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Meeting of Experts on Doctor-Patient Relationship

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1. Introduction

A meeting of experts from Member States of the South-East Asia Region of the World Health Organization (WHO) was held in New Delhi, India, on 15-16 February 2011. The majority of the participants, from nine of the 11 Member States who attended, were presidents of medical councils. Others included heads of national medical associations, medical teachers, consumer and legal experts as well as policy-makers. The WHO Secretariat consisted of senior officials of the WHO Regional Office for South-East Asia. (List of participants and Programme at Annexes 1 and 2).

2. Objectives of the meeting

The general objective of the meeting was to agree on measures for strengthening doctor-patient relationship that enhances the quality of care. The specific objectives were:

(1) To discuss experiences in strengthening doctor-patient relationship;

(2) To identify measures for strengthening doctor-patient relationship;

(3) To review the draft Strategic Framework for Strengthening Doctor-Patient Relationship in the countries of the WHO South-East Asia Region.

3. Inaugural session

The meeting was inaugurated by the WHO Regional Director for South-East Asia, Dr Samlee Plianbangchang. In his opening address, Dr Samlee emphasized the importance of good doctor-patient relationship which was integral to the improvement of health care, especially medical care, of the people. Good doctor-patient relationship was an important determinant of the quality of care, built on the solid foundation of trust and empathy. Doctors enjoyed a very high status in society, which, at times, treated him/her as god. It was important to maintain this relationship for which effective communication was a necessary prerequisite. Any breakdown in

the doctor-patient relationship could lead to mistrust, dissatisfaction and, in some instances, litigation. It could also lead to over-investigation, resulting in high costs to the patient. Therefore, effective communication imbued with empathy between the doctor and the patient and belief and trust in each other was of utmost importance.

Dr Samlee added that because of the heavy load of cases, doctors were unable to devote sufficient time to the patients' complaints and inquiries. This prevented effective communication and appropriate interaction between the two. Governments needed to redesign the health delivery systems in order to not overburden the doctor. At the same time, it was necessary to invest more in disease prevention and health promotion in order to lessen the burden on the health care infrastructure. The primary health care system also needed to be utilized at all levels and the workforce strengthened. The doctors also needed to be freed of administrative responsibilities which took away too much of their time from their main duties as medical professionals.

The Regional Director emphasized that medical schools and medical councils had a very important role to play in educating and training medical graduates about building the right attitudes towards their patients. They also needed to be taught empathetic and ethical behaviours so that they treated their patients in a sympathetic manner and did not betray their trust. Since a patient put his full faith in the doctor, it was incumbent on the doctor not to indulge in any kind of malpractice to take advantage of the patient when he/she was most vulnerable. Doctors needed to understand, respect and love their patients, which could act as effectively for their recovery as medication. Dr Samlee added that patients also needed to be better informed of their health status and health care practices and the role of doctors. They had to restrain their expectations from the doctor. They also should know how to take preventive and promotive measures so that the chance of their becoming sick itself got reduced.

In modern times, Dr Samlee said, there were various social, cultural, economic, psychological and legal aspects which made the doctor-patient relationship more complex than ever before. Legal actions by patients against medical malpractices had further complicated this relationship. Therefore, all those involved in the provision of health and medical care – governments, medical schools, medical councils, professional medical

associations and health and medical personnel – had their roles cut out very clearly.

In conclusion, Dr Samlee said that the Regional Office had developed a draft strategic framework for strengthening doctor-patient relationship. He looked forward to the meeting's guidance in refining and improving the framework, which would be suitable for application in the diverse social and cultural contexts of the Member States of the Region. (Full text of the Regional Director's address at Annex 3).

3.1 Background and rationale

The background and rationale for the meeting was explained by Dr Orapin Singhadej, Associate Professor, Secretary-General, Network of WHO Collaborating Centres and Centres of Expertise in Thailand – NEW-CCET). She said that the Regional Director was keenly interested in the topic of doctor-patient relationship. A lot of work in this direction was being done in Thailand, and inspired by its success, Dr Samlee was anxious that other countries in the Region should take appropriate steps to further strengthen this relationship for the overall improvement of the health care delivery system. She said that there was need to take patient-centred initiatives without moving away from primary, secondary or tertiary care. Also, patient care was to be extended to the family and, in fact, the community as a whole. That means, health care should move from patient-centred care to family-centred care. It was important to empower the community to know what was going on in the health system. Many associations in Thailand were working on training the people on self-care and also on where to get health care when needed.

3.2 Implications of doctor-patient relationship on health systems and objectives of the meeting

Dr Athula Kahandaliyanage, Director, Health Systems Development, WHO Regional Office for South-East Asia (WHO-SEARO), traced the history and implications of doctor-patient relationship. He said that this relationship was important to improve the care provided to the people. This meant that people should be put at the centre of all health care efforts. For this to be achieved, quality human resource was of the utmost importance. Primary

care was the main function of primary health care, and towards this goal, doctor-patient relationship was important for the health prevention and promotion component. Dr Athula explained the objectives of the meeting as given in Section 2 above.

3.3 Nomination of office-bearers

Professor Ranjit Roy Choudhury, Member, Board of Governors, Medical Council of India, was nominated as the Chairperson of the meeting. Dr Professor Boonchob Pongpanish, Chairperson, Executive Board, Faculty of Public Health, Naresuan University, Phisanulok province, Thailand, was nominated as Vice-Chairperson and Professor Lalitha Mendis, President, Medical Council of Sri Lanka, as Rapporteur.

4. Technical Discussions

4.1 Draft strategic framework for further strengthening doctor-patient relationship

The draft of the Strategic Framework for Further Strengthening Doctor-Patient Relationship, prepared by the Regional Office, was presented for consideration by the participants. It was pointed out that the relationship between patients and their physician was fundamental to the practice of medicine and was essential to the delivery of quality health care in terms of diagnosis and treatment of diseases. This was often viewed by patients and physicians alike as a "long-term personal relationship". Such a relationship was a key component of patient-centred care which could result in positive health outcomes for the patient. Satisfaction with the doctor-patient relationship was a crucial factor in people's decision to join and stay with a specific person, practice or organization.

The framework explained that the doctor-patient relationship starts with an interview, which involves gathering of details about the patient's complaint, developing a therapeutic regime and communicating information and advice. These three functions interact inextricably. A patient must feel confident about the competency of his/her doctor and must trust the doctor fully in order to confide in him/her. Here, confidence,

mutual respect, trust, shared values and perspectives about disease and good health foster a better doctor-patient relationship. Adequate time and attention devoted by the doctor in this interaction would result in accurate diagnosis and substantially increase the patient's trust in the physician while at the same time would increase his/her knowledge about the illness and the preventive and promotive measures that could be taken for self-care. Data increasingly suggest that in medical encounters conducted in such a congenial environment, patients feel encouraged to ask questions and participate more actively in their own treatment and care, resulting in higher levels of satisfaction and cure.

Taking into account the background to the issue and the factors affecting it, a model was proposed as a strategic framework to strengthen doctor-patient relationship. It focused on the following domains:

- Patient-related factors
- Doctor-related factors
- Doctor-patient encounter

The framework indicated possible areas where interventions were needed to impact various aspects of the 'domains'. It was, however, evident that some of the interventions were not domain-specific and would have impacts at multiple levels, e.g. the legal climate will affect patients as well as physicians in addition to having an impact on the health system organization itself.

Patient-related factors. A person's religion, culture, traditions and beliefs carried a strong influence on his/her attitudes and behaviour, which could significantly influence and affect his/her relationship with the doctor. Culture, tradition and religious practices could also have restrictions on or preferences for a specific health system or practice and also about seeking care at all. The educational status and access to health information of a person as well as his/her experience with health care services will also affect his/her decision while selecting a particular doctor or health care system. The financial status of the patient and peer influence and related factors would decide the choice of the care provider.

Doctor-related factors. A patient seeks care to get cured of immediate illness and also be free of future illness if possible. He/she seeks care from a doctor who is considered to be capable and competent. Such

skills would depend on the medical education and training the doctor would have received and the clinical experience he/she had gained. A doctor's attitude towards the patient and the empathy and bedside manners shown during an encounter would build a long-term relationship between the two. The doctor would be guided in this humane approach by the ethics and standards learnt at the medical school guided and governed by the medical council and the legal framework of a country. Professional medical bodies such as medical associations also have a major influence over the doctors and how they treat their patients.

Doctor-patient encounter. Availability, access and affordability to medical services are important considerations for a patient when seeking care. Once the decision is made and when the patients report at the health care centre, the attention and treatment received and the personal care offered are very important in building trust and a sound and long-term relationship. The interaction with the doctor is important for the exchange of information that is required for a correct diagnosis and a successful outcome. A doctor needs to spend sufficient time with the patient in order to understand his/her condition correctly.

The recent phenomenon of the entry of private insurance schemes and health plans into the medical care system in most countries in the Region have often worked towards cost containment in order to increase their profits. Insurance companies offered incentives to doctors to make this work to their advantage but this was not beneficial to the patient. The patient could get disgruntled with the doctor for the restrictions imposed and this may lead to a trust deficit between the two.

Continuity of care in an illness and its follow-up were important to the patient. How the services were organized to respond to patients' needs and how support services like referral systems functioned were important issues at the first level of doctor-patient contact.

4.2 Current status

There is insufficient published evidence available in the countries of the South-East Asia Region about the current state of the doctor-patient relationship. However, the general feeling was that due to a variety of reasons, this relationship was currently under considerable strain. Increasing specialization and over-dependence on technology as well as

commercialization of the medical profession were thought to be the underlying causes for this state of affairs. The increase in costs due also to private insurance schemes was adding to the patient's burden. The increasing incidence of medical litigation was a cause of great concern among medical professionals, leading to the practice of defensive medicine, costing the patient more. This affected the quality of care and hence the doctor-patient relationship.

4.3 Intervention areas to strengthen doctor-patient relationship

The draft strategic framework suggested the following areas for intervention in order to strengthen the doctor-patient relationship. It stated that these interventions will necessarily have to focus on several domains, of which the major ones were listed as follows:

(1) Strengthening medical education by the teaching of
- Ethics
- Sociology: cultural sensitivity, empathy, dignity
- Legal aspects of medical practice
- Standards of medical practice
- Continuing medical education.

(2) Recognizing patients as consumers with rights
- Patient education and empowerment
- Strengthening consumer protection (confidentiality and personal data protection, protection when patients are subjects in clinical research)
- Health literacy: demystification of health knowledge.

(3) Health system issues
- Health service organization for universal coverage and continuity of care
- Grievance redressal mechanisms
- Patient-friendly systems
- Audits.

(4) Addressing contextual factors

- The medico-legal framework
- Health insurance: reducing health care costs
- Influence of drug and medical equipment manufacturers (influence of industry on doctors and direct-to-consumer advertising)

(5) Operational research

Context-specific operational research that involved multiple sectors will help to identify inputs and interventions that will improve patient satisfaction and contribute to improved doctor-patient relationship.

In the discussions that followed the presentation of the strategic framework, it was emphasized that effective communication between the doctor and the patient was of utmost importance. Patients needed to be explained the treatment they were receiving for a better understanding of what was being done. Medical schools could play an important role by imparting communication skills to their students. A number of modules were available on the subject. Ethical behaviour and practice towards patients was another habit that needed to be inculcated in young medical graduates. The South-East Asia Medical Council Network had published a module on the teaching of ethics in medical curriculum. Medical students also needed to have good role models in their teachers. An increasing number of students were studying medicine outside of their countries. They may have difficulty in communicating with their patients at the place of training due to language barriers. This problem of communication would continue and would affect their interaction with patients when they returned home.

There was an ever-increasing commercialization of medical practice which adversely affected the doctor-patient relationship. Health and medical care had almost become an industry. The cost of obtaining medical education, particularly in private institutions, had become exorbitant. The drugs and medical equipment manufacturers were queering the pitch by offering incentives to doctors to prescribe high-priced drugs and advise expensive diagnostic tests which may not always be necessary. Doctors were gaining at the cost of patients.

The way a doctor and the support staff treated a patient was the cornerstone on which the future relationship between the two would rest. It was agreed that doctors in most settings were overloaded with work which left them little time to devote to patients individually. This needed to change. While the time a patient needed to spend with the doctor in order to explain his/her condition was of vital importance, the doctor also needed to be relieved of unnecessary burdens (e.g. administrative and supervisory duties, etc.) which did not relate directly to his technical role as a physician. A possible way out was that the work timings of doctors should be extended.

In most countries, care was patient-centred. It needed to be extended and enlarged to become family-centred or even community-centred health care. This would strengthen the doctor's relationship with the entire family and the community, resulting in healthy outcomes for a larger number of people.

The media had a major role to play in improving the doctor-patient relationship. It could at times deliver wrong messages not based on facts, which would paint a negative image of the medical professionals as well as the health system, thus alienating the public. It was therefore important that the media should be given the correct information at the right time and in the right manner. After detailed discussions, the strategic framework was revised by including the suggestions agreed by the meeting as per Figure 1.

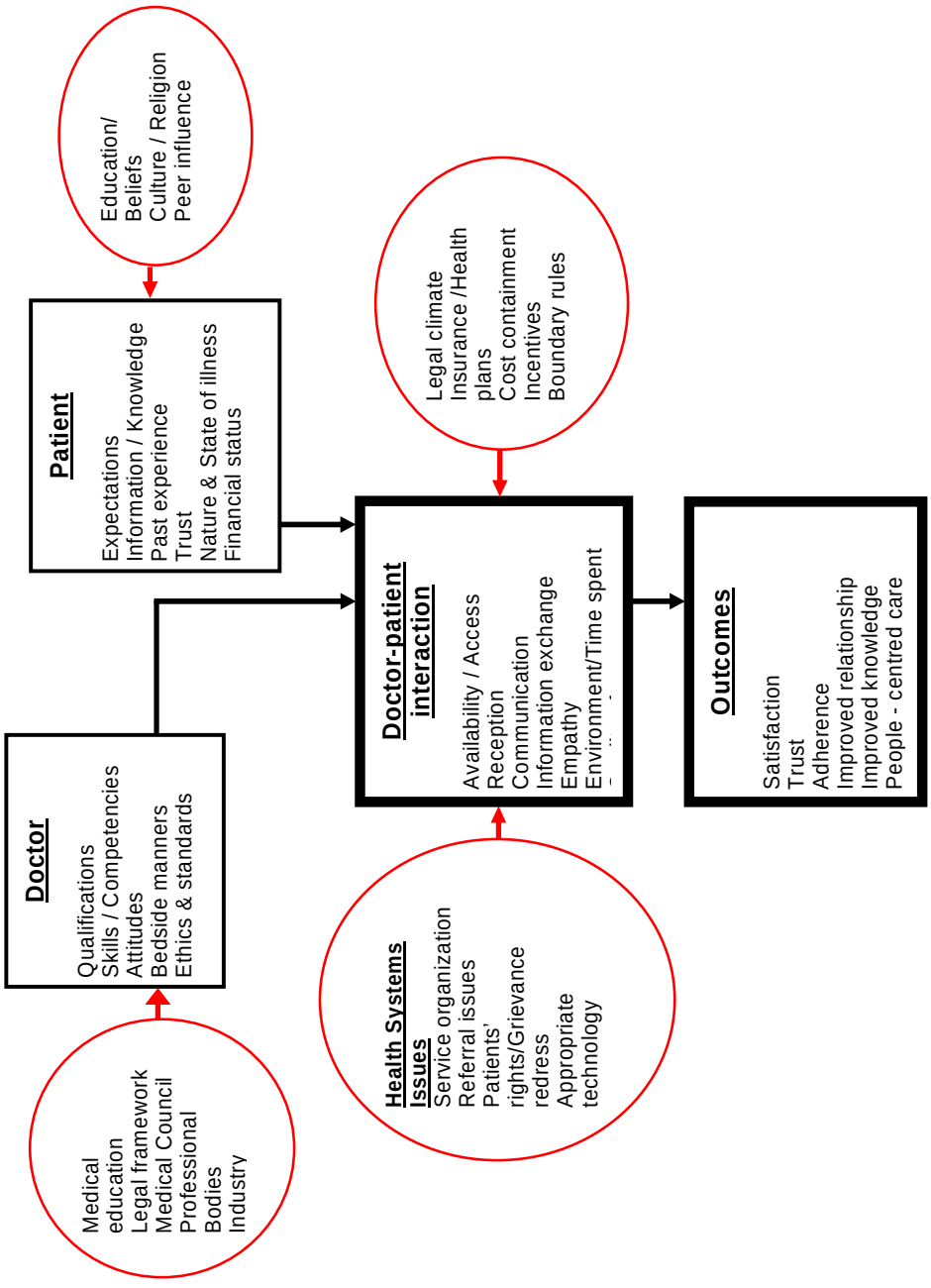

Figure 1: ***Draft Strategic Framework to Strengthen Doctor-Patient***

5. Panel discussion 1: Patient-Related Factors Affecting Doctor-Patient Relationship

5.1 Effects of sociocultural factors on doctor-patient relationship

Presented by Dr Suvajee Good, WHO Temporary International Professional, Health Promotion and Education, WHO-SEARO and Professor Peter Kunstadter, Senior Research Associate, Programme for HIV Prevention and Treatment (PHPT), Chiang Mai, Thailand.

In her presentation Dr Suvajee Good pointed out that research in the area of patient-doctor relationship in the countries of the WHO South-East Asia Region was very limited and hence not much information was available on the subject. This vacuum needed to be filled, especially by conducting qualitative research in this important area. She added that patient-doctor relationship was the main component of medical practice and was essential for the delivery of quality health care. It formed the foundation of contemporary medical ethics. This relationship was constructed socially where patients assumed the role of 'the sick' and doctors assumed the role of 'the healer'. This implied a great deal of expectations, which set up patterns of social conduct. Dr Suvajee said that social conduct by its very nature was interactive. The dynamics of interaction involved, on the one hand, the physician and the professional system and organizational setting he/she worked for and, on the other, the patient and his/her family, community and social setting they belonged to.

Doctors performed their jobs according to their professional roles but different societies had different expectations. A patient expects the doctor to know everything and wants to be treated fully. This may not always happen. Doctors also have their limitations, depending on the society they come from and the type of training they have received. Lately, more and more doctors were getting trained outside their own country, where they learnt different kinds of personal and social behaviours. Doctors also tend to use language which is not easily understood by patients. This creates conflict and results in lack of confidence. Doctors in public and private health care settings behave differently and, for obvious reasons, private doctors devoted more time to the patient than the doctors in public-sector.

Doctors also tended to be authoritative and issued 'orders' rather than giving gentle instructions and guidance. There was a lack of communication on the emotional, cultural and intellectual planes. This created a distance between the doctor and the patient. The result was dissatisfaction and disappointment for the patient, which affected treatment and case management, particularly in cases of chronic illness. In such situations it was common for the patient to turn to traditional healers where he/she felt more at ease, received more attention, felt more comfortable because of social and cultural homogeneity, and because it was felt that the treatment given was more holistic.

Therefore, in order to ensure positive doctor-patient relationship for healthy outcomes, it was necessary to improve interpersonal communications by understanding the cultural background of the patient, creating trust, using a language easily understood by the patient and maintaining confidentiality. A holistic care approach needed to be adopted which was patient-centred. Also, the health facility should be patient-friendly where the atmosphere should be welcoming with supportive and sympathetic staff and where the patient does not have to waste too much time waiting to be attended to.

In his presentation Dr Peter Kunstadter said that the world was changing fast and this had huge implications for disease and treatment as well as for health care and the role of health providers. Specialization and technology were increasing, which made health care more expensive. Health care was also more commercialized and intermediaries had cropped up between doctors and patients. Disparities had always existed in health care which were associated with social class or social status of certain population groups. These disparities were the result of high costs of health care which put poorer people at a disadvantage.

However, the doctor-patient relationship was not about any particular factor alone. Universal health coverage did not guarantee better health outcome for all. Dr Kunstadter presented the results of a research study conducted in Thailand on Thai and non-Thai citizens from the same ethnic group. It was found that the delay in seeking and receiving health care was due to various factors that included lack of language ability, not knowing what to say to the doctor, fear of discrimination, etc. Ethnicity in this particular situation was not the issue; there was a whole gamut of other constraints that affected doctor-patient relationship.

Dr Kunstadter said that the doctor-patient relationship was not just an interaction between two individuals. It existed in, and was affected by, a number of social, cultural, economic, political and environmental factors. It was, therefore, necessary to identify causes which were complicating this relationship and find interventions which were acceptable by both, in order to improve health care for all.

5.2 Protecting patients' rights as consumers (patient expectations, knowledge and rights)

Presented by Mr Bejon Misra, an international consumer expert from New Delhi, India.

Mr Misra mentioned the results of a study on top expectations of health care users which included standards, choice, accessibility, non-discrimination, transparency, accountability, information (in the language the patient desires and understands), and quality of service. While there were expectations, patients also had some rights and responsibilities. The rights included right to privacy and confidentiality of information shared with the doctor, respect for the patient's time, observance of quality and standards, safety, avoidance of unnecessary suffering and pain, and the right to complain when not satisfied. Patients' responsibilities included being courteous and transparent to the health care provider, not getting carried away by emotions and misinformation, sharing anxieties with the doctor to resolve problems, and never to become violent and act unlawfully at any time.

Mr Misra said that there was deterioration in social values because of a materialistic approach to life in general. Increasing commercialization of the medical profession had added to the malady. With increased awareness about the rights and privileges, patients' expectations had also grown. It was therefore necessary to create effective tools to ensure that services provided to users were transparent and accountable. For this it was necessary to develop a users' charter through a consultative process, design an efficient complaint redressal mechanism, conduct regular exit interviews with users and using the feedback thus obtained for innovation and for creating a healthy environment for improving the quality of service.

Mr Misra suggested that all standards on health-related activities should devote an exclusive chapter on how to respect patients' rights and,

at the same time, focus on patients' responsibilities. While setting quality standards for health services, the involvement of all stakeholders should be ensured. Lastly, health care services and regulators should introduce self-regulation and self-certification to build trust and credibility between patients and health care providers.

6. Panel Discussion 2. Doctor-Related Factors Affecting Doctor-Patient Relationship

6.1 Considerations for improving doctor-patient relationship

Presented by Dr Sophon Napathorn, Associate Professor and Vice-Dean for Academic Affairs, Chulalongkorn University, Bangkok, Thailand.

Dr Sophon enumerated the factors that had lately put the doctor-patient relationship at risk. These included: rising health care costs due to advances in science and technology, over-specialization, inappropriate use of drugs and diagnostic technology, changing patient/community expectations due to ready access to health care, gaining the right of partnership in decision-making, and increased awareness about adverse events. Increased commercialization of medical practice, its deregulation and privatization, mushrooming of private hospitals, aggressive intrusion of the pharmaceutical industry and medical insurance companies as well as globalization had resulted in highly increased costs of medical care. This exploitation of the patient had also resulted in complaints and a large number of legal claims.

There were specific doctor-related factors which affected the doctor's relationship with the patient. These included clinical skills for proper diagnosis and investigation, management of cases and procedural skills as well as communication skills. The doctor's unfriendly attitude, lack of good manners and unethical behaviour towards the patient affected the relationship.

Innovative strategies were needed to improve this relationship. Medical education curriculum needed to include teaching of ethics, sociology aimed at creating cultural sensitivity, empathy and respect for the patient's dignity, standards of practice as well as legal aspects of medical

practice. The doctor should learn to treat patients as consumers and should respect their rights as such. The doctor should understand the patient's perspective and explore all contextual factors, e.g. age, gender, family, socioeconomic status, culture, religion, beliefs, concerns and expectations about health and illness. Patients also needed to be educated and empowered to exert their rights and provided health literacy in order to demystify health-related issues. Health systems had to be strengthened to provide universal coverage in a patient-friendly atmosphere and maintain continuity of care, with provision for regular audits.

Dr Sophon suggested that the doctor-patient relationship should be participative in that the patient should be allowed to share information and be a part of the decision-making process so that the patient understands what was being done by way of treatment and was willing and able to follow the plan.

6.2 Medical ethics

Presented by Professor Ranjit Roy Chaudhury, Member, Board of Governors, Medical Council of India, New Delhi.

At the outset Professor Chaudhury cited an example of doctor-patient conflict in a large hospital in Delhi recently where a doctor was assaulted by a patient's relatives, who felt the patient had died because of lack of attention by the doctor. The doctors retaliated by beating up the relatives. In the process people from both groups got injured and the doctors went on a strike, resulting in other patients suffering. This showed that there was a serious breakdown and deterioration in doctor-patient relationship for which several factors were responsible. These included systemic factors such as too few doctors and too many patients, hence too little time to devote to all. Other factors were both doctor-related and patient-related. There was a serious lack of communication between the two as not much time was being devoted to patients because of the work overload, and the patients were not being treated with dignity and courtesy.

There were three pillars of a positive dialogue between the doctor and the patient: trust, communication and personalized care. Patients also expected ethical behaviour from the physician, who at times had ulterior motives when prescribing costly medication and unnecessary laboratory/ imaging tests.

Professor Chaudhury suggested that undergraduate medical curriculum should include teaching of behavioural and communication skills, knowledge and technical skills and ways to provide personalized care with a human touch and in a humane manner. He added that medical councils had a vital role to play in teaching of ethics and communication and management skills, encouraging continuing medical education, regulating relationships between pharmaceutical and equipment manufacturing companies and doctors, and giving incentives and rewards to doctors who performed well and ethically. Medical councils should also put in place a mechanism for punishing those doctors who indulged in unethical and unprofessional behaviour.

6.3 Legal framework

Presented by Professor Menaldi Rasmin, President, Medical Council of Indonesia.

Prof Rasmin said that Indonesia had produced two publications, titled "Standard of Medical Education" and "Standard of Competence", which set standards for medical and dental practice in the country. A law, Doctor-Patient Relationship in Indonesian Medical Practice Act (No. 29/2004), which says that, "Medical practice is organized based on the agreement between physicians or dentists and patients in the effort to maintain health, to prevent diseases, to improve health, to treat diseases, and to recover health." It lays down norms for medical practitioners to behave in a professional manner and support and respect the country's health policy and moral and ethical issues. It requires doctors to keep in mind medico-legal issues and implement the principle of patient safety. It also requires doctors and other medical professionals to demonstrate a professional attitude while working together as a team; to consider themselves to be part of government health services; be able and competent to practice medicine in a multicultural society; and always give priority to patient comfort and safety. The law emphasizes the need to give the patient informed choice about the treatment he/she is likely to receive and every high-risk tests should be conducted after the patient's express approval.

Professor Rasmin added that Indonesia had also produced books and manuals relating to (i) good medical and dental practice; (ii) partnership between doctor and patient; (iii) medical informed consent; (iv) effective communication; and (v) medical and dental records. These publications

were acting as guides to all medical professionals in improving the health of the patient and the general public as a whole.

In conclusion, Professor Rasmin said that in order to have good doctor-patient relationship, the doctor must have good communication skills, which should be taught in medical school. The doctor should always demonstrate a professional attitude and behave in a moral and ethical manner. The doctor should always work as a team member and be able to practice medicine in a multicultural society. Patient comfort and safety should always be uppermost in the mind of the doctor. Professor Rasmin added that governments should establish a legal framework to delineate principles of medical practice which should be strictly regulated by the medical council.

7. Panel Discussion 3: Contextual Factors Affecting Doctor-Patient Relationship

7.1 Service delivery within the context of universal coverage

Presented by Professor Boonchob Pongpanish, Chairperson, Executive Board, Faculty of Public Health, Naresuan University, Phitsanulok province, Thailand.

Dr Boonchob pointed out the problems that health systems were facing everywhere. These included: the increasing ageing population requiring care for multiple chronic illnesses; increased costs of medical care due to expensive technological and lab tests; shortage of health and medical workforce, especially in rural areas; the growing population requiring longer hours of work both in urban and rural areas; and increase in medical litigation.

He said that health systems everywhere had set goals of full coverage of, and accessibility to, health care for all, equity and efficiency and a high level of patient satisfaction. But problems like shortage of health workforce resulting in long waiting hours, inappropriate technology, budget constraints, over-specialization resulting in increased costs and a lack of good bedside manners were hampering the provision of improved quality of health care.

He mentioned that Thailand was experimenting with training doctors for work in rural areas for which the curriculum was appropriately designed. Their training was of the same duration and quality as other medical graduates and they were considered at par with others. Their orientation in rural medicine was of great value for the health care of rural populations.

Dr Boonchob said that ideal universal health care coverage would entail equity, efficiency, right of choice, easy access, patient seen not only as a recipient but also a partner, transparency, equity in budgeting for all populations, and reliability and accountability of the health system. Dr Boonchob concluded by saying that family and community medicine was the most effective means of health care for all. It not only provided curative care but also encouraged disease prevention and health promotion. He suggested that family medicine should be taught at the postgraduate level as well.

7.2 Urban setting

Presented by Dr Wonchat Supachaturas, Thai Medical Council Committee, and former Vice-Permanent Secretary of the Bangkok Metropolitan Authority.

Dr Wonchat said that because of large populations in cities, there was inadequate community outreach and availability of services. This affected the quality of health care. Hospitals were overcrowded with patients, resulting in doctors unable to devote sufficient time to them. There was also economic and cultural conflict between the doctors and patients as most of the patients were migrants from rural areas and were not so well off. They asserted their rights and demanded full attention which, at times, resulted in litigation. Medical practice had also become commercialized, with private hospitals competing with public health facilities. This resulted in unfair comparisons being made between the two. Dr Wonchat suggested that a standard of health care should be established where if a patient demanded special care he/she should be asked to pay for it.

Dr Wonchat added that it was necessary to create better understanding between patients and health providers. Providing outreach services to communities and establishing a satisfactory referral system would reduce congestion in city hospitals. Of course, it was also necessary

to produce more health professionals of all categories who will have the welfare of the patient at the core of their heart and will develop a relationship of mutual respect. This could be achieved only by harmonizing the work of bodies like universities, medical councils, professional medical associations, the ministry of health and other related ministries.

7.3 Governance and its impact on doctor-patient relationship

Presented by Dr Som Nath Arjyal, President, Nepal Medical Council.

Dr Arjyal quoted The World Bank which has defined governance as "an exercise of political authority and the use of institutional resources to manage society's problems and affairs." In the area of health, should the role of government be to only control health risks beyond the control of the individual or should it be to regulate personal health behaviour or health services? And, should the State play a traditional top-down role in the provision of health services or should the health services be left to the free market forces and individual choice? These were the questions which were not easy to answer.

Dr Arjyal then explained the role the Nepal Medical Council was playing in the area of regulating medical practice in the country. It accredits institutes of medical education and develops and ensures implementation of course curriculum. It also defines core competencies and admission and examination policies. It determines the qualification of a medical practitioner and issues licence to practice. The medical council is consulted before the government gives approval for the establishment of a medical college. The Nepal Medical Council ensures that the doctor has the necessary skills to communicate with the patients and their families with respect, politeness and compassion, as well as with other members of the health team. Other professional bodies take responsibility to protect the rights of patients as well as their members; make sure that their members carry out their duties and responsibilities; take steps towards professional development of their members; and also ensure that they follow the code of conduct.

The Ministry of Health decides the location of health facilities, the services to be offered, how much workforce is required and where, and takes care of supply of medicines, consumables and equipment. The

Interim Constitution of Nepal has recognized health as a fundamental right of all people; every citizen has the right to receive basic health services free of cost; and every citizen has the right to live in a pollution-free environment.

7.4 Role of medical regulations in doctor-patient relationship

Mr Keshav Desiraju, Additional Secretary, Ministry of Health and Family Welfare, Government of India, spoke on this topic. He said that the theme of the meeting threw up issues about the whole range of doctor-patient relationship. The biggest issue in India was the shortage of all kinds of health personnel, with the result that even the basic requirements of the people were not being met. While private hospitals in big cities could claim the best of facilities, the situation in rural areas was very different. For them the best doctor was the one who was available to them in the hour of their need. Some time ago there was a talk about drawing up a charter on citizens' right to health, but the idea was not pursued because the government could not guarantee to deliver what it would have set out to promise.

Another problem in health delivery was the emphasis on making the five-year-trained MBBS doctor as the central point of the system. Earlier, there were doctors with lower qualifications who were allowed to practice. There were also a large number of traditional practitioners and these were the people who mostly worked in unserved and remote areas. These categories of practitioners were now being treated as "alternatives". They were also present in public health facilities but patients preferred to get treated by the MBBS doctor who is placed as the senior-most in the facility.

About the code of conduct for doctors, Mr Desiraju said that it was the duty of the Medical Council of India (MCI) to lay down such a code and ensure that it was strictly followed by all doctors. There was a need for regulation of medical practice because self-regulation by practitioners was not happening. Mr Desiraju cited the example of foeticide which was rampant in the country. This could not have been possible without the active connivance of qualified doctors. This showed a complete lack of medical ethics and a breakdown of the sacred doctor-patient relationship. It was therefore the duty of professional bodies like the MCI to enforce the moral code of conduct for doctors and the government should not be expected to regulate medical practice. The government did, of course, intervene when there were serious charges of malpractice.

8. Country Experiences to improve Doctor-Patient Relationship

8.1 Patient education and empowerment

Presented by Assistant Professor Col Kidaphol Wadhanakul, Director, Health Promotion and Preventive Medicine, Royal Thai Army Medical Department, and Director, Center for Continuing Medical Education, Thai Medical Council.

Dr Kidaphol based his presentation on the experiences he gained when dealing with members of the minority Muslim community in Thailand. He said that educating the community was, in fact, empowering the community. The trust of the community was gained by talking with sympathy and concern to the patient and the family. It was important to follow up on earlier visits to convince the patient that he/she was sincerely cared for. The health team laid emphasis on improvement of sanitation and environment which reduced the incidence of disease and contributed to the community's general health and happiness.

Dr Kidaphol explained that in order to win the trust of the community, he enlisted the support of the community leaders, village elders and head of the local mosque. This helped his teams a great deal to establish a rapport with the people. The health teams kept going back to the community which convinced them that they were being cared for and that their health was the only concern of the medical teams. Good communication and transfer of knowledge about self-care, done with a lot of empathy and compassion, earned a lot of success for the programme.

8.2 Patient education and empowerment through support group/family-centred care

Presented by Dr Jariya Wittayasooporn, Director, WHO Collaborating Centre for Nursing and Midwifery Development, and Director, School of Nursing, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok.

Dr Jariya said that Thailand was implementing the concept of support groups/self-help groups (SG/SHG) for family-centred care because it

empowered patients and their families to improve patient care. Support groups/self-help groups were also a means of mobilizing resources of individuals, family and society for self-care. These groups had been active for more than 20 years and it has been considered as the best model. In her hospital, there were many such groups were functioning.

Tracing the history of family-centred care, Dr Jariya said that though such groups had been working for a few decades, the concept was not very clear. The Association for the Care of Children's Health in the U.S. define family-centred care as "a philosophy of care delivery that recognizes and respects the crucial role of the family, supporting families by building on their strength, encouraging them to make the best choices and promoting normal patterns of living during their child's illness and recovery."

In her experience, the family-centred care improved parent-provider communication, satisfaction with care and parents' confidence in the provider's competence in caring for their ill child. Implementing the family-centred care entailed respect for the child and the family, providing and/or ensuring formal and informal support though support groups, and recognizing and building on the strengths of each child and family in challenging situations. It also supported and facilitated choice about approaches to care and was flexible in its approach so that services could be tailored to the particular needs of each child and family. Family-centred care means sharing information with families in a transparent manner on an ongoing basis and in ways they find useful and affirmative; facilitating parent-provider collaboration at all levels of health care and in professional education policy-making programme development; and empowering each child and family to discover their own strengths to build their confidence to make informed choices and take decisions about their health.

Dr Jariya suggested that health professionals should actively consider how they can ensure that the core elements of family-centred care are incorporated in all aspects of their practice, of which support group/self-health group was only one element.

8.3 Medical education

Presented by Dr J.P. Aggarwal, Executive Director, National Centre for Health Professions Education, Institute of Medicine, Kathmandu, Nepal.

Dr Aggarwal said that there had been an increased awareness everywhere about better doctor-patient communication and a return to a more patient-centred approach in medical practice. With increased education and awareness, patients were demanding a more humanistic care from medical professionals and were more concerned with the doctor's interpersonal skills than with his/her competence. Studies had shown patients' dissatisfaction about the quality of communication in every phase of medical encounters. There was a lack of willingness or inability on the part of the doctor to explore the patient's social and psychological concerns and provide sufficient feedback to allay the patient's apprehensions.

It was well known that improved doctor-patient communication would result in increased satisfaction and cooperation of the patient and decreased duration of treatment and stay at hospital. It would also reduce his/her anxiety and result in improved compliance with treatment and thus less number of complaints. There will thus be fewer law suits for medical malpractice.

Dr Aggarwal enumerated the minimum essential requirements that were needed to be implemented to improve medical education. These included providing instructions to medical students in professional values, attitudes, behaviour and ethics; establishing a scientific foundation for the teaching of medicine; teaching of communication skills; training in clinical skills; orientation in population health and health systems as well as in management of information; and inculcating critical thinking and interest in research. He added that the Nepal Medical Council had developed a core curriculum incorporating most of these elements, which was being introduced in the undergraduate curricula by all medical schools in the country.

8.4 Teaching of ethics

Presented by Professor Lalitha Mendis, President, Sri Lanka Medical Council.

Dr Mendis said that there was an exponential growth in medical knowledge and there were added skills to be acquired. Patients' awareness

and knowledge about disease and medicine had also increased a great deal and their expectations had also grown. There were now many more interactions between the doctor and the patient than was the case some decades ago. The doctors' workload had also grown significantly and there was every chance of medical negligence and professional misconduct. Therefore, there was need for the teaching of good professional conduct and ethical behaviour by doctors. But the problem was how to bring this about.

She added that teaching ethics alone was not so effective. It had to be interactive and had to be reinforced repeatedly. Undergraduate and postgraduate medical students should be engaged in ethics teaching through group discussions, with specific examples of bad behaviours cited for future guidance. Senior teachers should guide their juniors on how best to treat patients and build a culture of ethical conduct. They should set good examples and become role models for their juniors. Medical councils should take up cases of unprofessional behaviour by doctors and should not desist from taking action against those who break the code of ethical practice. The Ministry of Health should be brought on board to see that the code of ethical conduct by doctors was practiced conscientiously, and enforced if necessary.

The meeting was apprised that the Sri Lanka Medical Council had published guidelines on "Ethical conduct for medical and dental practitioners registered with the Sri Lanka Medical Council" which contained clear instructions and guidance on the subject. She cited the example of the Christian Medical College in Vellore, Tamil Nadu, India, and suggested that the good medical practices established there and certain other medical colleges should be studied and replicated in the countries of the Region to improve doctor-patient relationship. Also, while selecting students for admission into medical courses, their psyche, attitude and personality should be studied to ensure that the person would fit into the profession he/she was intending to enter.

8.5 Ethics and the primary care physician

Presented by Dr Sarath Paranavitane, Specialist Family Physician, Consultant Health Care Management, Colombo.

Ethics is a complicated issue which cuts across social, economic, cultural, moral and spiritual beliefs and practices and it is a bridge between policy and human values. He said that almost half-a-dozen formal and non-formal medical systems were being practiced in Sri Lanka and most of them had a

code of ethical conduct prescribed for their practitioners. The purpose and outcome of ethics of every system remained the same.

A majority of the doctors in Sri Lanka now practiced modern (Western) system of medicine and instructions during their training were also Western-oriented, but they were treating patients who, while being culturally heterogeneous, were Asian in their ethos. There was thus a conflict here. Dr Paranavitane suggested that a unified ethical code should be developed which would apply to all forms of healing in all countries in the Region. It should, among other things, contain elements of gratitude, loyalty, commitment to patient and society, decency in professional conduct, respect for social and cultural values and laws of the land, compassion, empathy, integrity and competence. He added that raising ethical awareness in health care should not be a one-time event but an ever-continuing process.

8.6 Social influences on doctor-patient relations and gross national happiness

Presented by Dr Tapas Gurung, Medical Superintendent, Monggar RR Hospital, Monggar.

Dr Gurung said that Bhutan was the first country in the world where the concept of Gross National Happiness (GNH) was introduced. This was the initiative of the King of Bhutan himself, the rationale being that if people were sick, they could not be happy. GNH primarily rested on four pillars: good governance, good health, conservation of environment and sound economic development. However, the perception of policy-makers about GNH could be different from that of health staff, the private sector and the people, since the level of happiness was a relative commodity and could not be quantified by any measure.

It was stated that health services in Bhutan, even up to the tertiary level, were completely free. Even for patients who travelled abroad for specialized treatment, the government bore all the expenses. The government allocated around 10%-12% of its general budget to health, of which 25% was meant for medical education. Bhutan also promoted indigenous systems of medicine and these were integrated with the modern system, with provision for cross-referrals. Since Bhutan did not have enough of its own doctors because of admission problems in other countries, it was employing expatriate doctors and health volunteers. This did give rise to language problems and lack of communication with patients, which was being overcome by providing interpreters. Private

practice was still not allowed, but there were paid services being offered by some doctors outside of their normal working hours. This could gradually turn into private practice.

With the dawn of democracy in the country, people's exposure to the outside world had grown tremendously. The traditional roles were changing fast with the new awakening and people's expectations had grown. They were now complaining if they were not getting good service. The country was still short of all types of health workers at all levels. The burden of noncommunicable diseases was on the rise, which required a different kind of long-term care. Shortage of health workforce meant that they were working under tremendous pressure and were finding it difficult to always maintain positive relationships with patients. The media was not helping matters either, as they usually blew up cases of patients' dissatisfaction out of all proportions without going into the causes.

Dr Gurung informed that a medical and health council now existed in Bhutan which was considering what precise content of the medical curriculum should be. Brief guidelines were to be issued to doctors, all of whom were employed by the government. Since the State paid for the training of all doctors, it expected them to serve the people in the best possible manner.

Dr Orapin Singhadej, who had served in Bhutan as the WHO Representative some years back, described her experiences in the country. She said that people there generally looked happy. This could possibly be because of their restricted exposure to the outside world when they could not compare their life with that of others. Now that the Bhutanese people had opportunities to travel abroad as well as study in other countries, things could change and people's demands on the health services could grow.

9. Plenary Session on Strategies/Measures to Improve Doctor-Patient Relationship

In this session the draft Strategic Framework to Strengthen Doctor-Patient Relationship that had been prepared by the Secretariat was taken up for consideration. The participants had detailed discussions and made suggestions which were incorporated. It was later approved unanimously. The final diagram depicting the approved strategic framework is given in Figure 2.

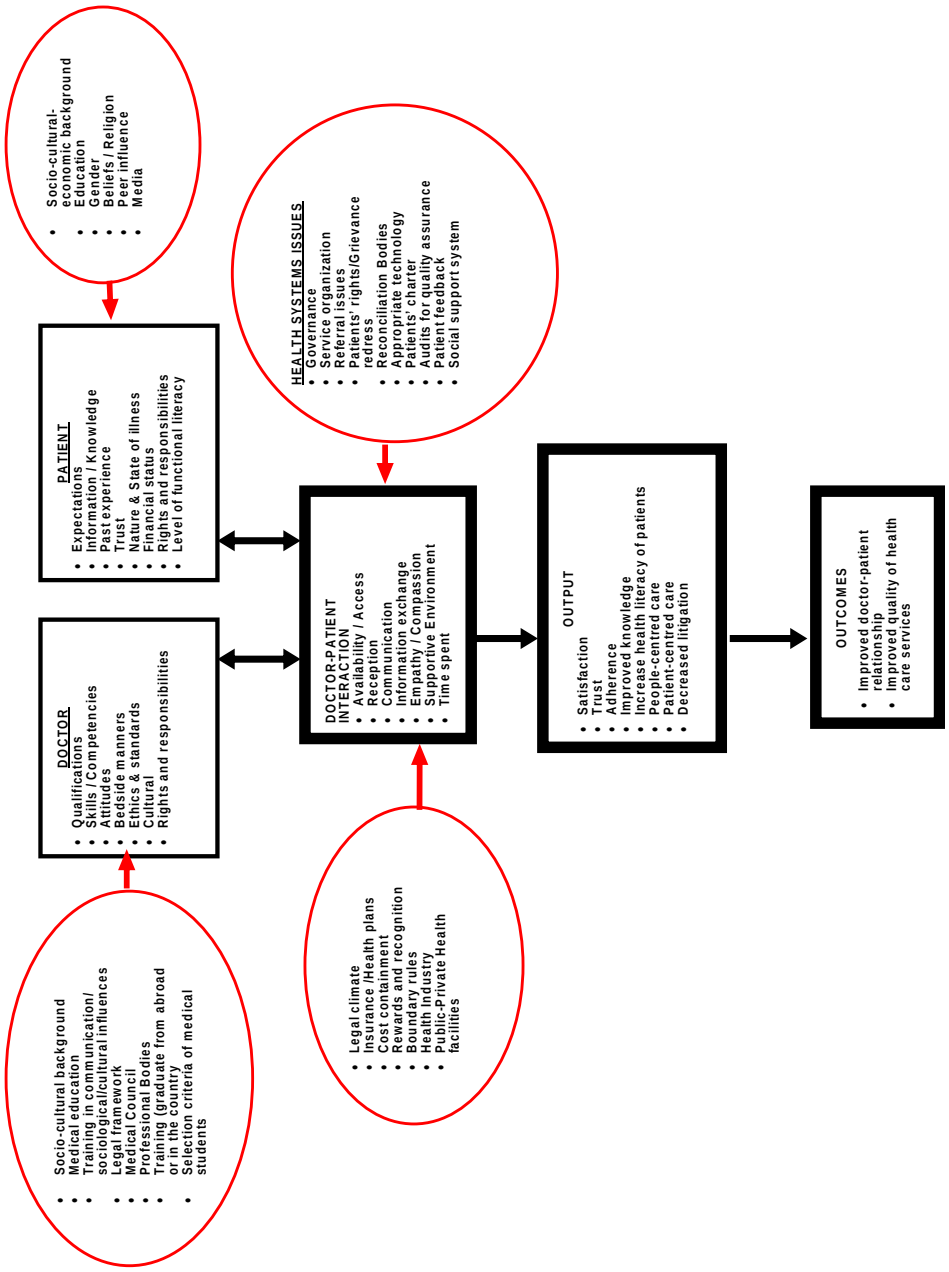

Figure 2: ***Strategic Framework to Strengthen Doctor-Patient Relationship***

10. Conclusions and Recommendations

The meeting arrived at the following conclusions and recommendations.

10.1 Conclusions

(1) Strengthening doctor-patient relationship should be considered an important element of health systems strengthening.

(2) Strengthened doctor-patient relationship will lead to improvements in quality of care and have the potential of improving efficiency and effectiveness of the health system.

(3) Improving doctor-patient relationship requires attention to several issues which include:

  (a) Medical education

  (b) Enforcing ethical codes of conduct among health care workers

  (c) Patient education and empowerment

  (d) An appropriate legal framework

  (e) Referral system

  (f) Overcrowding in hospitals and out-patient departments (OPDs) and reduction of patient load

  (g) Harmonizing the work of medical councils, medical associations, health services, universities and social welfare services.

(4) Several new developments have changed the doctor-patient relationship. These include:

  (a) Commercialization of medical practice

  (b) For-profit hospitals

  (c) Pharmaceutical industry

  (d) Globalization

(e) Cross-border medical education

(f) Inadequate health literacy

(g) Certain imperatives of private health insurance companies

(h) Non-holistic approach to medical system.

(5) Health care users have many expectations – quality care, accessibility, non-discrimination, transparency, accountability and information.

(6) Application of principles of primary health care (PHC) to strengthening health systems at all levels will contribute to improved doctor-patient relationship. This, among other things, implies:

(a) Appropriate investment in preventive and promotive health care

(b) Self-care that will promote health and reduce burden on health systems

(c) Optimizing the use of the health workforce

(d) Focus on improving coverage with good-quality primary care

(e) Strengthening the institution of family doctors.

(7) Medical councils need to also focus on protecting the interests of patients.

(8) There is a need to review and update code of medical ethics in Member States at regular intervals to reflect current realities.

(9) There is a strong need to improve the teaching/learning and assessment of medical ethics, medical etiquette and communication skills among medical students. Appropriate attitudes should be inculcated in them. Skills in verbal and written communication should be developed. The need for professionalism should be encouraged. Modern teaching/ learning methods, e.g. small-group teaching, problem-based learning, parables, case scenarios, etc. should be used.

(10) It is necessary for the health system to engage and maintain a good relationship and dialogue with the media to partner in improving health literacy and to encourage fair and balanced reporting of health issues.

(11) There is a paucity of qualitative research in the area of doctor-patient relationships in the Member States of the WHO South-East Asia Region.

(12) Health literacy of patients (including reasonable expectations from the health system and health care providers) needs to be addressed.

(13) Health care is becoming an area of conflict. It is getting more commercialized and technology-intensive and more costly.

(14) The commercial interests of pharmaceutical industries and insurance companies impact doctor-patient relationships.

(15) There is evidence to indicate that social, cultural, economic and ethnic factors influence doctor-patient relationship.

(16) To overcome barriers, health systems can consider innovations like mobile health service, interpreters in hospitals and longer OPD hours.

(17) In the era of a growing consumer protection environment, trust needs to be built between doctors and patients.

(18) It is important to realize that both patients and doctors have rights and responsibilities.

(19) Patient complaint redressal mechanisms need to be introduced at the point of service delivery.

(20) Research indicates that two important courtesies a patient expects are: (i) to be treated with dignity; and (ii) respect for his/her time.

(21) Research indicates that a large proportion of disputes between doctors and patients are the consequence of health system failure rather than due to incompetence and indifferent attitude of the doctor.

(22) Health facilities must develop a charter of services for patients and use effective communication to familiarize users with their rights and responsibilities.

10.2 Recommendations

In the context of strengthening doctor-patient relationship, the following recommendations were made:

For Member States

(1) Acknowledge that health is a fundamental right and that everyone has a right to receive basic health services appropriate to his/her needs and cultural beliefs.

(2) Revisit medical curricula to strengthen teaching/learning by using appropriate methods and assessments of professional ethics and communication skills in medical schools and institutions providing postgraduate education.

(3) Institutionalize continuing medical education (CME) on sociocultural aspects of medical practice.

(4) Work towards improving patient education and empowerment through various measures that should include the following:

   (a) Harmonize and strengthen collaboration between medical councils, medical schools and medical associations to focus on patient protection and building of a culture that promotes caring, compassionate and respectful doctor-patient interaction. Repetitive exposure to these concepts should be planned to achieve these goals. Role models should be part of this culture.

   (b) Work with medical councils/associations to strengthen/ reorient their roles to focus more on patient protection.

   (c) Develop/strengthen and disseminate patients' charter widely.

   (d) Establish grievance redressal mechanisms at the point of service.

(e) Establish forums for sharing of experiences/perspectives between patients and doctors.

(f) Establish a legal framework that supports a good doctor-patient relationship.

(5) Engage the media to convey appropriate and unbiased health information on health services in a user-friendly language.

(6) Continue efforts for health systems strengthening based on PHC by focusing on:

(a) Appropriate allocations for primary health care

(b) Strengthening community education and empowerment with emphasis on promoting self-care

(c) Working towards promoting the development and increased utilization of family doctors

(d) Rationalizing the utilization of doctor's services. Examine the feasibility of and implement task-shifting for optimal utilization of doctor's services

(e) Strengthening referral system.

(7) Revisit the regulatory framework to strengthen regulation of influence of industry on the medical profession.

(8) Work with medical councils to review and update the code of ethics for medical practitioners.

(9) Consider developing a national document on best practices for doctor-patient relationship.

For WHO

(1) Develop a prototype patients' charter and field-test it in different settings in the Region.

(2) Support qualitative and quantitative research in Member States to promote interventions for strengthening doctor-patient relationship.

(3) Finalize the strategic framework based on the deliberations during the Doctor-Patient Relationship Meeting.

(4) Support national efforts to strengthen doctor-patient relationship.

11. Concluding Session

The Chairperson thanked the participants for their valuable contributions during the deliberations and to the finalization of conclusions and recommendations of the meeting. He also thanked the Vice-Chairperson, the Rapporteur and the WHO staff who had worked so hard to make the meeting a success. He invited the WHO Regional Director to make his concluding remarks.

Dr Samlee Plianbangchang said that he was very glad that the meeting had arrived at excellent conclusions and made recommendations which covered all important areas of doctor-patient relationship. He said that even Hippocrates had talked about good doctor-patient relationship but something had gone seriously wrong in the recent past and that was the reason he thought it was time to revisit this subject. Dr Samlee pointed out that there was little that was being taught to medical students about social behaviour and etiquettes so far as these related to their interaction with patients. Doctors were treated as gods by their patients, who also expected them to behave similarly. They needed to learn about sociology because they were supposed to work in society among people. They must be taught to become socially responsible. He was apprehensive that medical councils may not perhaps do much to protect the rights of the consumers – in this case the people – because they might try to cater to their own constituency, which is doctors themselves. But that would not be the right thing to do. The cause of the people should remain supreme.

Dr Samlee said that now that the recommendations had been made, both WHO and Member States needed to move forward in a systematic way and implement the strategic framework and recommendations in the best possible manner. Someone will have to catalyze these actions. He assured the participants that WHO was ready to support Member States in the implementation of the recommendations in the best possible manner. He felt that there should be a follow-up meeting on the subject this year itself to take the matter forward.

Dr Samlee thanked the participants for sparing their time to attend this important meeting and making valuable contributions. He also thanked the Chairperson, the Vice-Chairperson and the Rapporteur for the successful conduct of the meeting, and all the WHO staff members who had worked very hard in the preparation of background documentation and facilitating the conduct of the meeting in all its aspects.

The Chairperson thanked the participants once again and wished them a safe journey home and declared the meeting closed.

Annex 1

Programme

Day 1: Tuesday, 15 February 2011	**Opening Session**	
08.00 - 08.50	**Registration**	
09.00 - 10.00	**Inaugural Session**	
	• Address by the Regional Director, WHO/SEARO	Dr Samlee Plianbangchang
	• Background and rationale	Dr Orapin Singhadej
	• Implications of doctor-patient relationship on health systems and objectives of the meeting	Dr Athula Kahandaliyanage
	• Appointment of Chairperson, Co-Chairperson and Rapporteur	Dr Samlee Plianbangchang
	• Introduction of participants and announcements	Dr Sudhansh Malhotra
	• Group Photograph	
	Business Session	
10.30 -11.00	**Draft Strategic Framework for further strengthening Doctor-Patient Relationship**	Dr Athula Kahandaliyanage
	- Discussion	
11.00 -12.30	**Panel Discussion 1: *Patient related factors affecting doctor-patient relationship***	
	• Effect of socio-cultural factors on doctor-patient relationship	Dr Suvajee Good/ Prof Peter Kunstadter
	• Protecting patient's rights as consumers (patient expectations, knowledge and rights)	Mr Bejon Misra

13.30 - 15.00	**Panel Discussion 2: *Doctor related factors affecting doctor-patient relationship***	
	• Considerations for improving doctor-patient relationship	Dr Sophon Napathorn
	• Medical ethics	Prof Ranjit R Choudhry
	• The legal framework	Prof Menaldi Rasmin
15.30 - 17.00	**Panel Discussion 3: *Contextual factors affecting doctor-patient relationship***	
	• Service delivery within the context of universal coverage	Prof Boonchob Poongpanich/ Dr Wonchat Supachaturas
	• Governance and its impact on doctor-patient relationship	Dr Som Nath Arjyal
Day 2: Wednesday, 16 February 2011		
08.30 - 09.00	**Recap of Day 1**	Dr Sudhansh Malhotra
09.00 - 10.30	**Country experiences to improve doctor-patient relationship**	
	• Patient education and empowerment	Dr Kidaphol Wadhanakul/ Dr Jariya Wittayasoonporn
	• Medical education	Dr J. P. Aggarwal
	• Teaching of ethics	Prof Lalitha Mendis / Dr Sarath Paranavitane
	• Societal influences on doctor-patient relations – gross national happiness	Dr Tapas Gurung
11.00 – 12.30	**Plenary session on strategies/measures to improve doctor-patient relationship**	
13.30 - 14.30	**Plenary session on finalization of strategic framework to improve doctor-patient relationship**	
14.30 - 15.00	**Concluding Session**	Dr Samlee Plianbangchang (in chair)
	• Summary of proceedings – Dr Ranjit Roy Chaudhury	
	• Recommendations – Prof Lalitha Mendis	

Annex 2

List of participants

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Annex 3

Opening Remarks by Dr Samlee Plianbangchang Regional Director, WHO South-East Asia Region

Distinguished participants, ladies and gentlemen,

I warmly welcome you all to this Consultation on "Doctor-Patient Relationship". In view of the prevailing situation in the area of medical care services in several countries of the Region, it is timely to revisit the issue of "Doctor-Patient Relationship".

Doctor-patient relationship is an important determinant of quality health care, especially medical care. Doctor-patient relationship is built on a solid foundation of "trust" and "empathy". Trust and empathy that comes from effective communication and interaction between doctors and patients. Patients, as human beings, come to health facilities with their own expectation for care. Care of not only their "body", but also their "mind" and "soul". They (the patients) expect fair treatment from the health care systems.

We (the health care providers) need to recognize health of everyone as a "fundamental right". We should treat the patients with the principle of "equity" and "social justice" in mind. The patients also expect us to respect their dignity as human beings.

The breakdown of doctor-patient relationship, due to any reasons, will lead to "mistrust" between them. This mistrust can lead to patient "dissatisfaction" and "resentment" that may cause "medical litigation" against doctors. In this situation, it is natural that doctors have to protect themselves, among other things they do is to secure "malpractice insurance". Doctors become more careful in their practice. Doctors may not rely much on "clinical approach" in dealing with patients - the approach that can strengthen and maintain good relationship between doctor and patient. Doctors will use more sophisticated tools for investigating the causes of illness. Doctors use newer medicines to ensure full expectation of cure of the disease. This phenomenon certainly will lead to, among other things, high, and eventually skyrocketing of health care cost. The situation whereby a vicious cycle is formed between:

- patient dissatisfaction;
- mistrust;
- medical litigation;
- over investigation as well as over treatment, and high health care cost.

Doctor-patient relationship has a critical role to play in this vicious cycle. Communication between doctors and patients must be adequately effective. Interaction between doctor and patient must be appropriate enough to create better understanding on both sides.

To ensure such a communication and such an interaction, doctors need to have and spend enough time with patients. It is difficult indeed for doctors to have enough time for all these aspects. Doctors today are over burdened with the huge number of patients coming for care. This situation will never end – people will continue getting sick and they will keep coming to get help from doctors. One of the important contributions to this situation is the design of our health care services delivery systems, the systems that are mainly designed to wait for people to get sick and come for treatment inspite of the prevailing national health policy on "health promotion" and "disease prevention", whereby people can be kept healthy as much as possible, not to fall sick easily or often; and not to overburden the treatment facilities.

The governments' investment is still too heavy in the development of infrastructure that is in favour of "treatment" at the cost of "prevention". Furthermore, the failure of referral systems of health care that leads to bypassing of patients in particular, to secondary and tertiary levels without proper reasons. And also, the lack of appropriate task shifting - delegating some simple medical procedures to other relevant professions at various levels of health care systems. These shortfalls contribute significantly to the overburn of doctors that jeopardize doctor-patient relationship.

We have to continue our efforts in convincing the governments to pay more attention to promotive and preventive care, the care that can reduce the burden of curative services institutions. We like to see the development of health services delivery that really keeps the right balance between promotive, preventive, curative and rehabilitative care.

Distinguished participants,

These are system issues or problems of the system that need long-term efforts from all of us to tackle. On the other hand, our immediate

attention is now required in helping doctors and patients strengthen their relationship, the relationship that can create the climate and environment that is conducive to positive interaction between doctors and patients, the interaction that can contribute to effective curative services and to the quality of medical treatment.

The subject of doctor-patient relationship needs to be attentively revisited in the development and implementation of medical education programmes. These programmes can be important entry points for strengthening doctor-patient relationship. This is primarily the role of medical schools, medical colleges.

Attention also needs to be paid to the ethical code of medical practice. We may need to see how this ethical code is implemented to ensure positive relationship between doctors and patients. This is primarily the role of medical councils and medical professional bodies, such as medical associations. Fairness for all in medical practice must be ensured by medical/health care service facilities. As much as it can be done, it has to be ensured that doctors have enough time with their patients by:

- Reducing doctors' workload;
- Promoting preventive care by other professions; and
- Delegating simple medical treatments to others.

On the other hand, for the patients, they need to be adequately educated to clearly understand the functioning of health care systems; to understand the roles of various professions, including doctors, who provide public health and medical services; to understand when and where to go for care, and at what level of the health services delivery system.

And, very importantly, the patients or people in general have to be educated and empowered to be able to take effective care of their own health. This is self-care – self-care at individual, family and community levels. Educating people to be functionally literate in self-care is an essential element for strengthening doctor-patient relationship.

Ladies and gentlemen,

With today's advancement in IT, patients can receive information about health from various sources, and from various directions. They, the patients are flooded with information, and often they are confused and misled. The patients may not need to be more informed, but they need to be better informed to better understand their doctors and medical practice.

We need to keep in mind also that all patients basically love, and highly respect their doctors. And they expect doctors to love them and respect them also. Doctors too need to better understand their patients, to understand not only the patients' sickness; but also their social, cultural and economic profiles, not less important, to understand the patients' expectations. And, if needed, try to help reconcile such expectations - expectations of patients and expectations of doctors.

We all know well that the patients need to be treated holistically: physical, mental, and social, and treated with sympathy and empathy. However, this holistic treatment cannot happen perfectly because of many reasons. I am sure all of us are aware of those reasons.

Colleagues,

It will take us a long way in further strengthening doctor-patient relationship if the principle of PHC is effectively applied at all levels of health care systems. If there is more investment in promotive and preventive care, if medical workforce is more rationally utilized, if primary care with the addition of "family doctor" is developed and is fully functioning in all villages of countries, and so on.

Distinguished participants,

These are some of my thoughts relating to today's doctor-patient relationship. The Secretariat has developed a draft strategic framework for addressing the issues. This draft reflects our primary thinking about what may need to be done to further strengthen doctor-patient relationship. We look forward to your guidance in improving and refining this framework. Your experiences and your combined wisdom will be most useful in guiding us in further development of the framework, the framework that is suitable for application within the social and cultural context of countries in the South-East Asia Region.

I sincerely thank all participants for sparing their valuable time to attend this consultation.

I wish their deliberations all success. And I wish them a very pleasant and enjoyable stay in Delhi.

Thank you.