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**Original Research Article**

# A qualitative study among doctors exploring the factors influencing the doctor-patient relationship in a Government Medical College, Nadia district, West Bengal

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## ABSTRACT

**Background:** An efficient healthcare delivery system needs a healthy doctor-patient relationship. One of the important factors in the desired treatment outcome is the soundness of this healing relationship, which depends on the perception and attitude of both doctors and patients. This study aimed at assessing the status of this relationship as viewed by the doctors and exploring different factors influencing their perceptions regarding the same.
**Methods:** In this qualitative study, the data were collected through 17 open-ended, in-depth interviews with doctors attending a Government Medical College in Nadia district, West Bengal. The participants' experiences and their perceptions regarding the relationship were subjected to grounded theory content analysis after transcription and coding.
**Results:** The findings revealed that the components of the doctor-patient relationship could be categorized into four key processes; ie; commitment; valuing the patient; doctor's character and competencies; and the balance of power. This further led to the formation of three necessary relational elements, namely, trust; peace and hope; and being acknowledged. Respect in both ways was the established theme from this analysis.
**Conclusion:** The physician-patient relationship plays a central role in patient outcomes. The factors affecting the same are quite comprehensible and these factors are to be taken care of, giving the highest priority, for the flawless running of health system.

**Keywords:** Communication barrier, Eastern India, Health care quality, Medical professionals, Patient satisfaction

## INTRODUCTION

Society commonly thinks that 'Doctors' hands are the hands of God.[1] A sound doctor-patient relationship is the utmost need for the smooth running of the healthcare delivery system and a patient's treatment outcome largely depends on this.[2] The relationship can be defined as "a consensual relationship in which the patient knowingly seeks the physician's assistance and in which, the physician knowingly accepts the person as a patient.[3] According to the eminent Indian physician and scholar 'Charaka', "A good physician nurtures an affection for his patients exactly like a mother, father or brother. The physician having such qualities gives life to the patients and cures their diseases."[2] But, this conventional approach has been recently debated for its simultaneous impact on the doctor-patient relationship and the treatment outcome.[4,5] An unhealthy relationship leads to workplace violence within the healthcare setting culminating into medico-legal actions against doctors, further leading to the incapability of doctors to provide the best therapeutic decision in such stressful

environments. This could result in a lesser chance of patient survival, slow recovery, and increased referrals.[6] Different factors influence such relationships, and the context differs from place to place. Therefore, critical investigation is required in every setting to identify the status of such relationships, and thereafter make certain to provide equal importance to the versions provided by both the patients and the doctors. Researchers should search for the causes of deterioration, if any, of this valuable relationship and develop tailored, context-based interventions to maintain or uplift the same. With the above background, this qualitative study among doctors has been taken up to explore the factors influencing the doctor-patient relationship in a Government Medical College, Nadia district, West Bengal.

## METHODS

### *Study type*

This qualitative study was conducted in JNM Medical College and Hospital, Nadia district of West Bengal, selected purposively for the same.

### *Study duration*

The study was conducted between January to March 2020.

### *Data collection*

Data were collected through 17 open-ended in-depth interviews with doctors belonging to clinical departments. The doctor's perceptions regarding the relationship was subjected to grounded theory content analysis after transcription and coding.

### *Selection criteria*

The participants were selected according to the following method. The ratio of doctors holding different posts in the setting was 1: 1: 2: 6: 7 (1 General Duty Medical Officer (GDMO), 1 Senior Resident (SR), 2 Post Graduate Trainees (PGTs), 6 house staff (HS) and 7 Teaching Faculty). Considering this, for qualitative interview, 17 doctors were selected randomly from the respective lists. Faculties were selected from seven departments which had the highest patient load in December 2019, namely, Medicine, Orthopaedics, Dermatology, Ophthalmology, Surgery, Pulmonology and Obstetrics and Gynaecology. 7 faculties were selected as per the ratio of faculties holding different Designations in that hospital, which was 2:2:2:1 (2 Clinical Tutors: 2 Assistant professors: 2 Associate professors: 1 Professor). Therefore, the same ratio of 2 clinical tutors, 2 assistant professors, 2 associate professors and 1 professor was maintained while randomly selecting from the separate lists of faculties, representing each post from seven major departments as mentioned above, using random allocation software to reduce the selection bias.

During the selection of departments, once a department was selected, it was excluded from the list of further selection. By this, at least one faculty from each of the 7 departments was selected and all the seven departments got an equal chance for representation. During faculty selection, each stratum (designation) once filled was excluded from further allocation. If anyone did not provide consent to participate after random allocation, the procedure was repeated and the next randomly allocated person was interviewed after getting informed consent. Rest of the 10 participants were selected randomly as explained earlier. After the first rotation of 17 IDIs (in-depth interviews), the procedure had been stopped since the data saturation was achieved.

Data collection was performed through an open-ended interview guide. The objective of the research and its methodology were explained to each participant individually before the interview and a written informed consent was also obtained from each participant. The place and time of the interviews were determined by the participants and the duration of the interviews varied between 20 and 40 minutes based on participants' willingness. Ethical clearance was obtained from the Institutional Ethics Committee prior to commencement of the study. After each interview, the researcher documented all recorded files and field notes. All statements and expressions of the participants were completely transcribed along with coding on three levels. This method gradually reduced the initial codes by removing the identical and overlapping codes and finally, sub-categories, categories and one common theme were extracted.[7,8]

## RESULTS

A total of 17 participants were selected for qualitative interview from the entire doctors` cohort of the facility. Table 1 shows the socio-demographic characteristics of the participants, whose mean age was 34.24+9.36 years. The majority were male (70.59%) and the participants' mean duration of practice was 4.97±4.09 years. The participants were majorly from the Department of Surgery, Medicine and ENT (11.76% each) (Table 1).

Table 2 shows the components of the doctor-patient relationship, which could be categorized into four key processes; i.e., commitment, valuing the patient, doctor's character and competencies, and the balance of power. According to the transcription of in-depth interviews, major findings were categorized into different components. Each category was divided into different subcategories and the categories were then converted into a common theme (Table 2).

**Table 1: Socio-demographic characteristics of the participants (n=17).**

| S. no. | Age (in years) | Sex | Duration of practice (years) | Department | Designation |
|---|---|---|---|---|---|
| **Participant 1** | 44 | M | 15 | Obstetrics and gynaecology | Professor |
| **Participant 2** | 40 | M | 10 | Medicine | Associate professor |
| **Participant 3** | 35 | M | 5 | Orthopaedics | Associate professor |
| **Participant 4** | 36 | M | 6 | Surgery | Assistant professor |
| **Participant 5** | 57 | F | 12 | Ophthalmology | Assistant professor |
| **Participant 6** | 32 | M | 5 | Pulmonology | Clinical tutor |
| **Participant 7** | 50 | M | 7 | Dermatology | Clinical tutor |
| **Participant 8** | 35 | F | 4 | Pediatrics (SNCU) | GDMO |
| **Participant 9** | 31 | F | 5.5 | Pulmonology | Senior resident |
| **Participant 10** | 27 | M | 3 | Surgery | P G trainee |
| **Participant 11** | 39 | M | 4 | ENT | P G trainee |
| **Participant 12** | 27 | F | 1 | Obstetrics and gynaecology | Housestaff |
| **Participant 13** | 25 | M | 2 | Anaesthesia | Housestaff |
| **Participant 14** | 27 | M | 1 | Cardiology | Housestaff |
| **Participant 15** | 26 | M | 1 | Emergency | Housestaff |
| **Participant 16** | 25 | F | 2 | Medicine | Housestaff |
| **Participant 17** | 26 | M | 1 | ENT | Housestaff |

**Table 2: Doctor-patient relationship-the qualitative model.**

| Category | Sub-category | Definition |
|---|---|---|
| **Commitment** | The continuity of the relationship | Constant communication with patients over time. |
| | Responsibility | Spending adequate time as well as maintaining quality of care in any set-up. |
| | Fidelity | Prescribe medicine and tests when needed, not only to avoid medico-legal purposes. |
| **Valuing the patient** | Communication | Effective communication with patients based on their character. |
| | Effective presence | Effective listening, appreciating the patient`s experience of illness and empathy. |
| **Doctor`s character and competencies** | Self-confidence | Doctor`s confidence in developing the diagnostic and therapeutic plan. |
| | Managing the emotions | The ability to be aware of his/her emotions and to control them. |
| | Mindfulness | The ability to consider the internal and external foreseeable factors. |
| | Logistic deficiency management | The ability to inform and convince the patients about shortcomings of infrastructure. |
| **Balance of power** | Shared decision-making | Engaging the patients in diagnostic and therapeutic decision making. |
| | Educating the patient | Explaining the medical terminology in an understandable language for the patient and educating them to follow advices and tasks. |

***Components of the doctor-patient relationship model: Commitment***

The first component of the model is commitment, which defines the duty of the doctor to patients. This category includes three sub-categories i.e., continuity of the relationship, responsibility and fidelity.

***Continuity of the relationship***

A common feature among the study participants was that they were practicing in this institution for more than a year, which led to constant communication with their patient. This type of opportunity could create a familial relationship between doctors and patients.

One of the participants said: "*I always tell my students to treat a patient as one of your family members*." (Participant 7)

Another participant asserted: "*I think doctors need to have a sense of close relationship with the patient*." (Participant 5)

In the case of follow-up patients, a long-term relationship developed between doctors and patients through repeated follow-up sessions, which could lead to a strong and rich therapeutic relationship between them.

Doctors used to show their commitment to their patients through caring activities like practising telephonic calls for patients. According to the participants, these activities act as a signs of showing respect towards the patient.

For example, one participant said: "*When a patient's date of operation is very near, we always give a phone call to his/her family members and remind the date*." (Participant 10)

Another participant said: "*When a patient becomes seriously ill, we always try to call his/her family member to stay with the patient*." (Participant 17)

Another participant said: "*When any critical patient stays at my unit or under my treatment mostly in case of ICU/CCU, I feel that patient party remains under a stressful condition, I give them my phone number, and based on my experiences, step by step I tell them what to do and this help them to trust me, and the outcome is much better than the expectations*." (Participant 2)

*Responsibility*

All the participants agreed to this point that they all used to spend adequate time in this setup. No one usually skips his/her duty until and unless unavoidable circumstances arise. This also could uplift the level of trust and confidence within this relationship.

One participant asserted in this context: "*Today private practice is legal and to do that, we leave the non-practising allowance, but we always pay similar attention towards every patient, whatever and whenever it may be*." (Participant 1)

Another participant said: "*I do not do private practice. Though many other doctors of this institution do it, but I think no one attends any patient casually because of the fact that patient is from this government institution*." (Participant 4)

*Fidelity*

This type of strong bonding between doctors and patients has led to none of the doctors wanting to write extra tests or investigations which was needed for only medico-legal aspect.

One participant said: "*Yes, many times we write an investigation though we know that our diagnosis is right, but to draw the satisfaction of the patient's relatives and also to confirm our clinical diagnosis, we suggest the test*." (Participant 11)

Another participant asserted: "*In our hospital, most of the patients belong to low socio-economic status. So, when we prescribe any test or investigation that is not available in our hospital facility, those are really necessary to treat the patient, not only to avoid medico-legal bindings*." (Participant 9)

One participant said: "*There is no such history in our institution that patient relatives are offended due to writing of any investigation because when we write any investigation, we always counsel the patient or patient party regarding the need of that*." [Participant 3]

So, there was mutual trust and fidelity between doctors and patients in this institution.

***Valuing the patient***

The second component of the model is the amount of value which the doctor considers for his/her patient. This category includes two sub-categories: communication and effective presence.

*Communication*

The valuing process begins with effective communication towards patients based on their individual character and respecting the patient's dignity irrespective of their socio-economic status, cultural background, the type or stage of the disease he is suffering from.

It was stated by one of the participants: "*I have the same attitude towards all my patients with different cultural and educational levels*." (Participant 14)

Another one asserted: "*It often happens in OPD that when I talk in local language, patient feels more confident*." (Participant 7)

Participants also said that, to build an effective rapport, communication between patients and the same doctors is necessary during every visit.

In this regard, one participant said: "*When patients hear that I will go on leave during their next visit, they sometimes say in OPD that they do not want to visit another doctor until I come back; I have nothing special to give them, it is just an emotional relationship*." (Participant 4)

This relationship was the result of considering the fact that the patient is a person, not just a diseased body.

In this regard, one doctor indicated: "*I must be both physically and psychologically helpful for my patients*." (Participant 15)

This type of treatment results in an integrated picture of the patient's body, mind, and spirit.

*Effective presence*

The second sub-category of valuation is effective presence at the bedside of patients and giving full attention to them.

*In this regard, one participant mentioned* "*There is not much patient load in our OPD or IPD like any government medical college in Kolkata. So, there is a scope of giving adequate time to every patient for effective listening*." (Participant 11)

Furthermore, understanding the patient's experience of illness and suffering requires the doctor's full presence. This would enable the doctor to communicate with patients in an empathetic manner.

*Another participant said "If patients feel that we are tired or we are not fully present, they will not trust us and the treatment will not be effective*." (Participant 2)

***Doctor's character and competencies***

The third component of the model is doctor's character and competencies including the capability of doctor to manage the overall situation. It is not only the academic knowledge but also the ability of the doctor to represent himself/herself as a friend in front of any patient and tackle every situation tactfully whether it is good or bad. This category includes four sub-categories of self-confidence, managing the emotions, mindfulness and logistic deficiency management.

*Self-confidence*

If the doctor is confident of his/her diagnosis and treatment, it will also uplift the confidence within the patient. In this regard, one participant said: "*When I tell any patient that, I am confident enough regarding understanding his complaint and nothing to worry about, immediately I can see that there is a smile on his face. It raises the confidence of patient*." (Participant 9)

A doctor's knowledge is important to build an effective communication. The doctor must have the capability to say something according to patient's level of understanding. While the patient should also be able to trust the doctor's knowledge and skills, at the same time, he/she must understand the doctor's limitations and the necessity of consulting with other medical practitioners too. In this regard, one participant said: "*When there is any conflict in my treatment protocol with patients' satisfaction, at first I counsel the patient, and then refer the patient for better management to Kolkata*." (Participant 2).

*Managing the emotions*

The doctor's ability to manage and control his/her emotions needs some fundamental skills such as understanding their own emotions and express appropriate emotional reactions in front of patients during treatment.

*One participant said* "*Many a time, patient party is not satisfied in OPD regarding treatment delivery etc. etc. but tactfully we have to tackle it. Obviously, the mode of treatment delivery is not science, it is art. In a government facility, there are lots of pros and cons, but we have to manage it through our patient management skills*." (Participant 3)

*Mindfulness*

Mindfulness is another important feature that is defined as continuous awareness and the ability to recognize whether or not the patient's words originate from his/her deepest emotions of fear, anxiety, regret, guilt.

*One participant said* "*Most of the patients here belong to low socio-economic families, and their educational level is also very poor. They will always say that they do not need to understand what disease they are suffering from but to give them the treatment that is appropriate according to me. In that case, often we lose our temperament, but it is not patient's fault. This happens due to a lack of consciousness because of low education. The patients are to be counselled properly*" (Participant 4).

*Logistic deficiency management*

It is also the responsibility of the doctor that he should inform the patient regarding which services are available and which are not, in that facility. Every setup has limitations regarding service delivery. If proper counselling is not done at the start of the treatment, there is a scope of clash between patient's expectations and actual treatment delivery by the facility. So, doctors should make his/her patient aware of this.

*Regarding this, one participant said* "*In our facility, most of the patients know the actual situation and also, we, the doctors, know our limitations, and according to this, we first explain the fact that up to what extent we can provide our treatment or service. According to that, we counsel patient and patient party and provide treatment or referral as needed*." (Participant 1)

*Another participant asserted* "*There is a general crisis due to lack of manpower as well as infrastructure. We need improvement in infrastructure to provide better service delivery*" (Participant 12).

***The balance of power***

The fourth component of the model is the balance of power which means that, doctors have more power than any patient regarding disease knowledge, hospital facility, and treatment availability but before finalization of any decision, it is also the right of the patient to participate in decision making. It shows the amount of respect a doctor

pays to the patient. This category includes two sub-categories, shared decision-making and educating the patient.

*Shared decision-making*

The participants of this study reported that they had often tried to empower the patients or their families by engaging them in therapeutic decision-making or treatment plans.

*One participant said* "*Though doctor's decision is final in finalizing a treatment protocol, we always try to counsel the patient and patient party first and this helps in the acceptance of treatment protocol by the patient wing and the delivery of service becomes easier*" (Participant 1).

*Educating the patient*

Another way to overcome the power imbalance is by educating the patients. This begins with the explanation and translation of medical terminology into an understandable and comprehensible language for the patient and educating them to follow the teaching.

*One participant remarked* "*When I deal with any patient, my prime duty is to counsel them properly because in our hospital, majority of the patients come from low socioeconomic as well as low educational backgrounds and often, they do not follow the advice properly*." (Participant 4)

*Another participant said* "*I have to talk with each patient in their language. The doctor should have the skills to convey his message*" (Participant 16).

Sometimes doctors must use their power and authority to encourage patients who do not accept responsibility for their treatment.

*For example, one participant mentioned* "*I tell my patients that if you think you can trust me, listen to me and obey my recommendations, and then, we will move ahead together*" (Participant 14)

All the doctors who participated in this study mentioned that they intuitively and cautiously understand when and with whom it is necessary to use their power and authority. This depends on the patient's needs and the type of doctor-patient relationship.

***Theme***

To understand the foundation of an effective doctor-patient relationship, the cultural context should also be considered. In this context, a basic element and a prerequisite is to respect the human dignity by viewing every human being as a creation of God.

*In this regard, one participant said* "*Many patients/their families think that we are just like God having the supreme power. But when I cannot do anything for a patient, I always tell them that I am not God, I will try my best but you also pray to God for saving his/ her life*" (Participant 12).

*Another participant stated* "*If I respect the cultural background, this will empower the inner confidence of patients and their families and being a partner of the patient, if I also pray to god for them, they trust me more than before and this ultimately improves the relationship*" (Participant 13).

Thus, behind the foundation of the doctor-patient relationship, the basic element is respect in both ways. If doctors treat his/her patients respectfully and patients also follow the advice with similar respect, this relationship becomes stronger.

## DISCUSSION

The findings of this study showed that those doctors who had more experience and capability of effective communication with their patients understood the therapeutic relationship and healing process more than others. In their view, healing means a cure and it could only be achieved by reducing patient's suffering from a state of disease. But, when cure is not possible, the only aim should be to reduce the suffering. One of the main foundations of this healing process is the therapeutic relationship between doctors and patients which is based on the common underlying beliefs, trust and hope.[9,10] This study tried to propose a model for doctor-patient relationship based on qualitative interviews among the participants.

In the current scenario of medical practice, the model should be well evaluated in order to determine the effect of this model. To begin with, the doctor-patient relationship could uplift patient's quality of life. Mutual trust, peace, and being acknowledged as the results of this relationship were equally important for both patients and physicians. 'In addition, some aspects of this therapeutic relationship were related to the nature and severity of the disease and the type of treatment required; however, the patients' and doctors' systems of belief also had important roles to play in this regard.[11,12] Furthermore, the healing relationship used to affect both parties (patients and doctors). Finally, it could be said that an effective and healing relationship is based on certain criterion, which includes the value of the patient as a human being, his inherent dignity as well as the physician's self-satisfaction after treating the patient. It could be proposed that some of the health system issues could be solved by ensuring this novel doctor-patient relationship.

The doctor-patient relationship is strained and the overall situation is very much crucial in the present time.[13] Violence against doctors is at an all-time high and doctors

are losing empathy.[14] There are multiple factors responsible for this strained relationship. Doctors have an immense work pressure. Due to this, they spend very little time with their patients. Patients, on the other hand, have now developed mistrust issues, largely due to a lack of awareness of their condition. This has been worsened by the general tendency to gain quick knowledge from the internet. Problems like inadequate staffing and logistics leading to long waiting lines for surgeries, lack of essential medicines and inaccessibility to a quality doctor/health-care provider among a large segment of the population also further worsen the issue.

The doctor's lack of communication skills further hinders their relationship. Many medical terminologies used to communicate with the patients are very difficult to explain in local language and this further lead to the worsening of the situation. Orientation to the local language could solve the problem to a large extent.

Over the last decade, the world of journalism has taken the colours of green and yellow due to the rise of television, internet and telecommunication. The new motto of current journalism is "Sensationalism", and healthcare providers became the victims of chaotic mass media campaigns in order to promote their television rating points (TRPs). Most of their "stories" are ill-researched and half-cooked with the potential to spread more rumor than awareness. This leads to a continuous negative impact within the minds of general public against the doctors.[15]

It was emphasized that doctors need to improve their communication skills as it is the key to build a healthy doctor-patient relationship. The new MBBS curriculum included a foundation course for this purpose.[16] It includes skill development in language, interpersonal relationships, communication, time and stress management. The main finding of this study was that respect in both ways is the foundation of this therapeutic healing doctor-patient relationship. So, to uplift this relationship, responsibility is needed from both doctors and patients. A smooth healthcare delivery system cannot run for a long time without this relationship.[17]

The study had some inherent limitations like purposively considering only one institution without any sampling. Therefore, the findings of this study might not reflect the picture of the whole state. Further, a broader multicentric research approach could help to address the issue.

## CONCLUSION

The doctor-patient relationship is a very comprehensive issue and may lead to valuable patient-centered outcomes. The current low caseload setting study provided the idea that even without adequate infrastructure, a set of good communication skills, mutually respectful behaviours among doctors and patients and shared decision-making can do wonders. Every setting has its own limitations, but a common theme should be identified as to maintain a minimum respectful relationship between provider and beneficiary. This would help to run a healthcare delivery system smoothly even in a logistically compromised situation. Further, operational research and multicentric studies should be conducted to address this important issue and for better projection of results.

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