

7 The doctor patient relationship

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Doctor patient relationship
Sexual relations
Financial matters
Advertising
Terminally ill patients
Second opinions
Ending a relationship

Effective doctor patient relationships improve health. Respect, confidentiality, honesty, communication and trust are important in this relationship. Cultural differences can affect the relationship. Sexual relations between a doctor and patient are unacceptable. Financial matters need to be clear and not used to take advantage of any patient or organisation. Second opinions can be useful. Terminating a doctor patient relationship may be necessary but must be done with care.

Doctor patient relationship

The doctor patient relationship is the core of clinical medicine. The doctor must have knowledge and skills to practise medicine safely, but the relationship he or she has with each patient will also affect outcomes. An effective relationship will help the patient feel better and be healthier,^{1,2} and will usually result in improved job satisfaction for the doctor.

What makes a good relationship will vary in different situations. Personality type, culture, illness and stage of life affect the interaction. A doctor's training and what a patient is used to can influence the expectations each has of the relationship. Some doctors have been trained to deal with illness whereas current emphasis is on patient centred care.

The essential ingredients of a good doctor patient relationship are communication, respect, confidentiality, professional honesty and trust. Both the doctor and the patient contribute to them but it is the responsibility of the doctor to ensure they are present because he or she is the professional whose diagnosis, treatment or advice is being sought and paid for.

The Health and Disability Commissioner's Code of Rights³ (see chapter 23) includes ten rights, from the right to be treated with respect through to a right to complain. Some groups of doctors have circulated a corresponding list of rights

for doctors. A good doctor patient relationship will balance the rights and responsibilities of doctor and patient.

Communication has always been important in doctor patient relationships but is becoming increasingly so. Patients today are considered health consumers and want to be active participants in decisions about their health.⁴ Effective communication is named as one of ten rights of consumers of health and disability services in New Zealand.³

Doctors who educate patients about what to expect, encourage patients to talk, check understanding, laugh and use humour tend to have less formal complaints than those who do not do these things.⁵ The average time these doctors spend with a patient is longer than those who have a less participatory style.

Sometimes communication is frustrating. Communication between people with different languages or expectations can be difficult, and with someone who is confused or unconscious it may be impossible. It is important to get help if communication seems a problem. A translator, friend or relative may facilitate understanding. Sometimes a nurse who understands the medical side of things can communicate this to a patient better than the doctor.

In cases where the poor communication results from serious illness or injury, decisions may need to involve consultation with relatives of the patient, or with colleagues. Care should be taken that the relatives involved in these decisions are immediate next of kin or holders of enduring power of attorney in the case of adults, and for children, their legal guardians. If the patient is conscious the wise doctor will seek permission to discuss matters with a relative and should establish with the patient which relative is preferred.

Respect is necessary in an effective doctor patient relationship. Doctors working in New Zealand will meet patients who have different values and priorities from their own. It is the doctor's responsibility to make sure the patient is treated with respect regardless of the patient's attitude and background.³ "You must not allow your views about a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social status or perceived economic worth to prejudice the treatment you provide or arrange. An awareness of cultural factors enhances medical practice in New Zealand, with its mixed ethnicity and policies of biculturalism."⁶

Cultural competence is the ability to communicate effectively and respectfully with people of other cultures. It is becoming increasingly important.

Confidentiality and privacy follow when a doctor respects patients. The doctor is responsible for keeping the patient's information confidential unless there is a serious or imminent danger in doing so.

Professional honesty is about the doctor knowing the limits of his or her own competence and when to refer to someone else for help. There is nothing shameful about not knowing the solution to a medical problem. It is dangerous to fake competence or pretend to know things.

A recent statement by the Medical Council, *Disclosure of harm*, acknowledges that all medical treatment carries risk and encourages doctors to disclose where a patient has been harmed as the result of their medical care. The Council quotes research that indicates a patient is more likely to complain if a doctor fails to disclose harm to the patient, or if the disclosure is not done in an open and honest manner.⁷

Trust is essential between a doctor and patient. A patient who needs to reveal him or herself intimately physically and emotionally to a doctor feels vulnerable. Doctors need to feel safe too. The best protection for both is healthy professional boundaries.

Ways of maintaining professional boundaries include

- asking only relevant personal details when taking a medical history;
- explaining sensitive examinations or treatment before carrying them out;
- keeping discussions and records confidential;
- providing privacy with screens for undressing, draping or dressing;
- checking if the patient wants a chaperone present or support person, and sometimes asking the patient to allow someone at the doctor's request;
- avoiding words, actions or jokes that are sexually demeaning or are embarrassing;
- the doctor keeping his or her own personal problems private.

Signs the professional relationship may be running into danger include

- arranging nonurgent appointment at odd hours;
- arranging to meet outside work times and places;
- telling patient intimate details of his/her life — especially personal crises, sexual desires or practices.

Sexual relations

Sexual relations between a doctor and a current patient are unacceptable. The Medical Council has produced a booklet to help explain what is considered a breach of sexual boundaries.⁸

As a doctor, if you think your behaviour or feelings towards a patient are becoming overly familiar or improper, discuss this with a trusted friend or colleague. You will need help to re-establish professional boundaries or you may be advised to help the patient find another doctor.

Financial matters

In general the patient pays a fee for the service they receive from a doctor. In some circumstances another person or institution pays for or subsidises this service. In general these agencies are entitled to check the doctor patient interaction took place, and have access to information which has been depersonalised for statistics, but they are not entitled to know personal health details.

Some people have medical insurance which enables them to claim back part or all of their treatment costs. Similarly the insurance company is entitled to ask for

proof the consultation or treatment took place (usually by seeing the receipt). Sometimes the medical insurance company pays the doctor directly for the service.

When doctors charge an organisation for a service provided to a patient there is an ethical obligation not to charge a higher price than they normally charge the patient directly, although when a doctor significantly discounts fees to a patient, that discount need not be applied to the fee for an organisation.

In other situations insurance companies or employers pay doctors to examine patients and give the company the information. It is important that patients give consent for this to happen and there is appropriate documentation of this consent.

Sometimes a family member pays for a child, parent or spouse to see the doctor and then feels they are entitled to information about the consultation. Who is going to have access to information from the doctor patient interaction should be sorted out before the interaction if possible. If it is requested after the event the patient's consent must be sought and gained before information is released to the other party. This may happen with family members, employers, insurance companies and the police.

When ACC pays for the consultation it has a form which requests enough information to determine whether it should pay for the services. If this is not signed it will not pay.

Advertising

Advertising is increasing in medical and health services. Doctors will differ in what level of advertising they feel comfortable with, but advertisements should be relevant, accurate and comply with the Fair Trading Act and with Advertising Standards Complaints Authority guidelines.

The *Code of Ethics*⁹ (chapter 19) and *Good medical practice*⁶ (chapter 1) recommend doctors provide information about their services in a way that does not put pressure on people to use their services; nor should they use comparisons with services provided by colleagues.

Terminally ill patients

The care of terminally ill patients requires good doctor patient relationships. Communication and teamwork are crucial when extended family or whānau and other health professionals are involved in a patient's care.

Continuity of care is important in these situations. Doctors who are part of shared after hours services may make different arrangements for terminally ill patients to minimise disruption to their care.

Some doctors reduce their charges for terminally ill patients and some patients have access to different subsidies. It is often difficult to discuss financial arrangements with terminally ill patients and their families but it is important the patient is informed about what costs they are likely to encounter. When care is more concerned with comfort and quality of life rather than length of life it is called palliative care. In New Zealand hospices specialise in this.

Hospices are for all terminally ill people in need irrespective of their religion, race, age or ability to pay. While most patients have cancer, patients with other terminal illnesses, like motor neurone disease, organ failure or HIV/AIDS also receive care.

Hospices can provide effective physical symptom management, including pain control. In an inpatient unit patients are admitted for a few days or weeks for specialist care. This may be for

- Symptom control—for better control of pain, nausea or vomiting
- Respite care—short term care to give carers a break
- Terminal care—for patients who are in the final stages of their illness
- In a hospital—mainly for symptom control and pain relief.

Thirty seven hospices come under Hospice New Zealand’s umbrella. To find out about the hospice in your area visit www.hospice.org.nz or phone 04 499 0266.

Ethical issues surrounding the care of terminally ill patients can be confusing. There is public debate about euthanasia which is not legal nor supported by medical authorities in New Zealand. It is advisable to remain informed about this debate. If a doctor is feeling pressured by a patient or family he/she should seek advice or support from colleagues.

People make requests of friends, family or doctors not to resuscitate them actively in certain situations. The decision to say a person is “not for resuscitation” (NFR) can change as the clinical condition of the patient changes. It is important to decide what the patient would want in the given circumstances. “Living wills” and “Advance directives” can help guide clinicians in their decisions but do not necessarily anticipate the problems which actually arise. Advance directives have legal standing in the Code of Health and Disability Services Consumer’s Rights.³

Second opinions

A second opinion should be arranged when a patient asks for one. Helping the patient get the second opinion may improve the relationship, and create an opportunity to learn from a colleague. Patients sometimes find it difficult to ask for a second opinion so any indication of their wanting this should be taken seriously.

If the patient wants to see someone whose views the doctor does not agree with this can put the doctor in a difficult position. Discussing the referral tactfully, asking why the patient would like to see that other health professional without being judgmental is hard but important. The doctor may need to say he or she has different views. However, if the patient wants to get an opinion from the other person they are entitled to do so.

A patient should be referred for a second opinion when the doctor is outside the limits of his or her competence, or is not happy with what is going on. It can be hard to explain to patients they would be better seeing someone else for a certain problem. If the patient will not agree to see another doctor, permission should be sought to discuss the case with colleagues.

Ending a relationship

The doctor patient relationship can be terminated by a patient who is moving to another place or who wishes to see another doctor. A doctor may decide to discontinue seeing a patient only when there is a breakdown in the patient doctor relationship such that the doctor is rendered incompetent to treat the patient.¹⁰ In such cases the doctor should usually tell the patient why the relationship is being terminated.¹¹

Termination of the relationship may be done providing the patient is not acutely in need of immediate care and has been given enough notice to find another doctor.

In situations where there is any possibility of a complaint from the patient it is wise for the doctor to seek advice from his or her defence organisation before ending the relationship. In these circumstances the doctor should make a clear note in the file.¹¹

It is prudent for the doctor to help the patient find a new doctor and transfer the records either directly or via the patient, whichever is requested by the patient or is most appropriate. If doctors want to keep original notes of their own, copies must be provided for the patient or new doctor at no cost.

If after the relationship has ended the patient should call on the doctor for help in an emergency the doctor is still obliged to attend.

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