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Perspective

Exploring the dimensions of doctor-patient relationship in clinical practice in hospital settings

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Abstract

The Doctor-Patient Relationship (DPR) is a complex concept in the medical sociology in which patients voluntarily approach a doctor and thus become a part of a contract in which they tends to abide with the doctor's guidance. Globally, the DPR has changed drastically over the years owing to the commercialization and privatization of the health sector. Furthermore, the dynamics of the DPR has shown a significant change because of the formulation of consumer protection acts; clauses for professional misconduct and criminal negligence; establishment of patient forums and organizations; massive expansion of the mass media sector leading to increase in health awareness among people; and changes in the status of the doctors. Realizing the importance of DPR in the final outcome and quality of life of the patient, multiple measures have been suggested to make a correct diagnosis and enhance healing. To conclude, good DPR is the crucial determinant for a better clinical outcome and satisfaction with the patients, irrespective of the socio-cultural determinants.

Keywords: Doctor, Doctor-Patient Relationship (DPR), Communication, Hospital

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Background

The Doctor-Patient Relationship (DPR) is a complex concept in the medical sociology in which patients voluntarily approach a doctor and thus become a part of a contract in which they tend to abide with the doctor's guidance (1,2). It has been proposed that an ideal DPR has six components, namely voluntary choice, doctor's competence, good communication, empathy by the doctors, continuity, and no conflict of interest (3). In fact, a poor DPR has been proved to be a major obstacle for both doctors and patients, and has eventually affected the quality of healthcare and ability of the patients to cope with their illness. Owing to poor DPR, patients does not show compliance with doctor advice completely; opt for doctor-shopping by changing their doctor repeatedly; remain anxious; may choose quacks or other non-scientific forms of treatment; significant increase in direct and indirect medical expenses. Because of recurrent change in line of treatment as per the advice of different doctors and non-completion of the entire course of drugs, there is a definite scope for the emergence of antimicrobial resistance, which further compounds the medical cost and anxiety, and finally may develop serious forms of disease or complications (4–6). From the doctors' perspective, they may ask for unnecessary investigations or may give over-prescriptions, just to be safe. There is also observed a remarkable decline in human touch or empathy; and a significant rise in unhealthy competition among doctors (3,7).

Changes in the Doctor-Patient Relationship

The DPR has changed dramatically over the years owing to the commercialization, quality of healthcare services offered in government set-up, sense of community ownership among members of the society, poor sensitization of health workers regarding important local issues, and privatization of the health sector, especially in developing countries (8). However, it has been recommended that irrespective of the continuing reforms in the health services, the patient should always remain the principal focus in the medical care arena (9). Considering the technological superiority and skilled nature of their job, the doctor tends to exercise an authoritative role, which may lead to conflicts if the patient is not willing to accept the same (1). It has been revealed that even doctors and patients that are from the same socio-cultural milieu have variable views pertaining to ill-health (6). Furthermore, the dynamics of the DPR has shown a significant change because of the formulation of consumer protection acts; clauses for professional misconduct and criminal negligence; establishment of patient forums and organizations; expansion of the mass media sector leading to increase in health awareness among people; and changes in the status of the doctors (10,11). In addition, factors like socio-cultural determinants (6), poor communication skills of the doctors (12–14), use of medical terms by the clinicians (15), doctors not listening to the complaints of patients (16,17), and a mismatch between the doctors' objectives and patients expectations for the doctor (18), have together created a wide gap in the DPR. All these factors have caused a massive impact on the trust level and the bonding pattern between the clinician and their patients (6,8,19).

Doctor-Patient Relationship: Scope & recent developments

The nature of the DPR has been studied in different clinical and socially sensitive conditions like breast cancer (20); people living with HIV/AIDS (21); and patients with chronic hepatitis-B virus infections (18); to gain an insight into the patient's expectations from the clinicians during the course of their treatment. Even now, especially for chronic lifestyle related disorders, most of the patients still prefer a long-term relationship with their treating physician, as the doctor is well aware of the entire history and reports and the patient being

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acclimatized to the familiar surroundings (22,23). A range of new initiatives has been proposed across the world to improve the DPR, such as use of placebos (24); the emergence of tele-health video consultations, especially for patients with chronic diseases, which requires significant amount of self-care at home (25–27); adoption of psychological models (2); and indirect measures like involving physicians in fund raising initiatives (28). In addition, it has been recommended that the DPR must be widened to a new type of relationship, in which several doctors are treating the same patient as a team (29).

Suggested measures to improve the Doctor-Patient Relationship

Realizing the importance of DPR in the final outcome and quality of life of the patient, multiple measures such as training sessions on communication skills for the doctors (12), sensitizing clinicians to respond to patients emotional cues, encouraging doctors to communicate without/with minimal use of medical terminologies (15), facilitating feedback from the patients after consultation, accelerating the empowerment of the patients (30), teaching DPR skills during undergraduate medical curriculum (31,32), reverting back to the traditional culture to negate the socio-cultural determinants (8), promoting listening by the doctors (16,17), involving family members (20,21), and enabling adoption of newer approach (2,27) have been proposed to make a correct diagnosis, enhance healing, and boost the DPR. In closing, good DPR is the crucial factor to ensure a better clinical outcome and satisfaction with the patients, irrespective of the socio-cultural determinants.

Ethical issues

Not applicable

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

SS prepared the proposal and drafted the manuscript. PS performed review of literature and revised the manuscript critically for intellectual content. JR supervised the research process and provided overall guidance in the writing of the manuscript.

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