# VII - THE DOCTOR-PATIENT RELATIONSHIP

# CHAPTER VII

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The doctor patient relationship is an important one in the medical sub-system. It was since the time of Henderson that inquiry was made into this relationship. The first formulations which resulted from these studies were in the years 1934 and 1935 and these studies considered the relationship as a social system.

The doctor–patient relationship is central to the practice of healthcare and is essential for the delivery of high-quality health care in the diagnosis and treatment of disease. The doctor–patient relationship forms one of the foundations of contemporary medical ethics. Most universities teach students from the beginning, even before they set foot in hospitals, to maintain a professional rapport with patients, uphold patients' dignity, and respect their privacy.

Patients have to confidence in the competence of their physician and have to feel that they can confide in them. For most physicians, the establishment of good rapport with a patient is important. Some medical specialties, such as psychiatry and family medicine, emphasize the physician-patient relationship more than others, such as pathology or radiology.

The quality of the patient-physician relationship is important to both parties. The better the relationship in terms of mutual respect, knowledge, trust, shared values and perspectives about disease and life, and time available, the better will be the amount and quality of information about the patient's disease transferred in both directions, enhancing accuracy of diagnosis and increasing the patient's knowledge about the disease. Where such a relationship is poor the physician's ability to make a full assessment is compromised and the patient is more likely to distrust the diagnosis and proposed

treatment, causing decreased compliance to actually follow the medical advice. In these circumstances and also in cases where there is genuine divergence of medical opinions, a second opinion from another physician may be sought or the patient may choose to go to another physician.

Michael Balint pioneered the study of the physician patient relationship in the UK with his wife Enid Balint resulting in the publication of the seminal book "The Doctor, His Patient and the Illness." Balint's work is continued by The American Balint Society in the United States, The International Balint Federation and other national Balint societies in other countries.

**Aspects of Relationship**

The following aspects of the doctor–patient relationship are the subject of observations and discussion.

**Informed consent**

The default medical practice for showing respect to patients is for the doctor to be truthful in informing the patient of their health and to be direct in asking for the patient's consent before giving treatment. Historically in many cultures there has been a shift from paternalism or "doctor knows best" to the idea that patients must have a choice in the provision of their care, and be given the right to make informed consent to medical procedures. There can be issues with how to handle informed consent in a doctor-patient relationship, for instance, with patients who don't want to know the truth about their condition. There are ethical concerns regarding the use of place and whether or not giving a place leads to an undermining of trust between doctor and patient and whether deceiving a patient for their own good is compatible with a respectful and consent-based doctor-patient relationship.

**Common decision making**

Common decision making is the idea that as a patient gives informed consent to treatment, that person also is given an opportunity to choose among the treatment options according to their own treatment goals and wishes. A practice which is an alternative to

this is for the doctor to make a person's health decisions without considering that person's treatment goals or having that person's input into the decision-making process.

**Physician superiority**

The physician may be viewed as superior to the patient, because the physician has the knowledge and credentials, and is most often the one that is on home ground. The physician-patient relationship is also complicated by the patient's suffering (*patient* derives from the Latin *patior*, "suffer") and limited ability to relieve it on his/her own, potentially resulting in a state of desperation and dependency on the physician.A physician should at least be aware of these disparities in order to establishrapport and optimize communication with the patient. It may be further beneficial for the doctor-patient relationship to have a form of shared care with patient empowerment to take a major degree of responsibility for her or his care.

**Benefiting or pleasing**

A dilemma may arise in situations where determining the most efficient treatment, or encountering avoidance of treatment, creates a disagreement between the physician and the patient, for any number of reasons. In such cases, the physician needs strategies for presenting unfavorable treatment options or unwelcome information in such a way that minimizes strain on the doctor-patient relationship while benefiting the patient's overall physical health and best interests.

**Formal or casual**

The differences of opinion between the doctors and patient in the formal or casual the doctor-patient relationship on treatment. According to a Scottish study patients want to be addressed by their first name more often than is currently the case. In this study, most of the patients either liked (223) or did not mind (175) being called by their first names. Only 77 disliked it, most of them were aged over 65 On the other hand, most patients don't want to call the doctor by his or her first name.

Some familiarity with the doctor generally makes it easier for patients to talk about intimate issues such as sexual subjects, but for some patients, a very high degree of familiarity may make the patient reluctant to reveal such intimate issues.

**Transitional care**

Transitions of patients between health care practitioners may decrease the quality of care in the time it takes to reestablish proper doctor-patient relationships. Generally, the doctor-patient relationship is facilitated by continuity of carein regard to attending personnel. Special strategies of integrated care may be required where multiple health care providers are involved, including horizontal integration (linking similar levels of care, e.g. multiprofessional teams) and vertical integration (linking different levels of care, e.g. primary, secondary and tertiary care).

**Other people present**

At the treatment the other people present in a doctor-patient encounter may influence their communication is one or more parents present at a minor's visit to a doctor. These may provide psychological support for the patient, but in some cases it may compromise the doctor-patient confidentiality and inhibit the patient from disclosing uncomfortable or intimate subjects. When visiting a health provider about sexual issues, having both partners of a couple present is often necessary, and is typically a good thing, but may also prevent the disclosure of certain subjects, and, according to one report, increases the stress level.

Bedside manner

A good bedside manner is typically one that reassures and comforts the patient while remaining honest about a diagnosis. Vocal tones, body language, openness, presence, and concealment of attitude may all affect bedside manner. Poor bedside manner leaves the patient feeling unsatisfied, worried, frightened, or alone. Bedside manner becomes difficult when a healthcare professional must explain an unfavorable diagnosis to the patient, while keeping the patient from being alarmed. At the treatment the body language affects patient perception of care is that the time spent with the patient

in the emergency department is perceived as longer if the doctor sits down during the encounter

The doctor–patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation, and support are provided. To managed care organizations, its importance rests also on market savvy: satisfaction with the doctor-patient relationship is a critical factor in people's decisions to join and stay with a specific organization.

The rapid diffusion of managed care into the health care market raises concern for many patients, practitioners, and scholars about the effects that different financial and organizational features might have on the doctor-patient relationship some such concerns represent a blatant backlash on the part of providers against the perceived or feared deleterious effects of the corporatization of health care practices. But objective and theoretical bases for genuine concern remain. This article examines the foundations and features of the doctor–patient relationship, and how it may be affected by managed care.

## A SPECIAL RELATIONSHIP

The relationship between doctors and their patients has received philosophical, sociological, and literary attention since Hippocrates, and is the subject of some 8,000 articles, monographs, chapters, and books in the modern medical literature. A robust science of the doctor–patient encounter and relationship can guide decision making in health care plans. We know much about the average doctor's skills and knowledge in this area, and how to teach doctors to relate more effectively and efficiently. The review data about the importance of the doctor–patient relationship and the medical encounter, then discussed for moral features. The described problems that exist and are said to exist, the clear promulgate principles for safeguarding what is good and improving that which requires remediation, and the researcher finish with a discussion of practical ways that the doctor–patient relationship can be enhanced in managed care.

The medical interview is the major medium of health care. Most of the medical encounter is spent in discussion between practitioner and patient. The interview has three functions and structural elements. The three functions are gathering information, developing and maintaining a therapeutic relationship, and communicating information. these three functions inextricably interact. A patient who does not trust or like the practitioner will not disclose complete information efficiently. A patient who is anxious will not comprehend information clearly. The relationship therefore directly determines the quality and completeness of information elicited and understood. It is the major influence on practitioner and patient satisfaction and thereby contributes to practice maintenance and prevention of practitioner burnout and turnover, and is the major determinant of compliance. The data sources has been suggest that patients activated in the medical encounter to ask questions and to participate in their care do better biologically, in quality of life, and have higher satisfaction.

Effective use of the structural elements of the interview also affect the therapeutic relationship and important outcomes such as biological and psychosocial quality of life, compliance, and satisfaction. Effective use gives patients a sense that they have been heard and allowed to express their major concerns, as well as respect, caring, empathy, self-disclosure, positive regard, congruence, and understanding and allows patients to express and reflect their feelings and relate their stories in their own words. Interestingly, actual time spent together is less critical than the perception by patients that they are the focus of the time and that they are accurately heard. Other aspects important to the relationship include eliciting patients' own explanations of their illness, giving patients information, and involving patients in developing a treatment plan. A series of organizational or system factors also affect the doctor–patient relationship. The accessibility of personnel, both administrative and clinical, and their courtesy level, provide a sense that patients are important and respected, as do reasonable waiting times and attention to personal comfort. The availability of covering nurses and doctors contributes to a sense of security. Reminders and user-friendly educational materials create an atmosphere of caring and concern. Organizations can promote a patient-centered culture, or one that is profit- or physician-centered, with consequences for individual doctor–patient relationships. Organizations (as well as whole health care

systems) can promote continuity in clinical relationships, which in turn affects the strength of in those relationships. For instance, a market-based system with health insurance linked to employers' whims, with competitive provider networks and frequent mergers and acquisitions, long-term relationships. A health plan that includes the spectrum of outpatient and inpatient, acute and chronic services has an opportunity to promote continuity across care settings.

The competition to enroll patients is often characterized by a combination of exaggerated promises and efforts to deliver less. Patients may arrive at the doctor’s office expecting all their needs to be met in the way they themselves expect and define. The doctor’s discover instead that the employer's negotiator defines their needs and the managed care company has communicated them in very fine or incomprehensible print. Primary care doctors thus become the bearers of the bad news, and are seen as closing gates to the patient's wishes and needs. When this happens, an immediate and enduring barrier to a trust-based patient-doctor relationship is created.

The doctor–patient relationship is critical for vulnerable patients as they experience a heightened reliance on the physician's competence, skills, and good will. The relationship need not involve a difference in power but usually does especially to the degree the patient is vulnerable or the physician is autocratic. United States law considers the relationship fiduciary; i.e., physicians are expected and required to act in their patient's interests, even when those interests may conflict with their own. In addition, the doctor–patient relationship is remarkable for its centrality during life-altering and meaningful times in persons' lives, times of birth, death, severe illness, and healing. Thus, providing health care, and being a doctor, is a moral enterprise. An incompetent doctor is judged not merely to be a poor businessperson, but also morally blameworthy, as having not lived up to the expectations of patients, and having violated the trust that is an essential and moral feature of the doctor–patient relationship. Trust is a fragile state. Deception or other, even minor, betrayals are given weight disproportional to their occurrence, probably because of the vulnerability of the trusting party (R.L. Jackson, unpublished manuscript).

## EFFECTS OF MANAGED CARE

A managed care organization serves a defined population with limited resources in an integrated system of care. Thus, a single organization may both provide and pay for care. Organizations as providers have duties such as competence, skill, and fidelity to sick members. Organizations as payers have duties of stewardship and justice that can conflict with provider duties. Managed care organizations thus have conflicting roles and conflicting accountability. The use of the primary care clinician to coordinate or restrain access to other services involves the primary care clinician in accountability for resource use as well as for care of individual patients. Although unrestricted advocacy for all patients is never really achievable, the proper balance and the principles of balancing between accountability to individual patients, a population of patients, or an organization need to be made explicit and to be negotiated in new ways.

The physician  expresses one of the most critical problems inherent in managed care for the doctor–patient relationship. Patients correctly wonder if doctors are caring for them, the plan, or their own jobs or incomes (the latter is equally problematic in fee-for-service care). This ambiguity erodes trust, promotes adversarial relationships, and inhibits patient–centered care. The recent controversy over gag rules has only confirmed this set of fears in the mind of the public which is now seeking regulation of the managed care industry through the political process. Professional ethics dictate that physician’s attempt, as individuals and as a profession, to ensure that their interests and those of their patients are congruent in clinical practice. Plan interests, however, can pull physicians away from this goal, as the organization's values and their implementation inevitably influence attitudes, behavior, and experiences. Alternatively, plans could promote patient-centered care by trying to maximize the extent to which patient, doctor, and plan interests overlap. For example, promoting continuity, communication, and prevention can further all three interests so long as value (and not cost alone) is seen as the plan's product. Similarly, resource stewardship can be honestly promoted as a way to ensure that quality care is available for future patients.

Another feature of managed care organizations is their emphasis, in principle, on primary care. They often rely on primary care clinicians to manage, coordinate, or restrain access to other services. Members are required to choose or are assigned a primary care physician. With the primary care emphasis comes an opportunity for the development of strong relationships between primary care doctors and their patients. The new relationships with patients who in the past never sought care and seldom entered into a doctor–patient relationship may be more likely in a system that emphasizes wellness and primary care, although this may be more apparent than real. It is unclear at present how a “relationship” between a primary care physician and a member of the physician's panel, who have never met, should be characterized, or what responsibilities are associated with it. It is not yet demonstrated that an emphasis, in principle, on primary care leads to stronger relationships, and to what extent countervailing forces such as lack of continuity counter this.

Integrated systems, characteristic of most managed care plans, introduce opportunities for improvement in continuity across the spectrum of care. For example, opportunities arise for case management or for coordinating care between doctors' offices, hospitals, nursing homes, and home care so that individuals do not fall through the cracks of a fragmented system. With integration come new responsibilities for doctors and other health care practitioners for communication, teamwork, and a more longitudinal approach to patient care. This continuity may be thwarted, however, by turnover in staff or members.

Standardization of practice, sometimes relying on “evidence–based medicine,” is often used by managed care to minimize costs or maximize or ensure quality of care. Standardization is often touted as promoting fairness by treating like individuals in like manner. Both standardization and the application of evidence-based principles in choosing care standards, however, rely on value judgments about what counts as good evidence and how that evidence should be interpreted and applied. The danger to the doctor–patient relationship in these movements is that individual patients with their individual needs and preferences may be considered secondary to following practice guidelines, adherence to which may form part of an evaluation measure of physician's

performance. Using practice guidelines and the “standard of care” to determine which benefits are covered, and for whom, ignores the incredible variation in patient preferences and characteristics. This approach treats the disease without reference to the illness.[35]Rather than treating individuals with similar illnesses in like manner, the result is that individuals who merely have the same disease are treated in like manner. Fairness is sacrificed to uniformity . Reliance on “data” may discount the patient's own story, thus discounting specific evidence about personal aspects of disease and its meaning and value. Obviously, discounting the person depreciates the relationship.

The effort to cut costs to increase competitiveness or profit means having doctors is more “productive” by seeing patients faster. The first thing dropped as visit length shortens is psychosocial discussion. So far, the average length of visits does not seem to have dropped significantly, probably because of inherent inefficiencies in scheduling and doctors' abilities to finagle time to fit the needs of patients. Yet both patients and doctors feel a heightened sense of time pressure, and patients worry about being on a conveyor belt with a production-line-oriented doctor. As companies attempt to increase providers' efficiency, these fears will be realized unless by consumers, professionals, or more visionary organizations. Less time, otherwise, will mean less relating time and damage to care: less-accurate and incomplete data; difficulty in identifying the real problems; less efficiency in test and treatment choices based on knowledge of the individual patient; less trust; less healing; more errors and more waste A penny of good communication time may avert a pound of unnecessary or even harmful spending used to reassure an anxious patient or substitute for a sketchy history.

The believe that in the long run the trust of the public that the physician is doing the absolute best for the patient must be maintained so that the doctor–patient relationship preserves its healing functions. At the moment, the momentum of control is such that industry and corporate leaders have the upper hand and care is or will suffer as a result.

**Role Practitioners**

Several principles physicians can follow to retain professional standards and nurture and sustain the public's trust in doctor–patient relationships. The first priority is to

enhance knowledge, skills, and attitudes of doctors, patients, and plans in the doctor–patient relationship. Currently, neither doctors and patients, nor plans have adequate skills in the doctor–patient relationship. Most doctors currently practicing have never been critically observed interviewing a patient, breaking bad news, or denying a patient's request for an unnecessary test. Doctors need no longer suffer from a lack of this skill—it is learnable and quickly taught. Physicians should each ensure their own competence in this vital area.

Principles for enhancing the Doctor–Patient Relationship in Managed Care Physicians should focus on continuity: in their relationships with individual patients, between their patients and other clinicians, and with the organization as a whole. Trust is most realistic when a relationship has a history of reliability, advocacy, beneficence, and good will (R.L. Jackson,). Continuity encourages trust, provides an opportunity for patients and providers to know each other as persons and provides a foundation for making decisions with a particular individual. It allows physicians to be better advocates for their patients and allows patients some power by virtue of the personal relationship they have with this physician. Patients value continuity in and of itself, apart from its effect on health outcomes, although its current value seems to be about 15 per month in added premium. Industry estimates are that an average patient will change plans and doctors if continuity costs more than  180 per year Rapid changes between plans, mergers, acquisitions, closings, changing panels of providers within plans, and physician non-competition clauses all detract from the continuity of patient care. Physicians should advocate for continuity as an important goal for themselves in their individual practices, as members of a group practice, as a profession, and within their organizations.

Practitioners should work to protect the interests and the preferences of individuals. Utilization management, standardization, guidelines, and other cost–containment efforts are morally neutral. It may be necessary to ensure that resources needed to care for those who are not yet sick are available when the time comes. Whereas administrators and managers must responsibly steward the pooled resources of health insurance premiums, each physician in a managed care organization should primarily be an advocate for individual patients. This is not to say that physicians should ignore the

cost implications of their decisions, or that it should be unconcerned with resource stewardship, merely that their primary responsibility as practitioners should be for the care of their patients.

Health care administrators, whose primary responsibility is stewardship, should not ignore the need for competence, compassion, and individualization of care. Physicians' roles as patient advocates mean they must attend to the needs of individual patients who may be exceptions to the rules or otherwise have special needs. As patient advocates, physicians must ensure that policies and procedures put in place that threaten the ability to individualize care do not go unchecked. Since this power may be beyond the capacity of individual physicians, it may require organization at the level of the whole profession.

Practitioners should contribute to quality improvement efforts. For efforts to be focused on improving the quality of care and not solely on restraining resource use, the role of physicians is indispensable. Physicians know when access is too tightly restrained and their patients' care is suffering, when restrictions on the use of particular drugs or equipment constitute unacceptable impingements on the quality of care, or in what circumstances a procedure is probably unnecessary. Physicians can, and should, serve as “quality police” by noticing, remarking, and, ideally, working for change when they see a feature that is detrimental to patient care. In addition, they should be proactive in spearheading and making clinically and humanly relevant quality improvement efforts in their organization.

Practitioners can practice prudence. Physicians should be prudent in their use of resources, and at a minimum should not waste resources by providing services of no benefit to patients. Physicians often complain that patients come in asking for x-rays, blood tests, and other services when physicians are skeptical of any benefit. Conversely, many patients have noted physician's overuse of “tests.” The role of insurers in the health care system means that a service rarely has direct costs for an individual patient, though it may be costly. Indeed, our culture seems to rely on technology to answer questions with a greater certainty than the technology can deliver. Physicians themselves have contributed to a culture of medical practice in which objective test results are given more credence

and are felt to be more reliable than the subjective story of the patient or assessment of the physicians. In truth more than 80 percentage  of diagnoses are made by the past alone. Physicians need to control their own reliance on objective but noncontributing data. By fostering a system of care in which concern for cost is acceptable and unnecessary services are not provided, physicians can be perceived as being socially responsible and perhaps restore some credibility in this area to the profession.

Because it is a matter of integrity not to waste resources on tests or other services, physicians must talk to patients, find out why they are requesting certain services, and meet those needs in other ways. It must educate patients about the limited ability of medical technology and the potential for harm in any treatment. This, again, involves skills that many physicians need to learn in order to understand the patient's underlying concerns, cultural background, and life history.

Physicians need to pay close attention to financial and nonfinancial incentives that might provide a strong conflict of interest when making decisions for individual patients. Physicians must look at how they are paid, realize how it might influence the care of their patients, and take steps to ensure that such concerns do not intrude unduly into decisions at the individual patient level. Remuneration schemes must be scrutinized for this possibility by paying attention to the number of patients the scheme affects, the ability to spread risks over a large population of patients in the case of capitates payment schemes, the implicit and explicit goals of remunerative strategies (including cost containment, but also potentially quality, patient satisfaction, continuity, and other worthy goals), and the extent to which the arrangements are public or, at least, open and understandable to patients. It is important to recognize that large fee for service payments and salaries without productivity standards or quality standards are equally likely to influence the care of individual patients and should be scrutinized with equal seriousness. Similarly, things like the size of a physician's panel of patients, its cultural variety, or morbidity can affect relationships because of their influence on time available per patient visit.

When taking on responsibility for a panel of patients, physicians could be said to join a relationship in theory that does not yet exist in reality. Physicians, working with their plan, should spearhead efforts to reach out to such members if only to ensure the

researcher are educated about preventive medicine issues and encourage them to follow healthy lifestyles. Although patients and doctors a like will not find frequent visits necessary when someone remains healthy, still the relationship between patient and physician may become important later, should the patient become seriously ill. Something as simple as an annual “Health Care Maintenance Reminder” postcard (with the doctor's name) may help members feel their faceless doctor is nonetheless caring for them. Developing relationships with all enrolled members is also a way for physicians and plans to become more accountable for the care of those who are not seen in clinical practice.

## STRATEGIES FOR MANAGED CARE PLANS

Often, plans do not know how to detect and remediate problems in doctor–patient relationships, how to train their practitioners and their staff to relate effectively and efficiently, or how to train their enrollees to be effective in their own care. the reseacher now know how to do all of these things, there is no longer justification for poor performance in the encounters between providers and patients. Doctors need training in dealing with difficult patients, about common aspects of life adjustment such as reaction to illness, in recognizing the underlying psychological problems that remain a leading cause of seeking medical care, in negotiating, and in handling tough situations like breaking news.

Plans can promote a culture that is patient- and member-centered. This variation on “put the customer first” acknowledges the vulnerability of patients as ill persons needing care, compassion, and special attention. It also implicitly and explicitly makes care, not profit, the center of attention for those doing the daily work of providing health care. Physicians and other clinicians are encouraged to put their patients' good first, ahead of profit (their own or the organization's), politics (e.g., reluctance to whistleblow or disclose mistakes), or personnel (e.g., the convenience of the other staff). Conserving resources for future patients or to expand services becomes an important part of serving the member population. Although creating a culture that is patient-centered is not a quick or easy task, there are resources available.

It is useful for plans to separate patient care from administrative rules communication. the practitioner is the person who has the difficult task of saying “no” to a patient. Plans can be purposefully deceptive or vague in communicating what they will not do for a member, when they are trying to enroll new members. It would ease the situation between doctor and patient if the patient clearly understood when the doctor said no that (when applicable) this is not the doctor's decision but the plan's. This approach is likely to require regulatory change.

Plans can structure contracts with employers that encourage accountability to the membership rather than the employer. It is hard to balance the competing interests of sick and well members, those who need resources now and those who may need them later, staff and the community. Employers' standing in decisions that affect primarily their employee members adds more complexity, and is fraught with conflict. The illusion remains that employers pay for health insurance. Actually their not paying the premiums would increase real wages for their employees, drop the cost of living, increase profits, or increase income due to greater competitiveness. This illusion, however, affects how health insurers view their accountability. Managed care plans do what it takes to please employers, because employees are their customers. The member, sick or well, has little voice. One way to alleviate this situation is to ensure that members have a voice, either through their employer or union, or in the health plan itself, for example, through representation on guideline development initiatives or benefits committees. If policies can be said to be self-imposed by the membership, physicians making judgments about resource use are acting for their patients, current and future, and not for employers ’ another strategy is to require management to use the same plans their employees do.

Plans must eliminate intrusive incentives in contracting with physicians. Intrusive incentives are those that combine strength (i.e., are large either in absolute or relative terms) with a tight linkage to individual patient care decisions. If a single decision about a single patient (including the decision to accept a chronically ill person into one's practice) is likely to result in a significant financial loss to the physician, then the relevant incentive is too intrusive. The intrusiveness of incentives is a product of the incentive's size (e.g., how much money is at stake) and its link to individual care decisions. For

instance, if referring a patient to a specialist “costs” a physician a loss out of the physician's pool, it is tightly linked. If, however, a prepaid arrangement covers several thousand patients, the relative size (or impact) of the incentive is small. Incentives need not be only financial; peer pressure, leisure time, the threat of deselecting, or a sense of fulfillment from work may also influence patient care decisions and thus also should be subject to scrutiny.

Plans can standardize “with heart.” Moderating the variation in clinical practice has often been touted as a way to save money without compromising quality of care. Yet some variation is necessary and inevitable. An organization that does not allow clinicians to open the gate for the justifiable exception to the rule, or is overly skeptical of clinical judgment about those with rare or poorly characterized conditions, ignores to its peril the rich variety of the human condition.

The openness and honesty of a system or organization can contribute to a climate of trustworthiness. For instance, discrepancies between marketing messages (“we provide everything”) and the availability of medications, equipment, or specialty care (“that's not covered in your plan”) create entitlement and convert it to disenchantment, resulting in an atmosphere of distrust that inevitably includes the doctor–patient relationship. Health care organizations may not relish the idea of promoting honest talk about limited resources and their consequences, but should at a minimum not try to raise expectations of unlimited access to unlimited services.

Plans should promote patient privacy and confidentiality. The expectation of privacy is one of the most important aspects of the doctor–patient relationship and influences the disposition to trust, but confidentiality is no longer solely in the doctor's control. Organizational personnel have access to patient information and must be required to keep it private, taught how to keep it private and monitored to be sure they do.

Time is another prerequisite for trust. Plans should determine a reasonable minimum average time for doctor visits. The researcher should pay attention when doctors or patients complain the researcher do not have enough time together. Because the time of visit varies by type of visit, type of doctor, and complexity of the patient,

patient complaints about visit time may be a useful patient-centered indicator of potential trouble in doctor–patient relationships.

Plans can encourage consideration of psychosocial issues in all forms of patient care. An organization can use continuing education, promotional materials, patient-directed education, and quality improvement efforts to promote this aspect of patient care. In doing so, discussions about these areas between doctors and patients will be enabled, patient satisfaction will increase, and unnecessary visits, such as to the emergency department for panic attacks, may even go down. Organizational change may be a more efficient way to promote caring than changing either medical education or the process by which medical students are selected

Plans should avoid business decisions that interrupt continuity between doctors and patients. Mergers and acquisitions, adding and deleting physician groups, agreeing to short-term contracts with employers, expanding or selling out, all are decisions with profound implications for one-on-one relationships between doctors and patients. To minimize harm when these decisions are unavoidable, exceptions can be made for those with important, established relationships. The “old doctor” may accept the standard fee, or the patient may be willing to contribute to some degree. If necessary, the patient's care can be gradually (as opposed to abruptly) established with a new physician “in the plan.” The latter strategy enables patients to take control over their choice of doctors and gives them time to find one acceptable to them in the network.

The fundamentals of the doctor–patient relationship, some features of the health care system found particularly in managed care settings that affect it, and approaches for protecting and sustaining the doctor–patient relationship in these settings. These are aimed at physicians and plans, but should be of interest to policy makers, other health care administrators, and consumer groups. In change there is opportunity. Our current opportunity is to examine the doctor–patient relationship, the context in which that relationship operates, and in particular, the influence of changes in the financing and organization of health care. The doctor–patient relationship deserves our serious attention and protection during these dangerous times.

Talcott Parsons was influenced by the studies.talcott parsons further analyzed the attitudes and activities that the two parties bring to the situation or care. Talcott parsons considered this relationship as a well rehearsed one. According to this was not a spontaneous happening, it was a socially learnt behaviour pattern. In other words the doctor and the patient have learnt to expect certain things and act in certain ways.

Parsons further added that the doctor patient relationship is a social relationship. It is a patterned relation-ship which is socially and culturally learnt. In this manner it is a learnt behaviour pattern like other behaviour patterns. The doctor patient relationship has also been considered as a dynamic one. The actors bring into the situation social and cultural factors such as those of social status, racial or ethnic around membership and health education standards. In this manner it is said that both patients and the doctor enter the situation with the knowledge and understanding of each other's expectations.

It has been observed that the doctor by virtue of his qualifications holds a higher position in this relationship. The relationship between the doctor and patient is not one of equals. It was noted that in Western countries the doctor who is having high technical qualifications was held in high esteem the patients. The doctor patient relationship has been turned as an asymmetric one, where the patient is a deviant and the practioner is an agent of social control.

Concluding on the Parsonian analysis of the doctor patient relationship, the researchers note a few main features. The patient is in a characteristic "situational dependency".

The doctor's attitude towards the patient has many facets. It may be discussed under what Parsons has termed as "affective neutrality". This is a device which keeps the practitioner at a sufficient distance from the patient. It prevents him from getting emotionally involved with the patient, so that the doctors may use his professional knowledge to the best. The basic requisite is that the doctors should understand the patient without self involvement.

The two other important dimensions under which Parsons has discussed the professional attitude are "universalism" and "functional specificity". The former refers to the professionals endear our to treat all patients alike. This means treating them objectively being guided by medical factors. The norm of "functional specificity" as applied to the doctor is used to denote the limitation of his interest to purely medical factors. It means that the doctor is not to interfere in the private life of patients.

It is understood that in actual fact it is not easy to achieve all the foresaid professional standards. The doctor may have to view the patient in a broader perspective especially in psychosomatic illness. It shall now briefly review the works of others which have followed in the wake of Parsons' "role analysis" and doctor patient relationships.

Szasz and Hollender discussed the doctor patient relationships in three dimensions. It consider the relationship to be determined by the nature of illness and organic symptoms. It brought forth the doctor-patient relationships based on three fold typology. These are the "activity passivity" approach, the "Guidance Cooperation" approach and the "Mutual Participation" approach.

In the first approach the doctor is active and the patient is passive. This refers to the helpless condition of the patient where he is totally dependent upon the doctor. Treatment is given irrespective of the patients contribution to the relationship with the doctor. The second one of guidance-cooperation refers to the situation where the patient is in not in such a helpless condition and can follow the acute nature of his illness, and is wanting to overcome and seeks the instructions from the doctor. In the third approach the situation is the treatment of chronic illness. Here the patient has to follow the treatment and instructions with occasional guidance from the doctor. An example of such a patient doctor relationship is that of the patient suffering from diabetes.

Szasz and Hollender have accepted the Parsonian analysis and consider the problem in functional terms. Hence any relationship not befitting the situation becomes dysfunctional.

Eliot Freidson has pointed out that Parsons in his analysis of the doctor-patient relationship has emphasised the expectations of the doctor ignoring the patient and his expectations. Freidson's premise is that each enters the situation with his own expectations and there arises a conflict. Parsons has overlooked this conflict.

The Freidson's study of attitudes and behaviour patterns in Montefiore Hospital in New York has made certain revelations. These are that patients choose their doctors on the basis of competence and interest shown by the doctor in the patient. Also the researcher found that the patients found the "solo Practitioner" better than the "prepaid practitioner". Freidison has enabled us to understand the doctor-patient relationship in the light of the lay referral system. The lay referral system is the course of events and consultations since the time the individual feels ill to the time of his consultations with the doctor. In these way two referral systems the lay and the professional referral cone interact with one another, each with its own basic differences. These basic differences are not purely based on expected doctor-patient expectations but on the structure of the role situation.

In an age where the type of illness has changed from serious to more percentage of chronic cases, prevention rehabilitation has become the point of concern.

Other studies such as those of Egbert, Freidson, Skipper and Leonard have shown that the doctor-patient relationship is important as it is therapeutic in itself.

Goffwan's strategic interaction is also useful in analyzing the doctor-patient relationship. In this relationship it has been said, that before and after each interaction there is an assessment and reprisal of each other. They try to assess the orientations that each has brought into the actual situation. They assess possible channels of accommodation in their future relations. These orientations are of social class, religion, profession and ideology. The author considered the ways in which these assessments were made. These were made by "interpreting expressions" given off by other actors as well as by communication transmitted. This communication may be verbal, and non-verbal.

The actors in a situation will also judge as to which is pretentious. In this way each tried to get the best out of this relationship.

It has been stated that the doctor-patient relationship has to be nurtured and channalized on to a harmonious and ongoing path by the efforts of the doctor. The doctor has to develop a social relationship with his patients. The doctor has to give them ample time to discuss their illness and prescribe the treatment in accordance with their expectations. A likelihood of a gap arising in this relationship has been foreseen in the case of the western educated doctor. He is highly placed because of His affluent economic condition compared to his patients. Dana W. Atcheley has listed certain pre-requisites for successful communication between doctor and patient. One of them is hearing to the patients' problems patiently. The others are understanding of the cultural and social values of the patient. It is also important to understand their educational levels so as to end the doctor to place the etiology of the disease before them. It has been noted that it always pays for the doctor to be humorous.

The present study of patients and doctors in England and Wales certain conclusions were drawn. It was observed that the patients were not happy if less time was given to them. They felt theta it was owing to the load of work on the doctor under National Health Services. Hence they preferred the home visits where they were assured of the desired attention.

It was also clear that a doctor got his patients on the basis of inheritance or through another doctor previously in the same place. 24% went to a doctor because he was accessible and 22% on the basis of recommendation of others some went to him because they were accreted to him since childhood. In other words he was their family doctor.

From this study certain conclusions were drawn. It was seen that most patients choose their doctor on the basis of accessibility or taking over of his practice from their old doctor. They very rarely go on the basis of qualifications and organization of practice. It was also seen that middle class people choose their doctor on the basis of recommendation compared to low class. It showed that high prestige enjoyed by a doctor

was by virtue of him being a family doctor and in close contact with the whole family. In Cartwright's study almost 80% of the respondents showed that they preferred to consult a family doctor rather than go to a specialist. They felt he was good for preliminary diagnosis and would refer them to a specialist if necessary.

Studies in America have shown that usually the persons occupying the higher income strata have a family doctor; low class individuals do not have a family doctor because of class and race differences. A middle class individual may go occasionally. It has been seen that a stable relationship with a physician is contracted by the upper and middle classes. It has been observed that physicians occupy areas of high income end are therefore more accessible to them.

According to B.L. Koos the family doctor has special value because of his psychosomatic treatment of illness. B.L. Koos fulfills all family medical needs. This study revealed that the high and middle class families had a fairly stable relationship with a family doctor as compared to the low class

The doctor-patient relationship is an important one. It is contracted to alleviate distress in the social system and the relationship is itself therapeutic. Parsons viewed this relationship as an unsymmetrical one and that between unrequited. Weight was given to competence of the physician and the limitation of the doctor's interest to purely medical grounds. The treatment of all patients was to be free from all considerations such as those of class. This relationship was seen as a well organized and socially learnt relationship. In this analysis the role of the doctor was over emphasized and the overall care of the patient was ignored. Szasz and Holiender have analyzed the do patient relationship in functional terms.

According to Freidson's study it was seen that the doctors as well as the patient’s expectations were important in this relationship. It was also observed that the patients liked the services of the "solo practitioner" better than the 'prepaid practitioner".

The other studies such as those of Goffman, Hasan and others showed that patients liked the doctor to give them ample—time and to take an overall view of their illness. They were more in favour of the doctor being free with them and not adopting a business like attitude.

The study clear that most patients preferred the single practitioner they felt that better attention would be given to them. It was seen that one of the most common factors operating the choice of a family doctor was accessibility and recommendation by others.

In this chapter data has been collected to throw light on the doctor patient relationship. It this chapter the researcher have analyzed the respondents responses regarding their expectations of a family doctor, the norms operating in the choice of a family doctor, the extent of the custom of having any doctor and to see the referral system operating in the consultation of the doctor.

The present study state that owing to specialization the medical field there is a feeling of frustration and helplessness among the patients. This has increased the practice of having a family doctor who reduces the gap between the patient and other specialists in the medical sub-system.

In this study the researcher shall examine the prevalence of this practice of having a family doctor among our respondents.

**Table 7.1**

**FAMILY DOCTOR**

| S.No. | Particulars | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | Having family Doctor | 243 | 81 |
| 2 | Not having a family Doctor | 57 | 19 |
| **Total** | | **300** | **100** |

The above table shows that the majority of the 81 percentage of the respondents are having a family doctor, only 19 percentage of the respondents are state that they do not have a family doctor. Therefore the study clear that the practice of having a family doctor is common among our respondents. Generally speaking it is therefore an observed that the concept of having a family doctor is present in this society.

It was intended to see the opinion of respondent regarding their idea of a good doctor. This was intended in order to examine the norms operating in the choice of a family doctor.

**T able- 7.2**

**Opinion about a Good Doctor**

| S.No. | Particulars | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | Qualified and whose diagnosis is good | 127 | 42 |
| 2 | Patiently hears to all complaints and gives his full attention | 159 | 53 |
| 3 | Does not charge too high | 14 | 5 |
| **Total** | | **300** | **100** |

The above table shows that 53 percentage or majority of our respondents feel that a good doctor is one who patiently hears to all complaints and gives his full attention. A minority of them that is 5 percentage feel that a good doctor is one who does not charge too high. 42 percentage of the respondents state that a good doctor is one who is well qualified and whose diagnosis is good. From this study the infer that the opinion of a good doctor is formed generally on the basis of one who gives a patient hearing to clients. Secondly the qualities of a good doctor are judged on the basis of qualifications and good doctor.

**Table- 7.3**

**Qualification of Doctor**

| S.No. | Particulars | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | Do not know the qualifications | 50 | 21 |
| 2 | M.B.B.S | 110 | 45 |
| 3 | Specialists | 79 | 33 |
| 4 | Not quoting any medical degree | 4 | 1 |
| **Total** | | **300** | **100** |

The responses of the respondents about the qualifications of their family doctor provided in the above table indicate that about 45 percentage of the respondents are having a family doctor who is qualified as an M.B.B.S doctor. 1 percentage of the respondents quote some degree other than medical as that of their family doctors. 33 percentage of the respondents are having specialists as their family doctors. 21 percentage of the respondents say that the respondents do not know the qualification the researcher clear that the majority of our respondents give importance to competence of their family doctor on the basis of qualifications. It is seen that 78 percentage of the respondent are having qualified doctors as their family doctor.

**Table – 7.4**

**Reasons for choice of Doctor**

| S.No. | Reasons | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | Recommended by friends | 59 | 24 |
| 2 | Close to our house | 94 | 39 |
| 3 | Related to us | 38 | 16 |
| 4 | Known since years by family | 35 | 14 |
| 5 | Friends | 17 | 7 |
| **Total** | | **300** | **100** |

The present study aim is to find out the norms operating in the choice of a doctor. It is seen that a majority of the respondents that is of them chose to have a particular doctor because he is close to their house. Only 7 percentage state that their family doctor is one who is a close friend of their family 24 percentage state that their family doctor is one who is recommended by their friends as a good doctor. 16 percentage state that their family doctor is related to them. 14 percentage of the respondents state, that their family doctor is one who is known to their family since years. It is seen that the most common cause of choosing a doctor is that they reside in the neigh bourhood of our respondents. In other words the doctor is easily approachable hence he is their family doctor. Only a very small percent of our respondents state that their family doctor is a friend of theirs. The study revealed that all the respondents having a family doctor state that their family doctor is patient. In other words he gives a good hearing to the patients' complaints. They also felt that the diagnosis of their family doctor was good. Respondents stated that they were able to have free rapport with their family doctor. Harlier studies revealed that people went to a doctor belonging to the same religion, and ethnic-group as theirs.

The details relating to the Caste of family Doctor is provided in table -7.5

**Table -7.5**

**Caste of family Doctor**

| S.No. | Caste of family Doctor | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | similar caste | 27 | 11 |
| 2 | Caste not known | 96 | 40 |
| 3 | Not our Caste | 120 | 49 |
| **Total** | | **300** | **100** |

The responses of the respondents about the Caste of family Doctor

provided in the above table indicate that most of the respondents state that their family doctor does not belong to their caste, 43 percentage state that their family doctor does not belong to their caste, whereas a minority that is 11 percentage state that their family doctor belongs to the see caste as theirs. 40percentage of the respondents state that caste of their family doctor is not known to them. From this study we infer that the respondents do not consider s same caste affiliation as important in the choice of family doctor. Only a very small percent of our respondents are having a family doctor of the same caste as theirs.

It was also intended to observe whether the family doctor beloved to the same religion as that of the respondents.

**Table- 7.6**

**Religion of Family Doctor**

| S.No. | Religion | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | Some religion | 172 | 71 |
| 2 | other than religion | 71 | 29 |
| **Total** | | **300** | **100** |

From this study the researcher clear that a majority of the respondents state that their family doctor belongs to the same religion as theirs. 71 percentage states that they belong to the same religion as theirs. Only 29 percentage states that their family doctor belongs to a religion different from theirs.

It was intended to see whether the family doctor' role was limited to the medical level only or whether he had a much wider role ID the finally. From this study it is clear that explain the gather information as to whether the family doctor participates in social functions of the family.

**Table- 7.7**

**Family Doctor and Participation in Social Functions**

| S.No. | Participation in Social Functions | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | Family Doctor participates in Social Functions | 107 | 44 |
| 2 | Does not participate in Social Functions | 136 | 56 |
| **Total** | | **300** | **100** |

The above table shows that a majority of the respondents state that the family doctor does not participate in social functions. 56 percentage state that their family doctors role is limited to that of medical treatment only. 44 percentage state that the family doctor participates in social functions of the family.

**Table- 7.8**

**Family Doctor and reference to other Doctors**

| S.No. | Reference to other Doctors | No. of Respondents | Percentage |
|---|---|---|---|
| 1 | Refers to other doctors (specialization) | 152 | 63 |
| 2 | Does not refer to other doctors | 91 | 37 |
| **Total** | | **243** | **100** |

The above table shows that the majority of the 63 percentage of the respondents states that the family doctors refer them to specialists for medical care. Only a very small percent 37 percentage the respondents are do not refer to other doctors or specialists. From this the researcher infer that the professional referred system is operative to a large extent, and there are few doctors who treat the patients themselves without referring to specialist care.

In this chapter it is observe that the practice of having a family doctor is prevalent among a majority of the respondents. Only a minority are not having a family doctor. The respondents opinion of a good doctor was that a good doctor should be qualified and diagnose well. This opinion of a good doctor was given by a majority of the respondents. Only a small minority stated that a good doctor should not charge too high. Therefore the general opinion of a good doctor in one who give the satisfaction of giving ample time to the patient. This may have become important because of the rush at the clinics and the hurried checkup of the doctors.

This chapter analysis also revealed that most of the respondents had qualified doctors as their family doctors. Competence of a doctor judged on the basis of qualifications seems to be important. Most of the respondents were having qualified doctors as their family doctors and of these a certain percent were specialists.

The other norms operating in the choice of a doctor were residing in the same neigh-bourhood. In other words the respondents chose a doctor who was close to their houses. It was seen that most of the respondents had doctors belonging to their own religion. The family doctor being the same caste as that of our respondents did not seem to be important.

It was also seen from the respondent's analysis in this chapter that the role of family doctor was limited to interest in treatment only. A very small percentage of our respondents participated in the social gatherings of our respondents.

From this analysis the researcher makes some observations. The study stated that this form of practice of having a family doctor is a common one. Besides this it is a successful way of treating illness family and from this basic relationship the individual may be referred for further specialist treatment if necessary. The researcher observes that the respondents are fully satisfied with their family doctor.

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