

CHAPTER 3

The doctor patient relationship

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The doctor patient relationship is central to the practice of medicine and to achieving effective clinical outcomes. While it has also been considered as the seventh element of quality in general practice settings, all practitioners can derive a deep sense of satisfaction through good doctor patient relationships.¹ Many relationship skills can be learned through role modelling, but specific educational interventions are required for higher levels of competence.² Clinical relationships need to be understood and developed effectively, as they can also be a source of great discomfort and even harm to both patients and doctors.

This chapter outlines the underlying principles of the doctor patient relationship, and how listening is essential to good medical care. We will then discuss two approaches to clinical practice called patient centred clinical method and whole person care. Reflection on practice is essential if relationship skills are to be improved. Finally, we will discuss more challenging interactions, including how to end the doctor patient relationship.

Qualities of an effective doctor patient relationship

Professionalism is the basis of medicine's relationship to society and can be viewed as a social contract.³ As part of this contract, doctors have an obligation to maintain their competence.

In addition, doctors are expected to be trustworthy, moral, honest, accountable, and compassionate. They need to work in the best interest of the patient while preserving their confidence.

Although the clinical context is rapidly changing, what patients want from their doctor is clear — caring, kindness, courtesy and compassion.⁴ General practitioners also focus on a “holding relationship” which maintains a trusting, constant and reliable relationship with ongoing support, often without the expectation of a cure.⁵

Doctors will interact with patients from a wide range of ethnic, cultural, social, and economic backgrounds. Patients may have lifestyles which include different underlying values to the doctor's own; it is essential that respect for all patients and whanau is upheld. This is also mandated in New Zealand's Code of Health and Disability Services Consumers' Rights.

Confidentiality can only be broken in extreme cases of imminent harm to the patient or others. It is the doctor's responsibility at all times, and through the systems that they work in, to maintain confidentiality and privacy of all patient information.

Trust is an important quality in the therapeutic relationship, yet it is often not explicitly negotiated with the patient. Patients may be quite vulnerable when they are making a decision to trust their doctor, sometimes within only a brief interaction. Trust can be developed and deepened if doctors show an early interest in the patient, display sensitivity to patient emotion, give time, build alliances and for short periods of time step outside their prescribed role (for example using shared humour).⁶ Doctors who encourage patients to talk, check understanding, provide information, and use humour are less likely to receive complaints.⁷ At the heart of each relationship is effective and culturally competent communication. Listening is a key ingredient.

The importance of listening

Many older doctors in clinical practice have developed their own style of consulting over time, largely through trial and error. While many have an effective bedside manner, the research on consulting skills indicates that good communication can be taught and learned and that it is not necessarily an innate or intuitive skill.⁸ For these reasons, most medical schools now include consultation training as part of their clinical skills programmes. Students are taught about the structure of each consultation and how to use “microcommunication skills” (introductions, open and closed questions, exploring the patient’s ideas, minisummaries, and so on).⁹ The outcome of this training is better listening, which in turn, improves the doctor patient relationship.

The three major functions of listening are to help make an accurate diagnosis, to develop and maintain the doctor patient relationship, and to act as a healing and therapeutic agent.¹⁰ Adler for example, has researched the “sociophysiology of caring”, where empathic listening can cause physiological changes in muscle tension and blood pressure.¹¹ It can be profoundly helpful if the doctor is fully present and engages with the patient’s story and situation. “Being heard” in this way can help the patient make better sense of their illness. These undergraduate training programmes are usually embedded in what is known as a “patient centred” approach to clinical practice.

Patient centred clinical medicine

The underlying knowledge basis of modern practice is known as biomedicine, a relatively new approach to individual illness that emerged in the sixteenth and seventeenth centuries. This particular medical model has of course, been very powerful, affording an advanced understanding of the problems of the human body. In the last 50 or so years, there is also increasing evidence that communication skills in each consultation will improve the health outcomes of patients.¹² Such evidence is the rationale for emerging models of clinical practice such as the patient centred clinical method.¹³

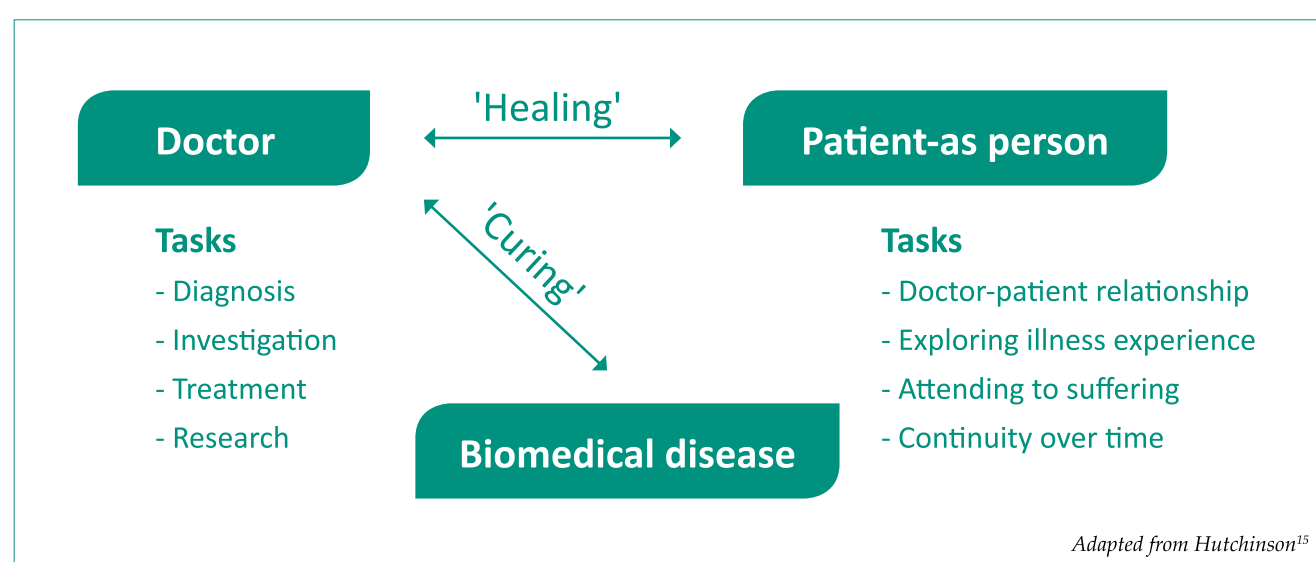
This clinical model differentiates between the “disease” (symptoms, pathophysiology, diagnosis, investigations, and treatment) and the “illness” (the patient’s ideas, feelings, effect on daily life, the meaning of being unwell, any anguish or suffering), or in other words, the personal experience of illness.¹⁴ While the patient’s disease is never really “separate” to that person, this conceptual differentiation is useful as it affords some objectivity for both doctor and patient. The doctor has a body of knowledge about each disease that usually helps to predict the clinical course. The patient’s concerns are validated and justified as he or she has a legitimate problem.

In the patient centred clinical method, doctors weave between the disease and the illness in each consultation, attending to relevant disease details while also eliciting the patient’s concerns and illness experience. This approach leads to a better negotiation of the outcome of the consultation where the patient’s ideas and expectations often impact on decision making. Being patient centred does not imply giving patients what they want; instead, the name emerged as a reaction against older more paternalistic styles of biomedical practice where doctors made unilateral decisions. The patient centred model of consulting has been very influential, even if most senior doctors have not been explicitly trained in its use.

Whole person care

The whole person care model further explores the implications of being patient centred.¹⁵ Hutchinson has usefully noted that the doctor really has two relationships to consider: his knowledge and skills in relation to disease (the details or “content” of medical work); and the doctor patient relationship (Figure 1). Each relationship has a different set of characteristics requires a specific approach. The goal with the former is cure, or at least modification of the disease process. The goal with the latter is modification of the illness experience through relief of suffering, professional guidance, support and long term care. The goal of this interpersonal relationship is to help the patient gain greater tolerance and equanimity in the face of disease.

Figure 1. The two relationships and tasks in medical practice



When the doctor and patient focus on cure of acute illness, the patient’s goal is usually to regain full function. In chronic disease however, disease is never fully cured. It is even more important here for the doctor to attend to the illness experience and any potential suffering caused by disease. A caring, long term relationship is required where the doctor stands alongside and supports the patient. Identifying and attending to suffering is crucial for many patients.¹⁶

The whole person care model is a helpful reminder to the medical profession of the two main tasks of doctoring: identifying and managing disease on the one hand, and attending to the person of the patient on the other. This is the essence of the doctor patient relationship.¹⁷

Monitoring your consultation style

Another feature of modern undergraduate medical training is the emphasis on careful review of clinical work. Reflection involves “thoughtfully considering one’s own experiences in applying knowledge to clinical practice, while being coached by professionals in the discipline.”¹⁸ Most medical students are now required to analyse and review their consulting skills as well as to write about or discuss their seminal learning experiences. These activities are known as “reflection on action”, as they usually occur after the event. The overall goal is “reflection in action”, the capacity for increased awareness of the ebb and flow in each consultation, whether in hospital practice or in primary care.

Modern methods of reflection include peer groups, video analysis, Balint groups, mentoring and supervision. Peer groups have been well developed in New Zealand and are included as part of general practitioners' requirements for recertification. These groups started in the 1980s and are self run by small groups of doctors who meet regularly to discuss their clinical work.

Video analysis of a series of consultations is now required by general practice trainees. Many report that such analysis has enabled a better understanding of their own style of consulting. Balint groups emerged in the United Kingdom in the 1950s when Dr Michael Balint ran general practitioner groups to discuss their more "difficult" or troubling patients.¹⁹ Some medical schools in Europe now use these groups in undergraduate training. The method itself has since evolved considerably and Balint groups are now becoming more popular, especially using multidisciplinary groups.²⁰

Mentoring and supervision are one to one methods of clinical review and support. Mentoring is usually with a more senior colleague who can help a junior enter their chosen field, provide support when doctors are under stress, or help a doctor start work in a new country.²¹ Supervision is usually with a psychotherapist and is more focused on the nuances of the doctor patient relationship. Because the therapist does not have medical training, there is less chance of becoming side tracked by biomedical details. Doctors can also improve their psychological understanding of patients through this ongoing method of professional support.²² All these methods are aimed at better understanding of the quite diverse doctor patient relationships in modern clinical practice.

Challenging situations

These methods of reflective practice are useful when clinical situations or particular patients are challenging to the doctor. There is an interesting literature from the UK on the "heartsink" patient, where the doctor's heart "sinks" to floor when consulting with or even thinking about a particular patient.²³ Most doctors will admit to having several such patients, where they feel quite challenged or even inadequate. While a few patients will prove problematic for almost all doctors, most patients who are labelled in this way are simply illustrating specific problems in the doctor patient relationship. Identifying and analysing why each patient is "difficult" can be extraordinarily helpful, both for the doctor and for the patient.²⁴

Some patients however, are problematic for many doctors.²⁵ "Challenging" patients tend to confront the doctor's assumed authority, while "clinging" patients make unrealistic demands on the doctor's time or potential effectiveness. "self destructive" patients include those with alcohol, drug and gambling problems. Many doctors find it difficult to acknowledge that they are relatively powerless to intervene. Cultural barriers or other factors preventing adequate communication can also induce feelings of frustration and impotence. All these patients can be troublesome because they don't conform to the doctor's own expectations of feeling competent and effective, or because they are not displaying the "proper" behaviour expected of patients.

Balint groups and supervision are particularly useful methods of reflection and support, as they focus directly on the doctor patient relationship. Acknowledging that some patients are challenging and disruptive to the doctor's self esteem and equilibrium is helpful, as without the benefit of such insight, some doctors avoid engagement. While this can lead to poor outcomes for patients, the doctor also misses out on his or her usual sense of purpose and meaning that emerges from productive therapeutic relationships.²⁶ In this way, reflective practice about these challenging or "heartsink" patients can also help avoid burnout and compassion fatigue.

Patients with somatisation can be particularly challenging to the doctor patient relationship. Such patients usually present with multiple somatic complaints but no underlying organic pathology is found. While many can be educated about links between their stress and their symptoms ("facultative" somatisation), there is a small group of "obligate" somatisers who are much more difficult to manage.²⁷ Unnecessary investigations often emerge from these unsatisfactory consultations, illustrating what is known as "somatic fixation" by both doctor and patient. Learning how to approach the somatising patient is an important clinical skill in all areas of medical practice.

Other challenging situations are in relation to maintaining appropriate professional boundaries and when ending a therapeutic relationship.

Sexual boundaries

Given the power imbalance between doctor and patient, setting and maintaining appropriate professional boundaries is the responsibility of the doctor. A sexual relationship with a patient is never acceptable, as it violates the trust in the relationship and is harmful to both parties. The Medical Council provides clear guidelines about sexual boundaries²⁸ and any doctor who is sexually attracted to a patient is strongly advised to seek help from a trusted colleague. As professional role boundaries are complex, both medical students and doctors need ongoing education and support in this area of professional practice.^{29, 30}

Ending a relationship

Occasionally, the therapeutic relationship may become too damaged to continue. The patient and the doctor must be clear about the reasons for ending the relationship and the transfer of care needs to be managed carefully. In some situations, expert medical and legal advice is helpful, but termination of care cannot occur if acute or emergency care of the patient is required. Further models around ending a relationship in the general practice setting are described by Stokes.³¹

In depth guidance is outlined by the MCNZ.

In summary, the doctor patient relationship is central to the practice of medicine. Clinical relationships require as much focus and attention as technical competence and biomedical details. The outcomes of this focus on relationship are improved clinical outcomes, enhanced practitioner satisfaction and a greater sense of professional wellbeing.

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