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Difficulties in Building the Physician–Patient Relationship: the Physician’s Perspective

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Abstract

The necessity of empirical research in the field of medical services provision is highlighted both by the numerous modifications within the legislative framework (through which the medical system is organized and functions) and by the dysfunctionalities within its existence.

The study proposes to pinpoint the factors that may influence the quality of the physician–patient relationship. We identified factors at the level of communication between physician and patient, of empowering and involving the patient, of understanding the patient, of the patient’s way through the system, and of relating to a “second opinion.” We also present solutions identified by physicians for optimising these relations. The study is based on the analysis of 12 interviews conducted with physicians within public and private institutions in Iași. The topics of discussion focused on the following aspects: physician–patient relationship, physician’s trust in the patient, particularities of trust relationship, patient empowerment and involvement, level of patient’s information, “the second opinion,” physician’s experience as a patient (or as caregiver). The paper brings attention to the difficulties pinpointed by physicians, in their relation with both the institutions and the patients. The main aspects identified are related to the way in which the physician–patient relationship is

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shaped, to the difficulty of communicating the diagnosis (mainly determined by the way in which the patient understands the diagnosis and becomes involved in the treatment).

Keywords: *trust, communication, physician–patient relationship, patient’s empowerment, patient’s involvement, “a second opinion”.*

1.1. Design of the study. Method, sample, data collections instruments

Our research ranges within the spectrum of qualitative studies, considering that it involved the use of semi-structured interview. We chose this research technique because it was able to cover the aspects of the research, by providing information, from the perspective of physicians, regarding the types of relationships determined between physicians and patients, as well as between patients and the institutional setting, in the context on a long-term interaction due to chronic diseases.

The data collection period was November 2014 – March 2015. The interviews were conducted face to face, based on an appointment set between the interviewee and the researcher, in physicians’ offices. The duration of the interviews varied between 60 and 90 minutes. After signing the informed consent form, the interviews were recorded and then transcribed verbatim and submitted to a thematic analysis. The sampling is theoretical, because the selection criterion was for the physician to have mainly chronic patients. We interviewed 12 persons – general practitioners and specialists within both the public system and the private system (with contracts with CASS or working exclusively in the private field). From among them, 9 had contacts with the medical systems of other countries through training courses, scholarships or participation to studies. The mean age of the respondents is 36; four of them are general practitioners and eight are specialists. Their accumulated service (including the residency) ranges between 6 and 14 years. Four of the physicians work exclusively in the public system; three of them work both in the public system and in the private system, while five physicians work only in the private system.

The discussion topics focused on the following aspects: physician–patient relationship, the physician’s trust in the patient, particularities of trust relationship, patient empowerment and involvement, level of patient’s information, “the second opinion,” the

patient’s way through the system, physician’s experience as a patient (or as caregiver) in relation to the medical system.

1.2. Building of the physician–patient relationship

Honesty, communication, confidence, safety, and competence are most frequently correlated with trust. Trust is a fundamental component of the therapeutic relationship and it may be defined, in very simple words, as a patient’s expectation for the care provider to act in his/her interest.

A relationship based on positive experiences is a trust relationship that will determine the patient to remain involved in the therapeutic relationship and follow the physician’s recommendations (Thom, Ribisl, Stewart et al., 1999). If premises for a positive relationship are not met, scepticism and mistrust will dominate the relationship’ within such a mistrust climate, there are poor chances for any of the participants to discover the knowledge and expertise of the other. The decision of having trust depends largely on previous experiences and on the reputation of parties involved in this relationship (Zaner, 1991)

It has been showed to affect some of the most important behaviours and attitudes, including patients’ willingness to seek care, reveal very personal information, submit to treatment, participate in research, remain with a physician, and recommend the physician to other patients (Parsons, 1951; Rhodes, Strain, 2000). It was also shown to mediate clinical outcomes.

Trust may be related to a host of health system objectives: access to the system, healthy behaviours, continuity and quality of care, improvement of lifestyle, and monitoring of health status. Trust is associated with increased access to healthcare services and to their effective use (Russel, 2005), to satisfaction with and loyalty to the physician (Safran et al., 1998), to self-monitoring of the health status (Wang et al., 2007), to the patient’s desire of recommending the physician, to other persons, and to adherence to treatment (Hall, Zheng et al., 2001). The quality of interaction, the involvement in decision making regarding the treatment, the continuity of the treatment, and the implication in behavioural change are determined by the trust between patient and healthcare provider. Socio-demographic factors, access to the healthcare system, use of healthcare services, and negative experiences

with the medical system influence the type of patient – medical system relationship (Schwei, Kadunc, Nguyen, Jacobs, 2014)

The physician–patient relationship or what determines the patient to choose a certain physician.

Starting from the topics of discussion and from the interview analysis, we pinpointed the following factors that influence the quality of the medical act: aspects related to work conditions, aspects related to the relationships established within the system and reflected in the relationship with the colleagues, the relationship with the family physician, the relationship with other institutions and aspects that reflect the relationship with the patients (patient’s information level, patient’s involvement and awareness, patient’s path in the system, patient’s possibility of choosing the physician, type of services accessed and the possibility of requesting a second opinion).

The analysis of the physician–patient relationship concerns, first, the interhuman / interpersonal characteristics of the physician; secondly, the technical skills of the physician and the efficiency of treatments; thirdly, the location of the consult.

The first contact is critical. After a first contact, you decide whether you want to come to the physician again. The way he talks [is very important]. Secondly, the effectiveness of the medication he prescribed during the first consult and, why not, even the location of the consult? (I.6, 37, nuclear medicine, State clinic)

Generally, it is all about recommendations; people hear of a certain physician. Patients talk to one another; they hear things from each other. Patients – and I believe this is the most natural source of information – talk to each other, they hear certain opinions on the clinic or they saw a commercial; they try it out, they come to check it out. A good physician makes a good clinic; people will come back to him. (I2. Neurology, 36, specialist, public ambulatory)

Physician’s experience as a patient

When they become patients themselves, physicians stress the interhuman / interpersonal characteristics of the person who treats them, the relationship with the said physician and, not least, the way in which the consult unfolds. When they become patients, they are able to pinpoint those mechanisms that may make it easier to obtain treatment, to get a consult without appointment, or to skip the family physician. At the same time, physicians understand the difficulties encountered by

patients when trying to get treatment. These difficulties often have a financial nature.

I was a patient and I went to a private clinic. I did not go to the family physician... which was a mistake. I asked my colleague to do a consult. She examined me for nothing because, after I solved my problem, I failed to go to the family physician for a reference and to pay for her consult. I had a prescription and I carried it around, very troubled. Then another colleague gave me a part of the treatment, free of charge. Finally, I managed to buy the rest of the drugs from a pharmacy; they cost around 200 lei. However, had I been a regular patient and had I had a salary of 4-500 lei, how would I have been able to pay 200 lei on such short notice? I managed to do it because I benefitted from a rapid consult and I got help with the pills. These are my experiences as a patient. (I.5., 35, private system, Rheumatology)

I can talk from experience, because I was involved in a car accident a few years ago. In the ER, the physician told me what he could do to help me, but he also mentioned that, in a private clinic, I could benefit from much better interventions. The recovery would be better on short term (fewer days in the hospital) and on long term (much better recovery). However, it would have cost me 1,000 Euros. I did prefer the second option, naturally, for it involved better intervention. Consequently, if you can afford it, you do go to a private clinic, for you had an alternative. (I.4, Neurology, 29, private system)

Personally, as a patient..., I never choose a renowned professor, I prefer to use my own criteria; fortunately, I have my ways because I am in the system. This is one of the benefits of being part of the system. You choose a physician and, should you trust him, then you observe everything he says. (I.7, 34, family medicine, nuclear medicine, St Spiridon)

Communication with the patient and patient’s level of understanding

A very important aspect of the physician–patient relationship is communication. Physicians are aware of the difficulties that may arise within the process. The difficulties are due, on one side, to their incapability of adjusting their language, of making themselves understood; on the other, to the patient’s education level, to their incapacity of understanding specific terminology, as well as to the multitude of (informal) information available, (media, Internet, other patients) which patients access frequently.

The way you talk to them and deal with them matters; some may need for you tell them the diagnosis clearly, to detail the entire treatment; other may only need you to encourage them. (I.2, Neurology, 36, specialist, public ambulatory)

...there are patients clearly in a lot of pain; in such a situation, you feel responsible for their pain; or, there are patients who do not have a serious condition and who are more relaxed. Hence, I am more relaxed and we talk on a more personal note; I do not feel they are patients. (I.4, Neurology, 29, private system)

Patients understand if you explain it; they do search on the Internet, but only a few of them do that. In most cases, you have to explain in their own terms. In school you learn to speak scientifically, in specialized terms, (you cannot say a patient has a headache during an exam!). However, once you are done with school and you face the patient, you cannot keep the same level. On the contrary, you have to speak as plainly as possible and, ironically, you can only think of scientific terms. We should have an informal language course, to learn the popular equivalents of scientific words. It is very necessary to have special time allotted for explanations, because the patient had to understand the disease and the treatment; he has to be part of the treatment... (I.4, Neurology, 29, private system)

Communication is a critical part of the therapeutic process, but it also requires time and resources. Busy schedules, short duration of consults, and bureaucracy, prevent the optimal unfolding of this process.

If you want to make people understand you... it takes time... I honestly don't know how much more time I can invest and how longer I can be patient. If I add up the time for every month... I think I get to six months. After six months, I feel that the patient finally knows something about his disease. (I.5, 35, private system, Rheumatology)

Patient's involvement and empowerment

Though they admit the need to involve and empower the patient concerning the disease, treatment, and lifestyle, physicians usually make the decisions.

A patient must listen to the physician... for he is the patient, not the physician. Generally, he has to pinpoint and to communicate to the physician his symptoms, but that is kind of all. From my point of view, the patient can share his opinion on the matter, but he should always listen to the physician... by no means should he be part of [decision making] per se. (I.6, 37, nuclear medicine, public system)

I don't agree with recommendations such as... a pink pill in the morning, a yellow pill at lunch.... Each patient should know the name of the said pill. If you don't know the name of the pill, then you are not interested in your own disease. It all comes down to the type of the patient. Some of them are very self-conscientious; all their documents are valid, they know their disease very well; however, there are patients who do not seem to understand you not even after 100 conversations. It does depend very much on their level of understanding... and of interest... of interest regarding their own fate. Some of them may understand, but they may simply not be interested. (I.7, 34, family medicine, nuclear medicine, St Spiridon)

Some of the patients – especially vulnerable groups, such as patients with severe conditions – cannot or do not wish to be in charge of their own health, but they prefer to leave it all to physicians.

...I am trying to get patients involved in the therapeutic process as much as possible, and I consider all physicians should do this, regardless of their specialty; they should explain very clearly the options available for each patient and they should involve them in the decision making. After all, it is a treatment, and the patient should participate actively in the decision-making process. There are patients who come full of ideas already; they read about the disease, they have access to data; there are also patients who just come... and say, 'doctor, just give me what you think is best.' Even if I try to guide them towards a decision, that decision will still have to be taken by me. (I.1, 36, private system, Psychiatry)

Patient's involvement and empowerment depend largely on their social, educational, professional status. Age, environment, relationship with caregivers are elements to consider when determining a treatment plan.

I present to them the guide and, at the same time, the adverse effects and how to take the medicine. I have to adjust to each patient. If the patient is young and he travels all day, he cannot take the medication in the morning, at lunch, and in the evening (he will forget to take some of them), mostly if it is a long-term treatment. Older patients are generally more consistent; if they have a problem, they call me. (I.5, 35, private system, Rheumatology)

You can feel the patient. You feel if he wants to investigate, to look up more details about the disease. You cannot simply prescribe him something without even telling him the name of the drugs. You write a prescription, but then you explain it to the patient, you tell him how many and when to take them, you try to understand his daily routine. You have to ask if he lives alone, if there is someone to do the injections, if someone else takes care of him. The professional activity of the patient is also essential. If his job requires him to have safe and steady moves, then you have to adjust the treatment, though adverse effects may emerge later. (I.4, Neurology, 29, private system)

Because patients are not considered able to understand properly the medical information, they are left with no choice but to trust the physician's professional competence (Katz, 1984: 87; Lupu, Rădoi, Cojocaru, 2014). The vulnerability entailed by the disease determines the patients to trust the physician beforehand. Even when physicians want to empower the patients in the decision-making process, they invoke their lack of medical knowledge, their inability to understand, their subjectivity or even their lack of interest. Finally, they are the ones who make all the decisions.

I have to admit, they seriously lack basic knowledge... few patients have medical notions; you cannot ask for too much, it is true, but they should have basic medical knowledge; they should be taught in school, actually. They are multiple information sources, which is both good and bad: it is good because people know they have to respect certain indications and recommendations. (I.2, Neurology, 36, specialist, public ambulatory)

My opinion is that most patients are misinformed. They are not aware of their rights and obligations and they see the physician as some sort of god, which is really bad. They do not know the name of the pills prescribed; they fail to grasp the importance of certain behaviour. This generates useless resource consumption, because every little thing they do wrong makes their state worse, which means they will end up back in the hospital eventually. (I.7, 34, family medicine, nuclear medicine, St Spiridon)

In terms of chronic disease, which entails long-term treatment and long-term improvement of health status, the role of the physician–patient relationship becomes crucial. This relationship must be based on trust.

All these drugs changing the disease... people must understand that pills do not work immediately. I have to tell patients that they must take them for two months, though they may not feel any effect. After two months, they begin to work and, by the third month, their effect reaches the peak. Hence, I must be very careful. I have to tell them to keep taking the meds though they may not see any difference in their lives, which is not easy. (I.5, 35, private system, Rheumatology)

Trust in the physician–patient relationship

The creation, development, and maintenance of trust are fundamental objectives for the fields of medical ethics, (Pellegrino, Thomasma, 1993) for healthcare legislations, and for public health policies (Cojocaru, Sandu, Oprea, Gavrilovici, 2013; Cojocaru, 2012).

A patient’s trust in his physician is based – according to physicians – on their availability, compassion, empathy, and openness. The capacity of listening to the patient’s opinion is essential for building a trust-based relationship. While when referring / recommending other physicians / colleagues to a patients, they choose by technical skills; however, when they become patients or caregivers themselves, they choose the physician based on interpersonal skills. The same type of skill is invoked when describing the relationship with their patients. At the same time, physicians admit the patient’s vulnerability entailed by the disease; precisely this vulnerability forces a patient to trust a physician.

I find it a strong point that a patient chooses to see me when he could just stand up and walk away theoretically, for nobody forces him to stay. A patient does not choose a physician if he suspects that the physician is not OK... He chooses him because he trusts him, not because he is out of options. There are issues when it comes to the technique of certain physicians, but they are not that relevant. People come to the physician persuaded that he knows what he is doing and that he wants their best. Usually, you have to go to the physician, reason for which you have to trust him. (I.6, 37, nuclear medicine, State clinic)

...in time, a genuine trust-based relationship is shaped between the physician and the patient. These are relationships between two people; this means they can be particular, special relationships. Therefore, yes, there are patients who come back and tell me they are much better; there are patients who come to ask for my opinion on matter outside my specialty. I actually have lots of those. This is a special situation, for work in psychiatry; I have more time for patients than physicians within other specialties. The type of intervention is longer than in other specialties; hence,

interhuman relationships become much closer and they develop beautifully. (I.1, 36, private system, Psychiatry)

When a patient comes to a physician, he puts his life in his hands and he trusts that the physician will act in his best health interests and that he will not take advantage of his disease-related vulnerability. Therefore, the patient believes hopes for the physician not to abuse his professional power and to actually act in his best interest. When the patient is not sure, when he does not know the evolution of the relationship, he will try to get hold of it. He will try to “buy off” the physician, thus trying to be on the same power position.

When a patient offers anything to the physician, (a gift in cash or in kind) trust is out of the scheme. If a patient pays or tries to pay for the physician’s trust, he does it precisely because he is not sure of it. (I.1, 36, private system, Psychiatry)

Trust is.... what makes a person go to the hospital hoping to find at least a part of the answers to questions regarding his health status. The patient wants to find somebody in whom to confide his problems. A patient does not feel important or understood if a physician does not give him enough time and if he talks to him on a certain tone; or if the medical professionals try to minimize his pain. (I.2, Neurology, 36, specialist, public ambulatory)

Physicians consider that the patient’s degree of satisfaction toward the services received is an indicator of trust, along with keeping the contact after the finalization of the treatment.

What make me believe they trust me?... If they say ‘thank you’ at the end of a consult and if their expression and nonverbal attitude show they are satisfied and they understood the problem they came for. As my mentor told me, you can feel a patient’s satisfaction in the air; you can always feel it. (I.4, Neurology, 29, private system)

Physician–patient relationship. A second opinion

In specialized studies, “a second opinion” is an indicator of an uncertain relationship and of a lack of trust. In our study, physicians do not believe such behaviour is negative; on the contrary, they consider it is almost a natural element of the health care process. The patient must be sure of his diagnosis and he must find the right physician for him.

A patient wanting a second opinion has never bothered me. I have often advised my patients to ask for a second opinion, (from people who have better insight)

to keep searching, to continue their investigations. Maybe I was not always able to provide all information; for this reason, I advised patients to go and see someone else, too. (I.2, Neurology, 36, specialist, public ambulatory)

This is good, actually, in a way ..., because they are more aware of their own disease; if several physicians tell them the same thing, they have to deal with it because they have no choice left. Some patients go and see several physicians, and then they come back to me. If they liked you, they will come back. If you are nice to them, if the treatment works, if they are fair play, they will come back. At the beginning, I got angry and I did not react well... I could not find my place on the chair, I was very angry, but I had to be nice, to refrain myself. I became persuaded that it is a good thing and that we should not prevent them from seeing other physicians; it is their health at stake, so they have the right to see whomever they want. After all, they are the ones swallowing the pills, not us; they are the ones traumatised by regular lab works, not us, so it is their right. (I.5, 35, private system, Rheumatology)

From the physicians’ perspective, patients ask for a second opinion especially upon receiving a serious, long-term incapacitating diagnosis, (they want to see another specialist because they have to be sure about the diagnosis) or if they are not satisfied by the relationship with their physician.

Because they do not trust him, because they received a certain diagnosis... or maybe because they did not like the physician (this really matters a lot)... If the patient feels that the diagnosis alters the rest of his life, he wants to ‘sweeten’ it somehow. There is a great difference between a physician who communicates the diagnosis in a cold tone and a physician who gives some hope, who says things may get better. Things are never simply black or white. (I.2, Neurology, 36, specialist, public ambulatory)

As a patient, you still have options. If you are interested in your health status, I believe you do have the possibility to ask for a second opinion if you are not satisfied with the first one, and to look for the right physician for you, whom you can trust. (I.7, 34, family medicine, nuclear medicine, St Spiridon)

1.3 Conclusions

Besides interpersonal skills, physicians’ technical skills are acknowledged as a factor that determines high levels of trust (Goold, Klipp, 2002), and keeping the same physician on a long-term basis may reflect a high level of trust (Kao, Green, Davis et al, 1998; Baker et al., 2003). The physicians’ behaviour and personality, interpersonal skills, and communication manners seem to be fundamental for building trust.

As for situational factors, the frequency of visits to the doctor is not a predictor of trust. Studies found that trust in the physician is often correlated with adherence to treatment (Zheng, Hall, Dugan, Kidd, Levine, 2002), with not changing the physician, not asking for a second opinion, recommended the physician to other patients, few disagreements with the physician, treatment effectiveness, and patient's self-management of health status. From the perspective of medical personnel (Rădoi, Lupu, 2014), a problem may be their ability of adapting communication and involvement depending on the style of each patient. For the care of patients with chronic disease, studies showed (Sandu, Cojocaru, Gavrilovici, Oprea, 2013) that an important factor – that provides the expected answer – is the trust relationship with the physician and the medical system.

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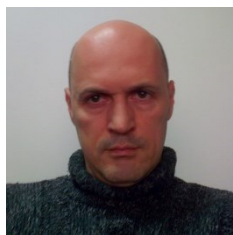
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