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REVIEW ARTICLE

Reflection Over Doctor Patient Relationship: A Promise of Trust

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ABSTRACT

The doctor patient relationship is of primary importance in the overall health care delivery model. It is a unique relationship which depends on trust and confidence between the parties for the provision of care. Establishing a doctor/patient relationship may take place formally in the office setting or informally, such as by giving verbal advice in a social setting. Doctors enter into a doctor-patient relationship with a commitment to provide their patients with quality service. Patients are entitled to be treated with respect and without discrimination during all stages of the doctor patient relationship, even if the relationship faces termination. However, when circumstances affect the doctors ability to achieve this, the doctors may decide to end the doctors patient relationship.

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INTRODUCTION

To attend those who suffer, a doctor must possess not only the scientific knowledge and technical abilities, but also an understanding of human nature. The patient is not just a group of symptoms, damaged organs and altered emotions. The patient is a human being, at the same time worried and hopeful, who is searching for relief, help and trust (1). The importance of an intimate relationship between patient and doctor can never be overstated because in most cases an accurate diagnosis, as well as an effective treatment, relies directly on the quality of this relationship (2).

The doctor patient relationship like any interhuman relation is made of what is said, what can be said and what cannot, of words and attitudes, but also of symptoms offered, accepted or refused, of exchange and barter (3). It is one of the most complex ones. It involves interaction between individuals in non-equal positions, is often non-voluntary, concerns issues of vital importance, is therefore emotionally laden, and requires close cooperation (4). Roter and Hall stated that "talk is the main ingredient in health care and it is the fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved". From this viewpoint, a good interpersonal relationship can be regarded as a prerequisite for optimal dental care (5).

The doctor patient relationship has undergone a transition throughout the ages (Table 1 depicts the evolution of the doctor-patient relationship over time). Prior to the last two decades, the relationship was predominantly between a patient seeking help and a doctor whose decisions were silently complied with by the patient (1). 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" (6).

The nature of the doctor/patient relationship essentially forms a simple con-

Table 1: Evolution of the doctor-patient relationship

Evolution over time	Transition in Doctor Patient Relationship
Ancient Egypt (approx. 4000 to 1000 B.C.)	Healer/ Doctor dominated
Greek Enlightenment (approx. 600 to 100 B.C.)	Partial egalitarianism
Medieval Europe and the Inquisition (approx. 1200 to 1600 A.D.)	Healer/ Doctor dominated
1700s	Patient dominated
The French Revolution (late 18th century)	Partial egalitarianism
1800s	Doctor dominated. Psychoanalytic and/ or psycho-social theories began to further constitute the patient as a subject
1956	Mutual participation of doctor and patient
1964	Introduction of Balint's Pschodynamic theories into general practice
1976	Byme and Long advocated patient centredness
21st Century	Continuing research into patient centredness

tract. In essence, patients seek professional services from a practitioner, with the expectation that their professional needs will be addressed, resulting in a "cure" of some type. The doctor, on the other hand, consensually agrees to treat the patient, with the expectations of affecting such a "cure" and receiving payment for the professional services rendered (7). Thus the primary duty of the doctor, the very first one, is to do all that is possible to allow and enable his/her patient to live according to his/her own convictions, his/her own scale of values, his/her most personal choices (3).

PATTERNS OF DOCTOR / PATIENT RELATIONS (8)

Stewart and Roter described four patterns of doctor/ patient relationship: Paternalistic, consumeristic, default, and mutuality

The four different styles of doctor / patient relations:

- **Paternalistic:** The paternalistic approach is typified by a doctor centred style. It relies on closed questions designed to elicit yes or no answers. The doctor will tend to use a disease centred model and be focused on reaching a diagnosis, rather than the patient's unique experience of illness.
- **Consumeristic:** Here the patient knows exactly what they want and forces the doctor into a patient centred approach.
- **Default:** This is where the patient centred style fails. The doctor is trying to relinquish control but the patient is unwilling to accept it. The result is an impasse.
- **Mutuality:** The doctor uses open questions to encourage the patient to talk about his complaint. This approach relies on taking time to listen and trying to understand the patient's point of view.

THE THREE BASIC MODELS PROPOSED BY SZASZ AND HOLLENDER (1956)

Szasz and Hollender (1956) (9) proposed three models of the doctor-patient relationship which are as follows (Table 2):

- The model of activity-passivity is entirely paternalistic in nature; this is analogous to the parent-infant relationship. They argued that this model is not an interaction, as the person being acted upon is unable to actively contribute. The patient is regarded as helpless requiring the expert knowledge of the doctor, and treatment is commenced "irrespective of the patient's contribution and regardless of the outcome". This is entirely justified in the medical emergency setting because the time required to get informed consent or involve the patient in decision making would clearly jeopardize the patient's health. This type of relationship places the doctor in total control of the situation and "in this way it gratifies needs for mastery and contributes to feelings of superiority" (10).
- The model of guidance cooperation is employed in situations which are less acute. They argued that despite the fact that the patient is ill, they

Table 2: Three basic models of the doctor-patient relationship

Model	Doctor's role	Patient's role	Clinical application of model	Prototype model
Activity passivity	Does something to the patient	Recipient (unable to respond to inert)	Anaesthesia, acute trauma, delirium etc.	Parent-infant
Guidance Cooperation	Tells patient what to do	Co-operator (obeys)	Acute infectious processes etc.	Parent-child (adolescent)
Mutual Participation	Helps patient to help himself	Participant in "partnership" (uses expert help)	Most chronic illness, Psychoanalysis	Adult-adult

are conscious and thus have feelings and aspirations of their own. During this time, the patient may suffer from anxiety and pain and in light of this patient may seek help. The patient is, therefore, ready and willing to ''cooperate'' and in doing so, patient places the doctor in a position of power. Therefore the doctor will speak of guidance and thus expect the patient to cooperate and obey without question. They described this model as a prototype in the relationship between a parent and a child (adolescent).

- The model of mutual participation (also advocated by Balint (1964) (11) is based on the belief that equality amongst human beings is mutually advantageous. In this model, the doctor does not confess to know exactly what is best for the patient. They argued that equality amongst human beings is critical to the social structure of egalitarianism and democracy. In order for the concept of mutual participation between the doctor and patient to exist, it is important that the interaction between them is based on having equal power, mutual independence, and equal satisfaction. This ultimately allows the patients to take care of themselves. The management of chronic disease provides a good example. This model therefore provides the patient with a greater degree of responsibility and is characterised by a high degree of empathy and has elements often associated with friendship and partnership, as well as the imparting of expert medical advice. Therefore, the doctor's satisfaction cannot be derived from power nor can it stem from the control over someone else, but rather from the unique service doctor provides to humanity (2).

THE 'PATIENT AS PERSON'

A biopsychosocial perspective alone is not sufficient for a full understanding of the patient's experience of illness, which depends on his or her particular "biography" (12).

Attending to "the patient's story of illness" (13) involves exploring both the presenting symptoms and the broader life setting in which they occur, (14) by eliciting each patient's expectations, feelings and fears about the illness (15). The goal, according to Balint (1964),(11) is to ''understand the complaints offered by the patient, and the symptoms and signs found by the doctor, not only in terms of illnesses, but also as expressions of the patient's unique individuality, his conflicts and problems.'' Therefore to develop a full understanding of the patient's presentation and provide effective management the doctor should strive to understand the patient as a distinctive personality within his or her unique context (11).

THE 'DOCTOR AS PERSON'

Balint *et al*. (1993) (16) described the biomedical model as "one person medicine" in that a satisfactory clinical description does not require consideration of the doctor. By contrast, patient-centred medicine is "two-person medicine", whereby the doctor is an integral aspect of any such description: "the doctor and patient are influencing each other all the time and cannot be considered separately" (16). Sensitivity and insight into the reactions of both parties can be used for therapeutic purposes (17). Balint *et al*. (1993) (16) describes how emotions provoked in the doctor by particular patient presentations may be used as an aid to further management.

Winefield *et al*. (1996) (18) described the dimensions of patient centeredness as attention by the doctor to cues of the affective relationship as it develops between the parties, including self-awareness of emotional responses.

FACTORS INFLUENCING PATIENT CENTEREDNESS

Mead and Bower (2000) (17) suggested that a large number of variables can potentially influences of a doctor's propensity to be patient-centred, both within the context of individual consultations and over the course of the professional career. The diagram below indicates some of their hypothesized influences. At the centre of the model, is the doctor- patient relationship expressed in the form of a behavioural interaction between two parties. These behaviours may be interpreted as more or less patient-centred across the five dimensions.

The most distant level, the "shapers" (such as cultural norms or clinical experience), may impact on more specific determinants (like gender or attitudes). For example, norms relating to gender mean that it is more socially acceptable for females to discuss feelings and emotions than males.

The specific context of medical/dental practice may also impact on doctors patient centeredness (19). However recent policy initiatives to promote greater team work and role substitution among primary care professionals (20) may reduce possibilities for sustained personal contact with individual patients, which may prove detrimental to the patient centred approach within the doctor-patient relationship.

Finally, Mead and Bower (2000) (17) pointed out that the consultation-level influences have the most immediate impact on the propensity of doctors to be patient centred. For example, ethnic differences may create barriers to effective communication. Time or workload pressures may limit possibilities for full negotiation and resolution of conflict between the doctor and patient 'agendas'. Alternatively, such pressures may increase the value placed by a doctor on such aspects of clinical work, encouraging adoption of specific mechanisms (e.g. offering longer appointment slots) to facilitate patient centred care.

Table 3 explicitly recognizes that the propensity of a doctor to be patient-

Table 3: The patient-centred model

Dimensions of patient centredness	Characteristic
Doctor factors	Attitudes, Values, Knowledge, Personality, Gender, Age, Ethnicity, Knowledge of patient
Professional context influence	Professional norms, Performance incentives and targets, Accreditation, Government policy, Initiatives
Patient factors	Attitude and expectations, Knowledge, Personality, Gender, Age, Ethnicity, Nature of problems, Knowledge of doctor
Consultation level influences	Communication barriers, Physical barriers, Interruptions, Presence of third parties, Time limitations, Workload pressures
Shapers	Cultural norms and societal expectations, Socioeconomic background, Formal and informal learning (eg media), Personal experience, Medical training and clinical experience (Doctor)

centred will vary over time, and that some dimensions (i.e. the patient as person and the doctor as person) require significant time to develop between the doctor and patient.

OBLIGATIONS UNDER THE DOCTOR PATIENT RELATIONSHIP (21,22)

A doctor patient relationship requires that the doctor must continue to treat such a person with reasonable care, reasonable skill, not undertake any procedure/treatment beyond his skill and must not divulge professional secrets.

Continue to treat such a person

Responsibility towards a patient begins the moment a doctor agrees to examine the case. He must not, therefore, abandon his patient except under the following circumstances-

- The patient has recovered from the illness, for which the treatment was initiated.
- The patient/attendant does not pay the doctor's fees (in case of a private practitioner).
- The patient/attendant consults another doctor (of any branch of medicine) without the knowledge of the first attending doctor.
- The patient/attendant does not cooperate and follow the doctor's instructions.
- The patient is under some other responsible care. e.g. the patient, after admission in a hospital, comes under care of senior doctors/unit head.
- The doctor has given due notice (orally or written) for discontinuing treatment.
- The doctor is convinced that the illness is a fictitious one.

To exercise reasonable care

- A doctor must use clean and proper instruments and provide his patients with proper and suitable medicines, if he dispenses them himself. If not, he should write the prescriptions using standard abbreviations and mention instructions for the pharmacist in full. He should give full directions to his patients as regards administration of drugs and other measures, preferably in local written language. He must suggest/ insist on consultation with the specialist in the following circumstances
- The case is complicated and beyond his abilities.
- Life threatening condition where he does not have necessary life saving equipment. For example: Ludwigs angina of dental origin.
- Medico-legal cases and cases where foul play is suspected. For example: assault, attempt to murder, poisoning etc.
- When desired by patients/attendants.
- When no one can give you informed consent, e.g. patient has no relative or next of kin.

To exercise reasonable skill

Reasonable skill is a relative attribute and it is difficult to draw a line between reasonable and unreasonable. For practical purposes it may be said to be "the average degree of skill possessed by his professional colleagues with the same background, education and experience."

He is not expected to show extraordi nary skills. At the same time his skills must not be of a standard that is too low and unacceptable by the professional community.

Confidentiality and Privileged Information

A doctor has the moral and legal duty to respect privacy and not divulge details of his patient's disease or treatment to anyone else. There are exceptions to this obligation. A doctor may be bound to divulge secrets of patients if it is requested by the law enforcing authority or the judiciary. Details of a disease may also have to be divulged if the matter is of concern to public health or potential loss of an individual's life. For example: Methicillin resistant Staphlyococcus aureus (MRSA) or plague or smallpox.

Reference and second opinion

A dentist must be reasonably skilled if he wishes to undertake a complicated procedure with attendant risks in the form of morbidity or mortality. Appropriate references to specialists or other dentists or physicians with specific competence in that area is a legally wise thing to do. This is a standard practice in India.

The concept of second opinion is quite popular in many western countries. When one is in doubt about the diagnosis or treatment, he/ she may refer his/ her patient to a colleague for an opinion. It is not an acceptance of ignorance or incompetence but rather a

reaffirmation of his/ her opinion from another colleague.

ENDING THE DOCTOR-PATIENT RELATIONSHIP (23)

Doctors are entitled to end the doctor-patient relationship under certain circumstances. Ending the doctor-patient relationship will usually have significant consequences for the patient, as he or she will need to find another health care provider.

Situations which may result in a decision to end a doctor-patient relationship

- Breakdown of trust and respect between the doctor and the patient: Trust and respect are essential elements of an effective doctor-patient relationship.
- Doctors may find in the course of providing services to a patient that these elements break down to the extent that the doctor is no longer able to provide quality care to the patient.

This may occur when there has been:

- Patient fraud, such as for the purpose of obtaining narcotics or other drugs;
- Serious threat of harm to the doctor, staff and/or other patients;
- Other forms of inappropriate behaviour towards the doctor, staff and/or other patients.
- A conflict of interest that compromises the doctor's duty to put the interests of his/her patients
- A communication breakdown that makes it impossible to provide quality care.

This list is not exhaustive

- The doctor's practice has become too large to manage (7, 23)
  - Doctors may find on occasion that their practice has become too large to manage and that they must decrease the number of patients to whom they provide services.
- Both the parties agree to end it.
- Either the dentist or the patient dies.
- The patient ends it by act or statement.
- The patient is cured.
- The dentist unilaterally decides to terminate the care.

The major causes that contribute to a decision to terminate treatment before it is complete are:

- The patient has not fulfilled the payment agreement.
- The patient has not cooperated in keeping the appointments.
- The patient has not complied with home care instructions.
- There has been a breakdown in interpersonal relationships.

Any of these is ample justification for the dentist to terminate treatment. The dentist should not discontinue treatment at a time when the patients health may be compromised.

CONCLUSION

The doctor patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnosis and plans are made, compliance is accomplished and healing patient activation and support are provided. The essential ingredients of a good doctor patient relationship are communication, respect, confidentiality, professional honesty and trust. Both the doctor and the patient contribute to them but it is the responsibility of the doctor to ensure they are present because he or she is the professional whose diagnosis, treatment or advice is being sought and paid for.

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