The doctor–patient relationship is an important determinant of quality health care. Until not very long ago, it was common for people to regard doctors as members of their families and the trust reposed in them extended to matters even beyond the medical needs of the family. Anecdotal information, however, suggests that the relationship between doctors and patients is becoming strained. There could be several reasons for this. Certainly, one of the most important factors is the commercialization and specialization of the practice of medicine that places a heavy reliance on technology at the cost of a meaningful interaction between health-care seekers and providers at a human level. The pressing demands on the doctor's time and the heavy dependence on technology for diagnostic and therapeutic practices has perhaps diluted the personal touch that is so necessary for a conducive doctor–patient relationship. In addition, the doctor–patient relationship is affected by a multitude of sociocultural, economic, political and health systems-related determinants. To discuss issues related to doctor–patient relationships, the WHO Regional Office for South-East Asia convened a meeting of representatives of medical councils and medical associations, medical teachers, policy-makers and legal and consumer rights experts in 2011. This meeting led to the emergence of a framework of action to strengthen doctor–patient relationships. This publication explores the various facets of the doctor–patient relationship and includes the framework of action that provides guidance about multisectoral actions that can contribute towards mutually beneficial relationships between doctors and patients.
Strengthening the doctor–patient relationship

A framework for action

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Preface

The doctor–patient relationship is an important determinant of quality health care. This relationship is built on a solid foundation of trust, empathy and respect for patient’s rights and dignity. Until not very long ago, it was common for people to regard doctors as members of their families and the trust reposed in them extended to matters even beyond the medical needs of the family. However, anecdotal information suggests that the relationship between doctors and patients is becoming strained. There could be several reasons for this. Certainly, one of the most important factors is the over-medicalization and over-specialization of the practice of medicine that places a heavy reliance on technology at the cost of a meaningful interaction between health-care seekers and providers at a human level. Related contributory factors include the relatively little time that doctors are able to, or willing to, spend with their patients – perhaps due to ever-increasing patient loads and sky-rocketing medical care costs.

The breakdown of conducive doctor–patient relationships, due to any reason, instils mistrust that, in turn, results in dissatisfaction and resentment, leading to increased incidence of medical litigations.

To ensure patient satisfaction, doctors need to have and spend enough time with their patients. It is obvious that in most instances, the presenting problem that the patient comes with has origins much beyond the immediate medical issues. Indeed, the importance of social determinants of health needs to be increasingly factored in while offering treatment options. It is difficult for doctors to have enough time for all these aspects. Doctors today are
over-burdened with the huge number of patients coming for care. One of the reasons for the large number of patients is the insufficient attention accorded by health systems to health promotion and disease prevention. I believe that if people were empowered to adopt health-promotive behaviour and take appropriate actions in their day-to-day lives, we can prevent a significant number of illness episodes. Further, health systems need to explore how best they can reduce the load on already over-stretched doctors. One obvious way to do this is to rationalize the use of the health workforce by identifying and delegating tasks that can be done by other members of the health team.

Medical education programmes can be important entry points for strengthening the doctor–patient relationship and the subject of doctor–patient relationship needs to be attentively revisited in their development and implementation. Attention also needs to be paid to the ethical code of medical practice. We need to provide legal frameworks to ensure that the rights of both doctors and patients are protected. These measures will go a long way in fostering positive relationships between doctors and patients.

We also need to focus on educating patients about realistic expectations from health-care providers. Patients also need to understand the functioning of health care systems; the roles of various professions, including doctors, and when and where to go for health care and at what level of the health services delivery system.

It is important that patients or people in general 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 the doctor–patient relationship. The information technology revolution and consumer organizations could be creatively harnessed towards this end.

We need to reiterate that patients need to be treated holistically – catering for their physical, mental and social needs. Doctors too need to better understand not only the patients’ sickness, but also their social, cultural and economic profiles and, above all, their expectations. Policy-makers and health services implementers need to explore how best they can reorient policy to realistically and objectively achieve better doctor–patient relationships. I believe this will be an important consideration towards universal health coverage.

This publication is a product of extensive deliberations with experts from the Member States of the WHO South-East Asia Region during a meeting held in February 2011 in New Delhi. We would like to place on record our
deep appreciation to Professor Ranjit Roy Chaudhury, National Professor of Pharmacology (National Academy of Medical Sciences, India), Chairman, Task Force for Research, Apollo Hospitals Educational and Research Foundation and former WHO Representative to Myanmar for developing this publication.

The publication provides guidance about multisectoral actions that can contribute towards better doctor–patient relationships. It is hoped that it will provide a platform for further debate on this issue and result in concerted action in countries for a mutually beneficial relationship between doctors and patients.

Dr Samlee Plianbangchang
Regional Director
Background note

In October 2006, the South-East Asia Regional Office of the World Health Organization initiated an innovative series of activities by bringing the heads of medical councils of countries in the Region together at Thimphu, Bhutan, for a regional consultation. This led for the first time to the formation of a network of medical councils of the countries. This network has now had very useful and productive meetings in Colombo (2007), Chiang Mai (2008), Kathmandu (2009) and Bandung (2010).

Having realized that a positive doctor–patient relationship would facilitate favourable outcomes to improve and protect the health of the people, the Regional Office initiated a dialogue in this regard in 2009 involving the network of medical councils.

The network has been very active and has made significant contribution in several areas including developing a module for teaching of ethics in the undergraduate medical curriculum; studying the best practices in countries within and outside the Region; developing measures for assessing quality assurance in medical education guidelines for accreditation of medical schools, continuing medical education programmes, and communication skills in medical graduates; as well as delineating the role of patient safety.

This publication on *Strengthening the doctor–patient relationship – a framework for action* is the culmination of activities that started in November 2009 when I was privileged to deliver a talk on “Ethics of medical practice: at the third meeting of the network in Kathmandu. The participants, the network of medical councils and the Regional Office felt that this topic, in view of its growing importance, should be the subject of a two-day meeting of experts on the doctor–patient relationship. This meeting was held in New Delhi on 15 and 16 February 2011 (WHO Document no. SEA-HSD-346).
This publication contains the collective contributions of all those who participated in the meeting, including the staff of the Regional Office. I must appreciate and acknowledge with respect the encouragement and guidance provided by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia, in organizing this important meeting and for his continued support to set up the network of medical councils.

I would like to thank Dr Athula Kahandaliyanage, Director, Health Systems Development, Dr Sudhansh Malhotra, Regional Adviser, Primary and Community Health Care, WHO Regional Office for South-East Asia, and Ms Chris Kurian, Consultant, for their help and contribution in the finalization of this document.

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Introduction

The World Health Organization South-East Asia Regional Office organized a consultative meeting in New Delhi on 15 and 16 February 2011 attended by 9 out of 11 Member States viz. Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand, to discuss the doctor–patient relationship. This publication is based on the presentations, discussions, suggestions and recommendations made at that meeting, all aimed at improving and strengthening such relations which form the backdrop for provision of quality medical care by the doctors to the patients.

The meeting concurred with the feeling and perception that there had been deterioration in doctor–patient relationships in recent times.\textsuperscript{1,2} This could be seen by the increased litigation against doctors and incidents, unheard or earlier, of doctors’ clinics being destroyed and occasional reports of doctors being assaulted by the attendants and relatives of patients.

It was observed that the doctor–patient relationship is affected by a complex set of factors which include sociocultural, economic, commercial and health system issues. Some of the reasons for deterioration of this relationship include the increased commercialization of health care, some doctors viewing it as a trade and not as a profession, the level of training in medical ethics at the undergraduate medical education course and the lack of time for doctors – at least in the public sector, to develop any sort of personalized empathic relationships. Added to these factors is the lack of communication skills in doctors. About 50% of complaints against doctors received by a medical council would not even have arisen if the doctors had cared to talk to the patient and the attendant, or if the concerned doctor had arrived on time and seen the patient himself instead of sending a junior doctor to the patient. Sometimes the busy doctor, looking at the computer records of the patient in the few
minutes available, does not even face the patient. Several suggestions were made to improve the doctor–patient relationship and these are discussed in this publication. These include strengthening medical education, and the role of medical councils and medical associations, and working towards education and empowerment of patients.

This publication deals first with patient-related factors which affect the doctor–patient relationship. One of the factors brought out was that doctors were authoritarian, while patients had little or no skills or knowledge to negotiate how they should be treated and respected.

It then goes on to discuss the doctor-related factors. As has been mentioned earlier, the reasons for deteriorating relations between the doctors and the patients include rising costs, changing expectations, commercialization and globalization. Ethical issues are important.

The publication then describes systemic factors which affect the doctor–patient relationship. Very often, the doctor is blamed and taken to task for faults in the system over which he has no control. One of the causal factors is the design of the health care services delivery systems, a system that waits for people to get sick and come to the health care centre for treatment.

Based on these discussions, a strategic framework has been developed to strengthen the doctor–patient relationship. Points have been highlighted for implementation in order to ensure that as a result of doctor–patient interaction – the output may be remarkable improvements in the doctor–patient relationship, leading first to increased trust of the patient in the doctor, ensuring thereby improved quality of health care services.

While making recommendations for improving the doctor–patient relationship, we need to keep in mind the changes which have taken place in the countries in the Region in the recent past. While newer challenges have been thrown up, the critical structures in human resources in all categories of health care personnel hampers the implementation of several strategies known to enhance the doctor–patient relationship.

This publication contains several suggestions which, if implemented, have the potential to considerably improve and strengthen the doctor–patient relationship.
Patient-related factors

The relationship between doctors and patients is central to the delivery of good quality health care. Much concern has been expressed recently about the doctor–patient relationship. This section deals with the patient-related factors and their role in shaping the medical encounter. There are several aspects to the doctor–patient relationship and the role of the patient therein. Sociology has discussed the ‘sick role’ that the patient assumes, an accepted exemption from productive activity until recovery. Part of this role is the submission to doctor’s authority in order to effect cure and mitigate suffering. There is much sociological literature on the power relationship and asymmetry of information between doctors and patients and other economic and cultural aspects that shape health-seeking behaviour in various populations.4

In the more recent discourse on the patients’ roles, the emphasis is on the economic aspect of health care and characterizes patients primarily as consumers of care and hence the interventions are geared towards protecting the consumer’s rights. However, it is critical to note that a person experiencing illness is a sufferer and expects to be cured and healed. He or she expects to be treated with care, sensitivity and dignity which are the cornerstones of the healing process. Herein the role of the patient is mediated through the social, economic and cultural context within which he or she is rooted. This context shapes his or her interaction with the institutions and practitioners who provide care. The response of the patient and his or her ability to interact with the doctor is shaped by hierarchies of gender5, race6, caste and class7 that interact dynamically to shape social and economic access to care, thus impinging upon the patient’s ability to continually seek care and his or her power in the doctor–patient relationship.
In the resource poor contexts of many countries of the South-East Asia Region, privatization rampant commercialization and corporatization of care are important impediments to seeking alleviation from suffering. The escalating costs of health care owing to the increasing privatization limit social access to treatment for most patients who belong to lower economic backgrounds. Despite the deficiencies in national health accounts, the data reveals that private expenditure exceeds 65% of the total expenditure on health care in countries such as Bangladesh, India, Indonesia, Myanmar and Nepal. Of this, out of pocket (OOP) expenditure constitutes about three fourths of the expenses. This puts in-patient care out of reach of large populations in these countries. In-patient health care expenditures are known to be among the leading causes of debts for rural populations in countries such as India.

Cost of care is also seen to escalate due to over-specialization, inappropriate use of drugs and diagnostic technologies and the aggressive intrusion of pharmaceutical companies into health-care settings.

Accessing care involves costs pertaining to transportation to these urban centres, loss of wages, expenditures on attendants and food. Often, patients in rural areas have to depend on a range of private practitioners, both formal and informal, to avoid these costs. In many cases, patients may be recipients of inappropriate treatment or may not be able to complete treatment for financial reasons, as a result of which the existing health conditions might worsen, leading to them having to resort to tertiary care. Well-known public care facilities in urban centres thus have to bear the brunt of excess patient loads impinging on the quality of care they might be able to provide.

Several studies in India and in public health care facilities discuss discrimination against women and those belonging to poorer strata and lower castes. The ability of populations from these sections to seek redress for poor quality care, negligence or inadequate care is seriously challenged by their limited access to educational and economic resources. Similar experiences have been cited in several studies that discuss health care access among vulnerable sections like the elderly or those suffering from HIV/AIDS. It has brought out effectively how men and women living in poverty and belonging to lower caste backgrounds are often at the receiving end for insensitive behaviour and callous judgements on the part of medical professionals even in public health care institutions. The doctors often rely on stereotypes of these patients as being uninformed, ignorant, and following irrational practices, often not realizing the complex interplay of factors that shape the health-seeking behaviour of people.
2.1 Overcrowding, waiting time and length of doctor’s appointment

As a result of poor distribution of facilities and the flooding of tertiary care facilities in urban centres with patients, the overworked doctors are barely able to spend time with patients. The interaction is thus very mechanical, the focus on the body at the cost of attention being paid to other factors pertaining to life-conditions that contribute to shaping of the illness experience. Given the paucity of time and the dynamics of the power relationship, the patients are rarely able to build a relationship with their doctors. They may not experience the comfort or the ease that they require from an interaction meant to heal. In the case of poor patients, this interaction becomes strained further by differences in framework, the severe hardships that they have to undergo merely to physically approach allopathic providers and the paucity of money that results in breaks in treatment which may be misconstrued by doctors as defaulting or refusal to adhere to instructions about treatment and care.

It has been suggested that the similarity in frameworks of the healers and sufferers makes the recommended treatments much more acceptable to the suffering populations. Their explanations appear personally and socially meaningful to the sufferers, thus giving patients a sense of greater power and control over their situation. This is not the case for illiterate populations approaching allopathic doctors in private or public institutions. They may be unable to understand the doctor’s explanations about their health conditions and the reasons for being asked to follow certain regimens. Language barriers and educational backgrounds are important determining factors causing the divide.

The differences in the frameworks within which health and disease are viewed contribute to the dynamics of this encounter. Hence, out of fear of judgement and retort, the patients often do not disclose various kinds of efforts that they might have made in order to handle the problem that they are faced with. The often insensitive behaviour towards people from poorer backgrounds contributes to the patient’s reluctance to access health care offered by practitioners of modern medicine.

In the current context of corporatization of care and commercialization of diagnostic facilities, the costs of health care are extraordinarily high even for middle-income populations. The unregulated commercialization has also contributed to an increasing tendency of malpractice on the part of medical practitioners. This has shaped patient responses to medical practitioners as
well. Depending on the resources at their disposal, including easy access to information on the Internet, patients attempt to secure their safety by seeking several options and consulting the available resources of information. This, in itself, adds to the costs and also affects the medical encounter. Dissatisfied patients, especially in urban areas, may resort to litigation to implicate the doctor for errors real or imagined on his or her part. The vitiation of trust between the patient and the doctor is thus leading to increasing suspicion, which is also affecting the process of curing and healing. The doctors on their part, to safeguard their interests and protect themselves, err on the side of caution by resorting to unnecessary treatments and diagnostic procedures, which add to the rising costs.

2.2 Need for respect, dignity and understanding

In addition to technical competence and sound treatment, the need for dignity, respect and comfort from the doctor is central to the healing process. Unfortunately, medical education pays attention to the former at the cost of the latter.

The popularity of informal practitioners with populations in rural areas and slum populations in cities has been a theme that has been widely studied in India and many other parts of the world. While in-depth knowledge of the healer is considered important, his or her religious faith and ritual purity, humility and exercise of authority with a sense of benevolence and protection are seen to be important attributes that facilitate the patient to repose faith and trust in a healer.

2.3 Empathetic treatment

Depending on their social conditioning, patients may resort to a range of practices such as home and herbal remedies, alternative-healing therapies, magicreligious treatments which may be considered ‘non-scientific’ or inefficacious in allopathic medicine. This lack of legitimacy to alternative practices is reflected in the attitude of the doctors who may scoff at or scold patients for resorting to such treatments. In such an event, patients may not be willing to reveal the various kinds of treatments they might have undergone.
2.4 Rising expectations

With the increasing availability of medical technology, the mushrooming of centres in urban areas providing state-of-the-art health care, the availability and access to information about diseases and treatments on the Internet and from a wide range of other sources, doctors are no longer dealing with uninformed patients. The patients, especially in urban areas and from educated backgrounds, take the trouble to gather information and obtain multiple opinions from other medical practitioners about the health conditions that they are attempting to deal with. Given the fact that they spend huge amounts of money on health care, they have rising expectations about the need for effective health care and expect to experience a complete cure. Private hospitals are often preferred by middle class patients due to the belief that they provide better quality care using the space and technology at their disposal. Patients are also extremely sensitive to the design of space in hospitals and clinics. This is one of the important factors that they value in the experience of treatment. Patient-friendly spaces, clean, aesthetically and functionally designed facilities coupled with limited waiting time are factors that are valued in their evaluation of good quality care.

2.5 The cultural context

In the South-East Asia regional context, care of patients is something that is often taken up by the family. Though doctors do establish communication with the family, enough is not often done to strengthen its role in caregiving. The care is very doctor-centred. Interpersonal communication is necessary for building trust and empathy. The patients and their families need to understand and respect the doctor’s limitations, while at the same time, doctors also need to respond to the patients’ backgrounds, economic and social capacities and needs. Thus, the interaction has to respond to the patients and their families at the emotional, cultural and intellectual planes. Hence, treatments prescribed have to take these aspects into account.
Doctor-related factors

The doctor–patient relationship is forged or destroyed by the attitude and behaviour of the doctor, by the perceptions and reactions of the patient, and by the prevailing systems which are conducive or otherwise towards developing a bond of trust and empathy between them. In this section, factors caused by the doctor are discussed.

The deteriorating doctor–patient relationship seen in the past few decades could be attributed to changes which have altered the doctor’s behaviour towards the patient. These changes have been described elsewhere in the document. The factors caused by the doctor relate largely to his/her behaviour and inability to communicate with the patients and the attendants of the patient. This could be because the doctor was not taught these skills in the undergraduate medical course. It could also be that he does not have time to communicate. Either way, the patient is disappointed with the apparent lack of concern, lack of time spent with him and the lack of communication. It has been well documented that a significant proportion of cases of malpractice are brought to the medical councils because of lack of communication between doctors and patients.

It has also been brought out that very often the doctor fails to maintain a standard of medical etiquette which treats the patient with dignity. The patient, after having travelled long distances and spending much time to see the doctor, expects from the doctor a little time, a kind word and display of some interest in him as a person. Very often he does not receive any of them. In one study, 33% of the patients in a particular country stated that the doctors had no interest in them as persons.

In the relationship between the doctor and the patient, the doctor is more powerful. It is easy, therefore, for the doctor to be authoritative – an attitude which may be resented by the patient, even though he may not, at the moment, be able to do anything about it.15,16
The patient needs to believe that the doctor follows an ethical code of conduct. He needs to set aside any of his concerns that he may be submitted to diagnostic procedures or a prolonged stay in the hospital or even surgery which may be wholly unnecessary. If the person has any suspicions that this may be happening and the doctor is not above board, then his confidence in the doctor is reduced, as a result of which his healing may be retarded.

Having discussed the various factors relating to the doctor which may retard the development of a good doctor–patient relationship, it will be pertinent to discuss the attributes that contribute to a good relationship. The doctor needs to possess good communication and managerial skills, and, of course, he must be competent, possessing sound clinical skills and observing a high level of ethical conduct.

3.1 Medical education

It is now important to discuss what changes need to be carried out to ensure that caring and compassion become an integral part of the functioning of a doctor. The aptitude of a person wanting to become a doctor is never taken into consideration during selection for admission to medical colleges. Over and above his entrance test marks, the caring doctor must have empathy if he is to become a doctor. Very few medical colleges look at this very important aspect while admitting students. Those that do assess these soft skills clearly demonstrate that they produce a different kind of doctor – a doctor who cares, who is not unhappy when asked to work in remote and rural areas and whose main objective in life is not the accumulation of material goods.

Once a student is admitted to a medical college, he immediately begins his course in basic sciences and then rushes through the different paraclinical and clinical subjects in the course of the next four and a half years. There are three things which need to be done. First, the curriculum of the undergraduate medical course is not appropriate for producing the type of doctor we need – the doctor who would improve the doctor–patient relationship. Hence, a change in curriculum is long overdue to make it relevant to our needs. The second requirement is to give the fresh medical student some time to adjust and broaden his mind before he starts his course. A foundation course of two months before he starts his medical training will help him to become a better doctor. During these two months, he would attend lectures in such subjects as communication, leadership, ethics, history, philosophy and even music relating to the process of healing. He would also be exposed to other traditional systems
of medicine being practised in the country. Third, during the four and a half years course, the student should be encouraged to take a four-month elective module where he could work wherever he wishes to. Both the foundation course and the four-month elective period would have a built-in rigid system of assessment.

One of the reasons for deteriorating doctor–patient relationships is the lack of communication skills in the doctor. He finds difficulty in talking to his patients not because he does not, in many cases, want to, but because he does not know how to. He finds it difficult to explain things to the patient and to break the news of death of a patient to the relatives. He also clearly does not know how to apologize and does not understand the power of apology. The doctor is never taught these skills. Hence, it is necessary to include a compulsory course of communication in his training. Doctors who would have taken this course and practised it will find it easy to develop positive doctor–patient relations.

The medical course should also include a module on ethics. Every medical student should be taught ethical principles. These could relate to his functioning as a health provider, researcher or teacher.

The WHO Regional Office for South-East Asia has produced a module for teaching ethics as well as a manual for those who will teach ethics. The study of ethics and assessment in ethics needs to be made mandatory for the medical students. If the medical councils of countries in the Region could take this statutory step, it would have far-reaching beneficial effects in producing good doctor–patient relationships.

The third component that is missing in the undergraduate curriculum is sociology. This would create in him respect for the patient and inculcate a spirit of equality in his relationship with the patient. He would want to treat his patients with dignity. Loss of dignity when going to visit a doctor or when, particularly, entering into a hospital is what the patient fears, and must be protected against. No doctor or paraprofessional should behave in a manner where the patient’s dignity is stripped or his privacy violated.

It should be mentioned that exposure of the medical student to communication, ethics and sociology should not be only through didactic lectures, but he/she should also develop these skills by practical exercise.
3.2 Essential skills

Communication skills

There can be no substitute for communication skills and the doctor needs to communicate more with the patient. Eye communication or touch communication is important, but verbal communication is a must. The patient must feel that the doctor is interested not only in the disease or condition of the patient, but also in the patient as a person. The doctor needs to understand the patient’s perception and needs. The three pillars of a positive dialogue between the doctor and the patient are trust, communication and personalized care. It is imperative that the patient is treated with dignity and courtesy. The doctor needs to answer the questions and even encourage him to ask questions about the treatment. The patient is already in an environment in which he or she is insecure. If, in addition, his questions are brushed aside with annoyance or irritation, it will cause further depression. Patient comfort, patient satisfaction and patient safety must be uppermost in the mind of the doctor. The lack of time which will be dealt with later can never be a reason for rude behaviour.

Managerial skills

The doctor is not expected to be an expert in management; however, he has also to function as a manager of sorts – in his dealing with the patients, in keeping records, in procurement of medicines and establishing procedures which make things easier for the patient. Very often, it has been observed that the doctor is devoid of any skills in management. Management skills are now being taught to the undergraduate in his medical training.

Clinical skills

Every patient wants to be treated in the best possible manner. This, however, is possible only in addition to possessing the required clinical competence and skills, the doctor also keeps up with the rapid advances in the field of technology and drug development. Thus, it is necessary for him to take part in programmes of continuing medical education by enrolling in courses and training programmes accredited by the medical council of the country in order to provide the best possible treatment. It is hoped that very soon the number of hours of continuing medical education taken by the doctor becomes mandatory before re-registration for being licensed to practice. These hours should not only be obtained by attending meetings, but also could be obtained by giving lectures, reading articles, taking part in distance learning programmes and in
many other ways. The main purpose is to provide the patient with the most appropriate treatment. The importance of keeping up-to-date has also become more critical because of the mass of information available on the Internet on diseases, drugs and treatments. Patients read these avidly, particularly if it is about a disease they are suffering from, or about drugs they are taking. They also question the doctors about what they have read. This is not something that doctors like, nor is it something that does not cause concern. However, this has come to stay and doctors have to deal with it. One way of dealing with it is to keep up with continuing medical education programmes.

**Ethical practice**

The patient expects the doctor to follow ethical principles. Medical councils in the countries have developed a code of ethics which describes how a doctor needs to function. The doctor should display his qualifications and registration with the Council, so that patients are aware of it. The doctor’s relationships with the patient and with the pharmaceutical industries are also defined. He should not accept unreasonable support from a company for attending meetings or for carrying out research. There is a feeling in the community that in return for some financial or other consideration doctors prescribe certain medicines of a particular pharmaceutical company to boost up sales. In the bargain, the patient may be prescribed a more expensive medicine instead of an equally effective, cheaper alternative. The doctor should never do this, as it is unethical conduct. In a similar vein, it is not ethical to ask a patient to undergo diagnostic procedures that are not essential, as the doctor will augment his income by receiving a cut from the diagnostic centre or from a laboratory carrying out the investigations. Doctors who carry out clinical trials of new medicines should not have shares or a financial interest in the company. All these guidelines and rules are there, but it is up to the doctor to gain the confidence of the patient by following these rules.

Maintaining confidentiality of the doctor–patient relationship is of paramount importance and should be emphasized as a part of ethical practice by doctors. This is especially important when dealing with patients with diseases that attract social stigma such as HIV/AIDS, leprosy, STIs, tuberculosis, as well as mental illnesses.

Unfortunately, the deterioration of relations between doctors and patients has led to a lack of trust and confidence between the two. As a result, doctors are afraid of being taken to court for inadequacy of diagnosis or treatment and ask for all types of tests to be carried out so as not to be accused of missing
a diagnosis. This, in turn, results in the patient paying more for unnecessary investigations. If there was trust and confidence and empathy between the doctor and the patient, the doctor would be confident that even if he makes a genuine mistake – and all people make mistakes, he would not have to face a court case.

Medicolegal concerns

Undergraduate medical education should also introduce the students to medicolegal aspects of which a doctor should be cognizant. Often, the doctor does not have the time to keep meticulous records of the patient’s examination, diagnosis, treatment and outcome. Being a professional, he does not consider other non-professional activities as priorities. Unfortunately, good record keeping is a priority today and if the doctor had been taught about it in his undergraduate medical education, he would be aware of what should be done. Many malpractice suits in the civil, criminal or consumer courts would not have been filed if the doctor followed what is entailed by law and maintained meticulous records.

Empathetic patient care

At the moment, in most cases, the patient is a supplicant and the doctor authoritative. If doctor–patient relations are to improve, this needs to change. When a patient comes into a hospital or sees a doctor, he is under stress. The doctor needs to remember this and go out of his way to create a mutually serene and friendly environment in the limited time available to him. A patient may have covered a long distance to see the doctor and waited for several hours to meet him or her. Not to be able to talk to the doctor and ask a few questions to which answers are given, and not to even have an eye contact or a touch contact, is sure to adversely impact the doctor–patient relationship. In this scenario, when the doctor looks at the computer instead of the patient, the patient goes away dissatisfied and if any opportunity presents to consider filing a malpractice suit against the doctor, he would have no hesitation in doing so, because he has not developed any bond with the doctor. However, if the doctor demonstrates on the computer screen as to where the problem lies and how it is going to be resolved, a bond is created in these few minutes. In fact, today in the person-oriented approach or personalized medicine approach, the doctor and the patient take part together in the decision-making process – what treatment to choose or what drugs are to be used. This type of behavioural change is important for a good doctor–patient relationship. Time constraint is a negative factor and this will be discussed in 4.10 Section. However, even in the
limited time available to the doctor today, he can inspire confidence and trust in the patient. There is absolutely no reason for the doctor to display irritation or annoyance at the patient or perhaps his questions just because the doctor does not have time. The patient is not responsible for the lack of time of the doctor and he should not suffer for this.

Another dimension which needs emphasis is respect for human rights and gender sensitivity of the patient. In the context of the South-East Asia Region, where women are generally uncomfortable being examined by male doctors, it is especially important that measures be instituted to respect the dignity and sensitivities of female patients.

Finally, it would be a very good step if the hospital or the nursing home or the doctor regularly measures patient satisfaction. Tools are today available for measuring this. The results of measuring patient satisfaction in one’s patients would be salutary and reveal the need for measures not really observed by the doctor. Action on what is recorded will not only result in improved doctor–patient relationships, but would also decrease actions against doctors for malpractice.
Health systems related factors

One of the causes contributing to the breakdown in optimal doctor–patient relationships is the failure of the health systems to give much-needed attention to conditions that foster good relations. The doctor probably has no role to play in this, but is often blamed. Diagnosis and treatment may be delayed due to equipment like an X-ray or MRI machine being out of order. Emergency services are hampered and patients are endangered if vehicles are not maintained properly, as sometimes happens when the driver is not available at the right place at the right time. Laboratory tests may not be carried out because the supply chain of reagents and chemicals is not functioning properly. Every medical council has a list of complaints against doctors because the patient was not looked after well due to health system factors. This chapter will discuss how the managerial defects that are often seen can be remedied. It will also discuss how the patient and the doctor could work together towards improving the health system.

4.1 Continuing medical education programmes

In the foregoing sections, certain areas of important concern for better doctor–patient relationship have been listed. The doctor needs to be exposed to, gain awareness of and get trained in these areas. However, one exposure is not adequate, as with advances in medicine and therapeutics, these concepts also change. Continuing medical education programmes for doctors are, therefore, very relevant. Such programmes should cover not only advances in medicine, but should also deal with subjects such as ethics, human rights, communication, patient safety and medicolegal rules. Only then should the physician be certified competent and allowed to maintain his registration and continue to practise. Therefore, continuing medical education programmes need to be available. In
countries with far flung areas with difficult communication problems, it may not be possible to have face-to-face continuing medical education programmes. The advantages of information technology should be used to organize online programmes. A certain number of continuing medical education hours should be mandatory before re-registration. Knowing that the doctors have undergone such courses will make the patients more confident, not only because the skills of the doctor are up-to-date, but that he is also exposed at regular intervals to the human face of medicine.

4.2 The role of medical councils

The medical council has a very important role to play, because it is the regulatory agency for doctors. The medical council should not only lay out guidelines, but should actively ensure that the guidelines are followed. In addition to ethical guidelines, the doctors need to follow a code of etiquette which does not exist at present. There is no redress today for things which would not be seen in a court of law. For example, not speaking to the patient or speaking in an irritable manner, for giving only a few minutes to the patient, not coming to see the patient when an appointment has been given or sending a junior or a postgraduate student instead are the things that are happening today. These are not regulated at all. As a result, the patient feels resentful, thereby again leading to a deterioration of doctor–patient relationship.

In summary, the doctor needs to develop a patient-centred approach and to understand the social, cultural, and economic profile of the patient and his expectations, to communicate with the patient, with a smile if possible, and to give adequate time to a person who is already ill and insecure.

4.3 Enforcement of codes of ethics

As has been stated earlier – every council has brought out an ethical code of conduct for doctors. Unfortunately, this code may be read once at the time of registration, but is not referred or adhered to in later years. The medical council should make certain that doctors refer to the code of conduct from time to time. This can be done by holding continuing medical education sessions on the code. Students should also be taught medical etiquette in addition to the code of ethics. Breaches in etiquette may not be unethical in the strict use of that term nor breaching a rule of law, but certainly lead to a breakdown in the doctor–patient relationship which is our concern here. Reference has already been made earlier to rude behaviour, delay in keeping appointments, showing
irritation in answering questions and not spending more than a few minutes with the patient. The medical councils should pay particular attention to these failures in good communication that damage the traditional good relationship between the doctor and the patient which existed in earlier years.

Therefore, the medical council should play a vital role in a country (which they are not doing now) in improving doctor–patient relationships. They can do this by:

1. including the teaching of ethics in the undergraduate medical curriculum;
2. holding or encouraging more programmes in continuing medical education;
3. regulating the relationship between pharmaceutical houses and doctors;
4. ruthlessly punishing doctors for unethical conduct;
5. giving recognition and incentives to doctors who have demonstrated exemplary ethical conduct;
6. by protecting doctors from unnecessary harassment and unjustified malpractice suits.

### 4.4 Legal assistance

The hospital should make available a mechanism for providing legal help for immediate problems faced by a doctor. This would give confidence to the doctor, as very often he is not aware of the different rules and regulations which govern the code and conduct of the doctors in the hospital.

### 4.5 Patient facilitation

Patients also need to be educated to clearly understand the functioning of the health care system. They must be made to understand the roles of various professionals including doctors who provide medical services. Patients need to understand where to go for care and where not to go.

Hospitals also should have a patient-friendly approach. They need to employ people with the specific responsibility of guiding patients, answering their questions and making sure that the waiting time is reduced and spent in
a patient-friendly environment. Where a large number of patients come from other countries, they could be helped by interpreters. Since many persons are unable to visit the hospital in the regular outpatients hours, the hospital could consider increasing the hours of the outpatients on certain days of the week. One could even think of the hospital providing mobile health services. All these innovations in the systems would only enhance the doctor–patient relationship. It is true that a large proportion of disputes with patients are a consequence of failures of the health system, rather than the incompetent and indifferent attitude of the doctor. Even so, some of the changes mentioned above would be useful to convince the patient that in spite of all efforts, systems do fail and that this should not be attributed to the doctor.

4.6 Educating patients about their responsibilities

It is important to understand that the patients also have some responsibilities and should also have some sort of code. Very often, patients get to know of a new drug being prescribed elsewhere for a condition they or their relatives have and demand to be given the same medicine. This is not fair. Again, patients may go from one doctor to another without informing the first doctor. Sometimes the patient is taking medicines which he does not disclose to the doctor. In many cases, the patient is taking traditional medicine and does not inform the doctor. This could lead to serious interactions. These are only some examples of the patient laying the possible basis of discord.

4.7 Patient safety

Patient safety in hospitals is a cause of concern because it has been documented that medical errors or events as these are called today, take place in all hospitals. The patient goes into a hospital or nursing home to get well; it is unacceptable if the patient is endangered by being admitted into a hospital. However, this is happening. In the countries where such information is available – for instance, deaths due to adverse medical events and reactions due to negligence form a sizeable proportion of total deaths in the United States. One of the main causes for this increase is prescription errors – that is, prescription of the wrong drug, the right drug for a wrong period, or too many drugs – some not necessary – including interactions and side-effects. In one geriatric hospital, one third of all the admissions were due to side-effects of medicines. Rational use of medicines including antibiotics is a major strategy to improve doctor–
patient relationship. The patient must be convinced that the doctor has not unnecessarily prescribed a medicine to please the pharmaceutical firm from which he has received favours. Once he is convinced, the relations between the patient and the doctor will remain warm and be based on empathy. It must be clearly stated that to prescribe a more expensive drug when an equally effective cheaper drug of equal quality is available is not ethical. Patient safety, therefore, assumes prime importance and medication errors and medical events need to be brought down to the minimum.

4.8 Patient safety and standard operating procedures

Doctors should be protected by a system of patient safety measures, as they would not then have to be at the receiving end of criticism for failure of systems. There should be regular audits which would detail medical errors and prevent such errors from occurring. Each case of failure or error needs to be investigated. There should be regular meets to review the systems in place. If necessary, the systems should be modified or even replaced by other systems based on demonstrated advantages of the new system.

The system should have tools in place which make the functioning more effective as well as more transparent. Standard operating procedures should be prepared for all the different categories of personnel in the health care facility.

In the use of medicines, the field where most medical events occur as medication errors, there should be a system in place to minimize these errors. Proper and regular functioning of drugs and therapeutic committees and an antibiotics policy committee would help a lot in the rational use of medicines and in preventing resistance to drugs such as antibiotics. There should also be lists of essential drugs, a hospital formulary, standard treatment guidelines and an antibiotic policy for the hospital. These documents and publications need to be used and the doctors should be aware of the standard treatment guidelines and the hospitals using such guidelines. Just production of these tools is not enough. If quality drugs are always available due to a good system of procurement and distribution and if the drugs are prescribed well, this will be one long step in the acceptance of the doctors by the patients.
4.9 Grievance redressal systems

One important mechanism to prevent unjustified blame being apportioned to the treating doctor is to have a grievance redressal system. An active system available to all the patients and the attendants as well as the employees of the hospitals would help in better understanding of the drawbacks and constraints which prevail in any situation. The opportunity to talk about and share the experience will in itself have a calming influence on both the patient and the doctor. Breakdowns in relationships would be avoided. In recent years, there have been cases of doctors being assaulted by the attendants of the patients and clinics being destroyed. This is unheard of behaviour in the yesteryears and one needs to investigate into the causes for such incidents. No longer is the doctor considered to be a member of a hallowed profession providing service to the community unfortunately, the feeling has got around that the doctor’s main interest is in making money and not always by fair means. This perception needs to change and it can only be brought about through changes in the doctors behaviour and by preventing the systems failure which leads to distrust in the patients being reduced to a minimum.

4.10 Patient load and time availability

One of the main constraints under which the doctor is functioning is the very limited time available to spend with each patient. This is particularly so in the crowded public hospitals. It is all very well for this document to state that to improve the doctor–patient relationship, the doctor should develop a personalized approach to the patient, but is that really possible? In many hospitals, the case-load and the number of outpatients are so great that all the time the doctor can give to the patient is few minutes.

This lack of time is related to the patient load and the numbers. This is a problem of the system and both will be discussed together, as one is the cause of the other. There are several ways in which this enormous load on the doctor could be reduced. All patients need not be seen by the doctor. A category of persons akin to the nurse practitioner could be the frontline of care. Only if this person feels that the patient needs to be seen by the doctor, will the system allow him/her to be examined by the doctor. Not only the doctor, hopefully, will have less patients to manage but he/she could take advantage of the notes prepared by the medical or health assistant. A second way is to introduce a referral system where the doctors at the larger public facilities would only see patients who are referred. This would also reduce the number
of patients enabling the doctor to spend more time with the patient – again leading to good doctor–patient relationship. Unfortunately, the general wish of any patient, particularly, in some countries in the Region, is to see, the senior-most and the best-qualified doctor. Perhaps because he has not been served well in the past, he does not have faith in the medical practitioner at the first level – irrespective of whether there are doctors or nurses of health workers. One needs to explore how much and in what ways other paraprofessionals like pharmacists and traditional medicine practitioners could reduce the load on the doctor.

4.11 Health promotion and disease prevention

Programmes of wellness and promotive and preventive health care will also reduce the load of patients. Many hospitals have now introduced such programmes. However, this has to be a national programme. Promotive and preventive programmes would very clearly have an impact on the number of patients seeking medical care. Reduction of lung cancer and lung problems due to smoking and an increase in lifestyle diseases such as coronary heart disease and diabetes as a result of unhealthy diets and lack of exercise would all together help in reducing the burden of disease. However, whether the preventive programmes would reduce the load on the individual doctor at the hospital or the clinic remains to be assessed. Public health programmes, often neglected in many countries of the Region, would also reduce the disease burden. Empowerment of the public to look after, to a certain extent, their own health, would again reduce the number of patients. Self-empowered programmes at the moment are too few.

One also needs to point out that all the traditional systems of medicine had a very strong element of preventive and promotive health. Unfortunately, even the practitioners of the systems are themselves not using the age old well-tried approaches. These systems could also be used beneficially by the modern system of medicine.

In an attempt to reduce the number of patients, expecting that this would provide more time for the doctor to attend to the patient, the following mechanisms have been suggested:

(a) use of nurse practitioners and health assistants;

(b) development of a referral system;
(c) establishment of systems of promotive and preventive health – wellness clinics;
(d) establishment of a strong public health system;
(e) using preventive and holistic methods for preventing lifestyle diseases;
(f) using methods described in the traditional system of medicine in the modern systems;
(g) empowering the public to look after their own health: one of the new programmes linked with much that has been said is the programme of self-care. This, in fact, will be one of the results of empowering the public and the patients to look after their own health and to form a partnership with the doctor for maintaining good health.

4.12 Media relations

Another area in which the health system could help in improving the doctor–patient relationship is in its relationship with the media. The media is playing an increasing role in informing the public about health-related issues. It is incumbent upon the health system to ensure that the media have proper information on which to base their reporting/articles. Not infrequently, the media highlights unpleasant experiences of the public in health facilities. Very often, these critical stories are based on an incomplete or inadequate understanding of the situation. It needs to be ensured that reporting by the media is balanced and success stories are also highlighted. It is, therefore, important for the health system of the hospital to maintain a dialogue and a good relationship with the media. The media should be encouraged to partner the hospital in enhancing the health literacy of the public and to encourage fair and balanced reporting of health issues.

4.13 Other factors

The remaining paragraphs summarize those factors in the health systems in a hospital or health care facility which could be modified to create an atmosphere for development of an excellent doctor–patient relationship.

The systems need to be patient-centred and patient-friendly, leading to confidence and trust of the patient in the hospital. Information about where one has to go and about the systems prevailing in the hospital will go a long
way to assuage apprehensions. Trust is of great importance – to the doctor of course, but also to the patient and his attendants. Waiting time should be reduced to a minimum.

There should be transparency in all the prevailing systems and it must be ensured that the situation is explained to the patient. An opportunity to complain and a complaint redressal system needs to be put in place if it does not exist. This would be part of the services being offered to the patient.

There should be a system of accreditation and the hospital should be accredited either by a national or international accrediting body. This will give more confidence to the patient that the tests are being carried out in a standardized manner and that the records and procedures of the hospital are being assessed and recorded from time to time.

The hospital should run courses in ethics and communication not only for the doctors, but also for every person who works at the hospital. If the doctors communicate better with the patients and follow a code of medical ethics and etiquette, very rarely will problems and allegations of malafide and malpractices arise at the hospital.

Congestion needs to be removed, but this is easier said than done. Outpatient hours could be extended. Patients should be informed of the problems the hospital has in recruiting good quality doctors, nurses and paraprofessionals and equally important, the problems of retaining them once they join.

Finally, of course, patient records must be meticulously kept, and the cleanliness of the hospital should make it a pleasing place to work in. The diet should be tasty and varied. The system of follow-up visits should be explained to patients and their attendants.
Having considered the factors which affect the doctor–patient relationship, it is now possible to set up a strategic framework to strengthen this relationship. The following domains affect such a relationship:

- patient-related factors
- doctor-related factors
- doctor–patient encounter.

Satisfaction with the doctor–patient relationship is a crucial factor in a patient opting for treatment from a specific practitioner. Most of the medical encounters are spent on discussions between the practitioner and patient. The medical interview can be considered as the major medium of health care. The interview has three main functions and needs many activities to make it successful. These three functions are (i) gathering information, (ii) developing and monitoring a therapeutic relationship, and (iii) communicating information. These three functions interact with each other.

A long-term good relationship between a patient and the doctor could be developed into a “personal relationship”. Such a relationship is a key component of patient-centred care and may have positive health outcomes for patients as it allows a “therapeutic” relationship between the physician and the patient. This therapeutic relationship begins not just during the first treatment session, but at the moment they first meet as a doctor and a patient.

Increasing data suggest that patients encouraged to ask questions in the medical encounter and to participate in decision-making regarding their care respond better to treatment and certainly have a higher satisfaction than those patients who only listen and are instructed. If the relationship is poor, the
physician’s ability to make a full assessment is compounded and the patient is more likely to mistrust the diagnosis and the line of treatment being followed. This may even cause decreased confidence on the part of the patient.

Studies have shown that patients who have a good and trusting relationship with the clinics are more satisfied and satisfied patients get better clinical results. They are more willing to follow the doctor’s advice and take the medications as prescribed. They are motivated to take care of themselves and are more comfortable seeking help when problems arise. Many medical schools teach students, even before they start working in the hospital, to maintain a rapport with the patients, uphold the dignity of the patient and respect their privacy.

Today, with increasing specialization and commercialization, the doctor–patient relationship is under strain. One indication of this is the increasing number of malpractice suits against doctors and, unheard of earlier, assaults on doctors in some countries by relatives and attendants of the patient.

The accompanying diagram depicts a framework which could be used to strengthen the doctor–patient relationship. At the centre of this is the doctor–patient interaction. This doctor–patient relationship should lead to outcomes which are desirable. The outcomes are: satisfaction and trust of the patient in the doctor, and an improved relationship resulting in better treatment results, and at the same time, leading to decreased litigation against doctors.

There are several factors that affect the doctor–patient relationship as has been described earlier. In this strategic framework, factors related to the patient, the doctor and the doctor–patient encounter are described.

### 5.1 Patient-related factors

Culture, religion and beliefs have a very strong influence on the attitude and behaviour of a person, which in turn, can significantly affect the doctor–patient relationship. Culture and religion sometimes can have restrictions or preferences about seeking care. Some religious practices do not encourage western medicine and some cultural influences have affiliations to traditional medical practices.

The educational status and access to information and the prior knowledge a person has about the illnesses and the available health services, his past experience with such services and the trust that he has developed will affect the decision of that person in selecting the care he wishes to seek. The nature
Strategic framework to strengthen the doctor–patient relationship

- Sociocultural milieu
- Medical education
- Training in communication/sociological/cultural influences
- Legal framework
- Medical council
- Professional bodies
- Training (graduate from abroad or in the country)
- Selection criteria of medical students

Doctor-related factors
- Qualifications
- Skills/competencies
- Attitudes
- Bedside manners
- Ethics & standards
- Cultural factors
- Rights and responsibilities

Patient-related factors
- Expectations
- Information/knowledge
- Past experience
- Trust
- Nature & state of illness
- Financial status
- Rights and responsibilities
- Level of functional literacy

Doctor–patient interaction
- Availability/access
- Reception
- Communication
- Information exchange
- Empathy/compassion
- Supportive environment
- Time spent

Output
- Satisfaction
- Trust
- Adherence
- Improved knowledge
- Increase health literacy of patients
- People-centred care
- Patient-centred care
- Decreased litigation

Outcomes
- Improved doctor–patient relationship
- Improved quality of health care services

Health systems issues
- Governance
- Service organization
- Referral issues
- Patients’ rights/grievance redressal
- Reconciliation bodies
- Appropriate technology
- Patients’ charter
- Audits for quality assurance
- Patient feedback
- Social support system
and status of the illness and the financial status of a person has a very strong influence on the level of care that person selects. Peer influence is another factor that can affect the doctor–patient relationship. Another important factor is that the patients now understand their rights and responsibilities.

Having considered all these factors, with a lot of expectations of relief, the patient finally decides to seek care from a doctor.

5.2 Doctor-related factors

A patient seeks care with a view to get cured from his/her immediate illness and be free of future illnesses if possible. A patient will seek medical advice from a doctor that he/she feels is capable, skilled and competent to attend on the illness. Such skills and competencies would depend on the medical education and training the doctor receives and the subsequent clinical experiences he gets. Cultural influence also plays a part in fashioning the doctor’s attitude.

The doctor’s attitudes towards patients, and the empathy and bedside manners he shows will have a strong influence on the relationship he would build with the patient during an encounter. He would be guided by the ethics and standards of the medical practice. The medical practice would be governed by the medical councils and the legal framework in a country. Medical professional bodies also have a major influence over the doctors and how they treat patients. The doctors also need to understand their rights and responsibilities.

5.3 The doctor–patient encounter

Availability and access to services are important factors to a patient in seeking care. Once the decision is made and when the patient reports to the hospital to seek care, the reception he receives, attention paid to the personal comfort of the patient and waiting time are very important in building a relationship. The communication the patient has with the supporting staff and the doctor is important to the exchange of information that is required to reach a correct diagnosis, and successful quality of care in the eyes of a patient will depend on all these factors. The doctor has to treat the patient in a caring and compassionate manner which induces empathy between the patient and the doctor.

The influence of private insurance schemes and health plans quite often works towards cost containment. Insurance agencies offer incentives to the
doctors to make this work to their advantage, and this is not beneficial to the patient. The patient can get disgruntled with the doctor for the restrictions imposed.

Continuity of care in an illness and its follow-up are also important to patients. How the services are organized to respond to patients’ needs and how support services like referral systems are arranged, are important at the first level of contact with a patient. How patient complaints and grievances are organized and the rights of patients are respected will also have a major influence on the patient’s response to the relationship. There could be a system of reconciliation bodies which will help, as also audit council and regulatory body for quality assurance. Patient’s feedback and gauging the satisfaction index is another mechanism for use. A patient’s charter would also help.

A favourable outcome of a healthy doctor–patient relationship is patient and doctor satisfaction, based on which a sense of trust is built in both individuals, which can result in a long-standing relationship and adherence to the doctor. This relationship will improve the knowledge of the patient about his health and medical care. A patient would feel more comfortable in an environment that enables him to freely communicate with the doctor. A patient-centred culture would be more sought by patients than a profit or a doctor-centred one. Therefore, both parties should work towards building a patient-centred care model that would be high in a positive doctor–patient relationship benefitting both parties in the long term. If possible, a social support system for the patient could be created.

5.4 Current status

There is not enough evidence available within the South-East Asia Region about the current status of this relationship. However, the general feeling is that, due to a variety of reasons, the doctor–patient relationship is currently under strain. Increasing specialization and over-dependence on technology and commercialization of the profession and the effects of private insurance associated with escalating costs of care are thought to be the underlying causes for this malady. It is felt that an increasing trend in medical litigation is also a concern among the medical profession, leading to the practice of defensive medicine which, in turn, affects the quality of care as well as the relationship between the physicians and the patients. Improving medical education with special emphasis on ethical aspects and soft skills in communication are considered important to reduce this effect.
5.5 Ways to strengthen the doctor–patient relationship

It is suggested that several approaches should be followed to improve the doctor–patient relationship and that this relationship should actually be considered an important element for strengthening the health system. Some of the approaches are listed below:

- teaching of ethics and medical etiquette in the undergraduate medical curricula;
- continuing medical education programme in ethics;
- enforcing an ethical code of conduct amongst all health workers;
- patient education and improvement.

In addition to these education-oriented mechanisms, some systems should also be changed or introduced. These include a shorter waiting time to see doctors, a possible referral system to enable doctors to spend some more time with the patients and providing information and help to the patients.

There are several organizations trying to improve the doctor–patient relationship and as far as possible, the efforts of these could be harmonized. These include medical councils, medical associations and professional bodies.

Patients have many expectations when they come to consult a doctor. They expect easy access to the doctor, quality up-to-date treatment, transparency, nondiscrimination and a certain amount of information. As far as possible, these expectations should be met.

Every effort should be made to promote a dialogue between doctors and patients and special platforms should be created to enable this to happen. Some of these could be forums for sharing of experiences and perspectives and grievance redressal meetings at the point of services.

A patients’ charter could be developed and disseminated widely. Unbiased information about medicines should be made available to the patients. The media should also be cultivated by having regular interaction with them so that damaging unjustified news harming the doctor’s position as an honest provider of care is not published.
One area of deterioration in the doctor–patient relationship is the nexus between doctors and pharmaceutical companies, which kindles a suspicion in the mind of the patient that he is paying more than he needs to. This relationship needs to be regulated not only by a code of conduct, but also by statutory measures.

It is expected that if the components of the strategic framework are implemented, there would be a marked improvement in the doctor–patient relationship, which would ensure quality health care for the patients and a sense of satisfaction in the patient.
Conclusion

This publication reflects the discussions and conclusions of a meeting of experts on doctor–patient relationship held at the WHO South-East Asia Regional Office in February 2011. The meeting was held at a time when there has been deterioration in this relationship. Some of the reasons for this deterioration could be traced to recent developments in commercialization and globalization. The different factors which contribute to the doctor–patient relationship have been discussed. Based on these discussions, a strategic framework for action has been developed to strengthen the doctor–patient relationship. Several recommendations have been made throughout this publication. If implemented, the recommendations would arrest the deterioration of the doctor–patient relationship and would help in providing better health care to the patients in a more empathic and humane manner.
References


The doctor–patient relationship is an important determinant of quality health care. Until not very long ago, it was common for people to regard doctors as members of their families and the trust reposed in them extended to matters even beyond the medical needs of the family. Anecdotal information, however, suggests that the relationship between doctors and patients is becoming strained. There could be several reasons for this. Certainly, one of the most important factors is the commercialization and specialization of the practice of medicine that places a heavy reliance on technology at the cost of a meaningful interaction between health-care seekers and providers at a human level. The pressing demands on the doctor’s time and the heavy dependence on technology for diagnostic and therapeutic practices has perhaps diluted the personal touch that is so necessary for a conducive doctor–patient relationship. In addition, the doctor–patient relationship is affected by a multitude of sociocultural, economic, political and health systems-related determinants. To discuss issues related to doctor–patient relationships, the WHO Regional Office for South-East Asia convened a meeting of representatives of medical councils and medical associations, medical teachers, policy-makers and legal and consumer rights experts in 2011. This meeting led to the emergence of a framework of action to strengthen doctor–patient relationships. This publication explores the various facets of the doctor–patient relationship and includes the framework of action that provides guidance about multisectoral actions that can contribute towards mutually beneficial relationships between doctors and patients.