a consensus about the preferred treatment.
4. An agreement (consensus) is reached on the treatment to implement.



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Traditionally, studies have identified that about **50% of patients with chronic conditions do not take their treatment as prescribed**, with major reasons being because they do not share the doctors' view of the appropriateness of the drugs prescribed, or are worried about immediate side-effects or possible long-term harmful effects of the drugs.

Achieving **concordance** does not necessarily mean that both parties are convinced that a particular drug or other course of action is the best possible treatment for the patient. In some situations, where both parties have differing preferences and views, they might achieve concordance and endorse a particular treatment as part of a negotiated agreement.



# Concordance – as element of Shared model of medical decision-making

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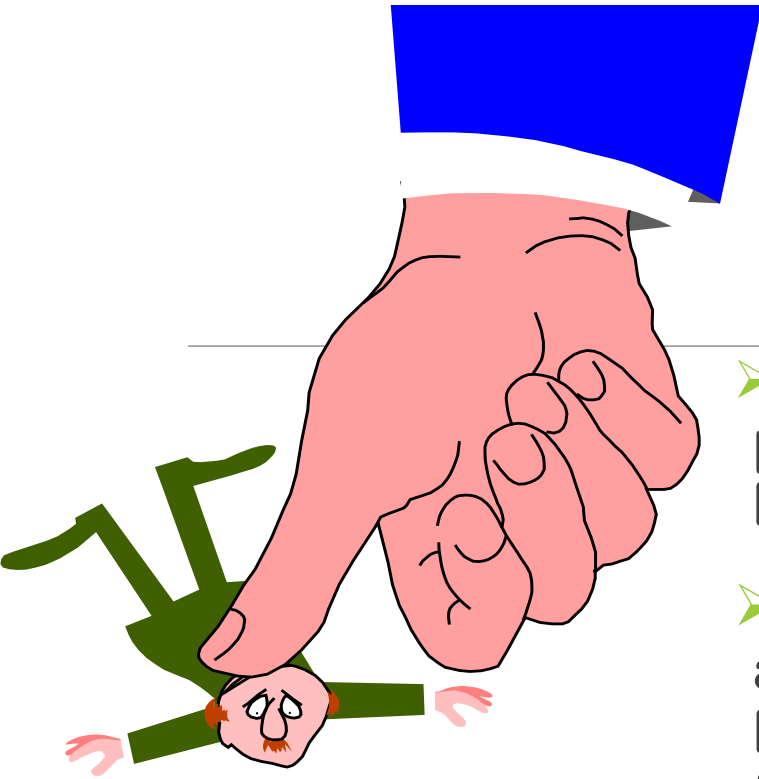
**Concordance** is based on the notion that the work of the prescriber and patient in the consultation is a negotiation between equals and that the aim is a therapeutic alliance between them.

This alliance may, in the end, include an agreement to differ. Its strength lies in a new assumption of respect for the patient's agenda and the creation of openness in the relationship, so that both doctor and patient together can proceed on the basis of reality and not of misunderstanding, distrust or concealment.

(Marinker 1997, p 8)

# The informed model

(may correspond to consumerist relationship)



“You’re paid to do what I tell you!!”

- **Informed model**, involves a partnership between doctor and patient based on Information transfer.
- Information transfer is therefore seen as the key responsibility and only legitimate contribution of the doctor to the decision-making process, with the deliberation and decision-making being the sole prerogative of the patient.
- **!!! It is mostly appropriate for outpatient assessment for minor illnesses.**

Two polar types of consultation style have been identified, based on video-recordings of consultations: 'doctor-centred' and 'patient-centred' (Byrne & Long 1976).

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1. **A doctor-centred consultation** is characterized by the traditional Parsonian model and paternalistic approach, based on the assumption that the doctor is the expert and the patient merely required to cooperate.

Doctors adopting this approach focus on the physical aspects of the patients' disease and employ tightly controlled interviewing methods to elicit the necessary medical. Questions were thus mainly of a 'closed' nature, such as 'how long have you had the pain?' and 'is it sharp or dull?'.

# ‘Patient-centred’ approach

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2. At the other end of the continuum are doctors whose consultation style conforms to **a ‘patient-centred’ approach**. These doctors adopt a much less controlling style and encourage and facilitate their patients to participate in the consultation, thus fostering a relationship of ‘mutuality’. An important feature of this approach is the greater use of ‘open’ questions, such as ‘tell me about the pain’, ‘how do you feel?’ and ‘what do you think is the cause of the problem?’.

This approach also requires that doctors spend more time actively listening to patients’ problems through picking up and responding to patient cues, encouraging patients to express their own ideas or feelings, clarifying and interpreting patients’ statements, etc

These differences in communication style reflect not only doctors' communication skills but also differences in their attitudes and orientations to the medical task

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- Doctors who hold a strictly **doctor-centred model** focus almost exclusively on the objective description of physical symptoms and the classification of these within a **reductionist biomedical model**, with the aim of reaching a differential diagnosis as quickly as possible and prescribing appropriate treatment.
- By contrast, **doctors taking a more patient-centred approach** aim to understand patients' own illness framework in terms of their subjective experience and meanings of illness, to **identify possible psychosocial causes of illness onset** and the impact of chronic and disabling illness on the patient's self concept and everyday activities, and to understand patients' beliefs, priorities and preferences for treatment.

# Key aspects of a of patient-centred consultation

from Mead & Bower (2000).

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- ❑ Biopsychosocial perspective (willingness to become involved in the full range of difficulties patients bring to their doctors and not just their biomedical problems)
- ❑ Patient-as-a-person (understanding the individual's experience of his or her illness)
- ❑ Sharing power and responsibility (mutual participation of patient and doctor)
- ❑ Therapeutic alliance (creating a situation in which the patient feels able to be involved in treatment decisions)
- ❑ Doctor-as-a-person (doctor is aware of and responds to patient cues).



Pressures of time encourage a more tightly controlled doctor-centered (or 'paternalistic') consultation with less attention paid to the social and psychological aspects of a patient's illness.

As a result, fewer psychological problems are identified and more prescriptions are issued.

(Howie et al 1992).

## Errors most frequently encountered during the establishment and development of doctor-patient relationship

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- **Inappropriate attitude features of the doctor:** rush, impatience, fatigue, boredom, raised voice.
- **Acceptance of insufficient communication** with the patient.
- **Excess of or lack of authority** with the patient.
- **Engaging in conflict situations.**
- **Underestimating difficult patients**, with increased psychogenic tendencies.
- **Polimedication** as an expression of the doctor's submission to patient's insistence.



# Deficiencies in doctor-patient communication

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- Failure to appropriately greet the patient, introducing oneself and explaining one's actions.
- Failure to get easily accessible information, mainly due to fears and expectations.
- Accepting imprecise information, failure in seeking clarifications.
- Failure to verify with the patient what the doctor understood from the situation.
- Neglecting obvious clues or clues not provided verbally or in a different manner by the patient.
- Avoiding information concerning the patient's personal, family, social status, including problems in these areas.

# Deficiencies in doctor-patient communication

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Failure to elicit information about the patient's feelings and the perception of the illness.

- Directive style with closed questions, frequent interruption and failure to make the patient speak freely.
- Rushed focusing without testing theories.
- Failure to provide appropriate information concerning the diagnosis, treatment, side effects or prognosis, or in verifying the patient's understanding of these issues.
- Failure to understand the patient's viewpoint.
- Poor comforting.

# Categories of Doctor's Communication Skills

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**Content skills – what doctors say**, e.g., the substance of the questions doctors ask and the answers they receive, the information they give, the differential diagnosis list, the medical knowledge base they work from (questions and the information gathered, the understanding the patient's perspective (ideas, concerns, expectations, etc.), and the treatments they discuss.

**Process skills – how doctors say it**, e.g., how doctors ask questions, how well they listen, how they set up explanation and planning with the patient, how they discover the history or provide information, the verbal and non-verbal skills they use, how they develop a relationship with the patient, and the way they organize and structure the communication process.

**Perceptual skills – what doctors are thinking and feeling**, e.g., awareness of their own decision making and other thought processes, awareness of their own attitudes and emotions during an interview, whether they like or dislike the patient, your biases and prejudices, noise or discomfort that distract them from attending to the patient.

# Skills that will help doctor to deal in a good way the medical consultation

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1. Assess what the patient **already** providing information, find out what a patient already knows about his or her condition).
2. Assess what the patient **wants** to know. (Not all patients with the same diagnosis want the same level of detail in the information offered about their condition or treatment).
3. Assess if the patient **need** to know (in case of danger).

# Communication skills and steps to be achieved in the consultation (from Silverman et al (1998)).

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1. Initiating the session (establishing the initial rapport and identifying the reason(s) for the consultation)
2. Gathering information (exploring the problem, understanding the patients' perspective, providing structure to the consultation)
3. Building the relationship (developing rapport and involving the patient)
4. Explanation and planning (providing the appropriate amount and type of information, aiding accurate recall and understanding, achieving a shared understanding and planning)
5. Closing the session



- ❑ Patients are regarded as particularly sensitive to and observant of the non-verbal communications conveyed by their doctors, because illness usually involves emotions such as fear, anxiety and emotional uncertainty. **Patients therefore often look for clues to assess the situation.** By maintaining eye contact, looking attentive, nodding encouragingly and using other gestures, the doctor can provide positive feedback to the patient and facilitate his or her participation.
- ❑ By contrast, continued riffling through notes, twiddling with a pen or failing to look directly at the patient convey disinterest and result in patients failing to describe their problems or to seek information and explanation. Similarly, the patient's body language and eye contact can convey whether he or she is feeling tense, anxious, angry or upset (Lloyd & Bor 1996).

# Arguments for communication skills developing

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- Doctors with good communication skills identify patients' problems more accurately
- Patients who **feel at ease** and who **are encouraged** to talk freely are more likely to disclose the real reason for consultation. As a result, **patients are more likely to adhere to treatment and to follow advice on behavior change**
- **Advice, reassurance and support** from the doctor can have a significant effect on recovery. Doctor become as the **placebo** for patient!
- **Good physician communication skills** improve patient satisfaction and clinical outcomes and that **good communication skills** can be taught and learned.
- Doctors with good communication skills have greater job satisfaction and less work stress.

# Learning communication skills

- ❑ ***Communication is a basic clinical skill.***

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- ❑ ***Communication is a series of learned skills, rather than a personality trait, anyone who wants to learn, can.***
- ❑ ***Experience alone can be a poor teacher,*** as we often don't perceive our own communication very accurately.
- ❑ ***Knowledge by itself does not translate directly into performance.*** If you really want to enhance skills, five elements are necessary:
  - 1 - Systematic delineation and definition of skills to be learned.**
  - 2 - Observation of learners performing the skills (live or on videotape).**
  - 3 - Well-intentioned, detailed, descriptive feedback**
  - 4 - Practice and rehearsal of skills.**
  - 5 – Systematic repetition.**

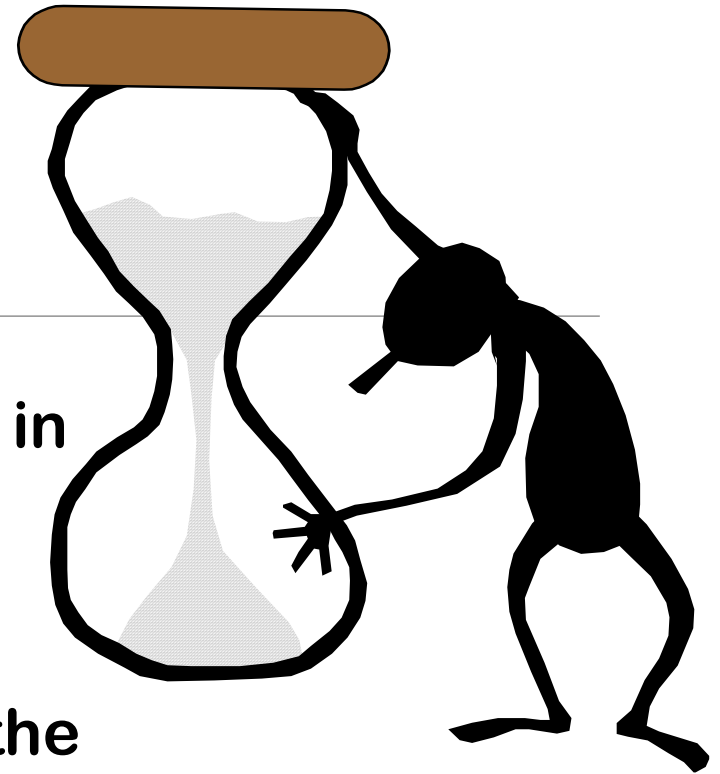


## Time is a factor in learning communication skills

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Physicians who did not engage in patient-centered practice took 7.8 minutes on average per consultation.

Physicians who had mastered the patient-centered skills took 8.5 minutes – less than one minute longer. However, while they were learning the skills, physicians took nearly 11 minutes.



# Principles of Effective communication learning:

- ❖ Ensures interaction not just transmission
- ❖ **Reduces unnecessary uncertainty.** Uncertainty distracts attention and interferes with accuracy, efficiency, and relationship.
- ❖ Requires planning, thinking in terms of outcomes
- ❖ Demonstrates dynamism engaging, flexibility in relationship with different patients or with the same patient in different circumstances.
- ❖ Follows a helical rather than a linear model - each time moving up the spiral to a little different level of understanding.
- ❖ **Communication among team members must be clear and complete.** A patient may be jeopardized when the referring doctor provides too little information to a consultant or when nurse-to-nurse communication lacks critical data.
- ❖ **Avoid Deliberate Critical Comments.**
- ❖ Show interest and care for others.
- ❖ Do not conceal or assume.

# THE BARRIERS TO GOOD COMMUNICATION IN THE DOCTOR-PATIENT RELATIONSHIP

- Deterioration of Doctor's and Patient's communication skills.
- Non disclosure of information.
- Doctor's Avoidant behavior.
- Discouragement of collaboration.
- .....



# Main communication traps to avoid

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- Using highly technical language or jargon when communicating with the patient.
- Not showing appropriate concern for problems voiced by the patient.
- Not pausing to listen to the patient.
- Not verifying that the patient has understood the information presented.
- Using an impersonal approach or displaying any degree of apathy in communications.
- Not becoming sufficiently available to the patient.

# In conclusion

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Communication techniques are a learned skill.

Unfortunately, many health care providers discover this after an adverse event occurs.

If this is the case in your facility, turn that negative experience into a positive teaching tool by asking these questions:

- **What can we learn from this situation?**
- **How can we prevent a recurrence?**
- **Is there anything we can do now to alleviate the situation?**

**Repetition, reiteration, feedback** are essential elements of effective communication.

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# Thank you for atention

