Impact of the Doctor-Patient Relationship

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever wondered what makes the doctor-patient relationship so powerful? Have you ever considered what you could do to strengthen it or to prevent it from crumbling? Have you thought about the consequences of unsatisfactory or adversarial relationships? If you have, then the following case vignettes and discussion should prove useful.

CASE VIGNETTE 1

Mr A, a 43-year-old man with a 20-year history of intravenous drug abuse (complicated by hepatitis C and recurrent abscesses), was admitted to the hospital for treatment of acute bacterial endocarditis. His inpatient medical team consulted the addictions consult/substance abuse team, who evaluated and enrolled him in an outpatient methadone clinic. Mr A noted that prior to this assessment he had never had a "decent" conversation about addiction treatment.

CASE VIGNETTE 2

Ms B, a 75-year-old woman with an alcohol use disorder and gastroesophageal reflux disorder, presented to the oncology clinic following her new (incidental) diagnosis of gastric carcinoma. During the visit, the oncologist explained the importance of assessing the depth of the tumor's invasion into the gastric wall (ie, to stage the tumor and to decide on treatment options). He noted that if the tumor was confined to the most superficial layer of the stomach, it could be excised during an endoscopy. If the tumor went deeper, Ms B would need radiation and/or chemotherapy or surgery. The oncologist arranged for an immediate visit by the surgeon, who informed her that the cancer would almost certainly be invasive and that he planned to remove a large part of her stomach. He described her surgery as very serious, but necessary, because her cancer was very likely to lead to death. As the surgeon turned to write his note in the electronic medical record, Ms B began to shake her head from side to side and cry.

WHY IS THE DOCTOR-PATIENT RELATIONSHIP SO IMPORTANT?

The doctor-patient relationship involves vulnerability and trust. It is one of the most moving and meaningful experiences shared by human beings. However, this relationship and the encounters that flow from it are not always perfect.

The doctor-patient relationship has been 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."[1(p6)] At its core, the doctor-patient relationship represents a fiduciary relationship in which, by entering into the relationship, the physician agrees to respect the patient's autonomy, maintain confidentiality, explain treatment options, obtain informed consent, provide the highest standard of care, and commit not to abandon the patient without giving him or her adequate time to find a new doctor. However, such a contractual definition fails to portray the immense and profound nature of the doctor-patient relationship. Patients sometimes reveal secrets, worries, and fears to physicians that they have not

Clinical Points

- Trust, knowledge, regard, and loyalty are the 4 elements that form the doctor-patient relationship, and the nature of this relationship has an impact on patient outcomes.
- Factors affecting the doctor-patient relationship can be patient-dependent, provider-dependent, health system–dependent, or due to patient-provider mismatch.
- Solutions to each of these factors are rooted in the 4 elements of the doctor-patient relationship.

yet disclosed to friends or family members. Placing trust in a doctor helps them maintain or regain their health and well-being.

This unique relationship encompasses 4 key elements: mutual knowledge, trust, loyalty, and regard.[2] Knowledge refers to the doctor's knowledge of the patient as well as the patient's knowledge of the doctor. Trust involves the patient's faith in the doctor's competence and caring, as well as the doctor's trust in the patient and his or her beliefs and report of symptoms. Loyalty refers to the patient's willingness to forgive a doctor for any inconvenience or mistake and the doctor's commitment not to abandon a patient. Regard implies that the patients feel as though the doctor likes them as individuals and is "on their side." These 4 elements constitute the foundation of the doctor-patient relationship.

WHAT IS THE STRUCTURE OF THE DOCTOR-PATIENT RELATIONSHIP?

In their seminal article from 1956, Szasz and Hollender[3] outlined 3 basic models of the doctor-patient relationship.

Active-Passive Model

The active-passive model is the oldest of the 3 models. It is based on the physician acting *upon* the patient, who is treated as an inanimate object. This model may be appropriate during an emergency when the patient may be unconscious or when a delay in treatment may cause irreparable harm. In such situations, consent (and complicated conversations) is waived.

Guidance-Cooperation Model

In the guidance-cooperation model, a doctor is placed in a position of power due to having medical knowledge that the patient lacks. The doctor is expected to decide what is in the patient's best interest and to make recommendations accordingly. The patient is then expected to comply with these recommendations.

Mutual Participation Model

The mutual participation model is based on an equal partnership between the doctor and the patient. The patient is viewed as an expert in his or her life experiences and goals, making patient involvement essential for designing treatment. The physician's role is to elicit a patient's goals and to help achieve these goals. This model requires that both parties have equal power, are mutually interdependent, and engage in activities that are equally satisfying to both parties.

While each of these models may be appropriate in specific situations, over the last several decades there has been increasing support for the mutual participation model whenever it is medically feasible.[4]

Table 1. Health Outcome Variables Related to the Doctor-Patient Relationship

Outcome Category	Outcome Variable
Objective	Blood pressure Frequency of visits Knowledge/recall Serum glucose level Serum triglyceride level Survival
Behavioral	Adherence to treatment Coping Emotional status Functional status Recovery
Subjective	Global health status Knowledge Pain Satisfaction Understanding

HOW DOES THE NATURE AND QUALITY OF THE DOCTOR-PATIENT RELATIONSHIP AFFECT HEALTH OUTCOMES?

Gordon and Beresin[5] asserted that poor outcomes (objective measures or standardized subjective metrics that are assessed after an encounter) flow from an impaired doctor-patient relationship (eg, when patients feel unheard, disrespected, or otherwise out of partnership with their physicians[6]). Thus, there are many different outcome measures. However, these measures can be divided into 3 main domains: physiologic/objective measures, behavioral measures, and subjective measures. Examples of outcome measures for each of these categories are shown in Table 1.

Stewart et al[7] noted that the physician's knowledge of the patient's ailments and emotional state is associated positively with whether or not those physical ailments resolve. In this instance, the outcome measure is resolution of symptoms (ie, recovery).

In a follow-up meta-analysis of how doctor-patient communication affected outcomes, Stewart[8] noted that the quality of communication during history-taking and management also affects outcomes (eg, frequency of visits, emotional health, and symptom resolution) and that such communication extended beyond creation of the "plan." The manner in which a physician communicates with a patient (even while gathering information) influences how often, and if at all, a patient will return to that same physician.

Furthermore, the quality of communication between doctor and patient involves assessment of the doctor's willingness to include a patient in the decision-making process, to provide a patient with information programs, and to ask a patient about his or her explanatory model of illness

Table 2. Patient Factors That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Patient Factors	Strains on Relationship	Solutions
New patient	Trust: Not yet established Knowledge: The doctor does not know the patient and vice versa Loyalty: There has been limited opportunity to demonstrate loyalty	Regard: Maximize the patient's comfort and feeling of being liked Knowledge: Take time to get to know the patient to maximize your knowledge of the patient
Poor prognosis	Trust: Medical knowledge and interventions may be exhausted Regard: "Pathologic altruism," in which a physician may damage his or her relationship with a patient if the physician fails to recognize when treatment is futile, but continues to aggressively treat the patient, rather than focus on the patient's goals of care[19]	Trust: Ensure that the patient knows you have done everything possible Loyalty: Do not abandon the patient Regard: Find out what is important to the patient and work with him or her to maximize the quality of his or her final days[20,21]
Afflicted with a "frustrating" disease[a]	Trust: The doctor might not trust the patient Regard: The patient and the physician might not like each other; the patient may feel judged; the doctor might have trouble being empathic	Loyalty: Make sure the patient knows that the physician is there for him or her Trust: Educate oneself about the disease in question and the best ways to connect with the patient; create a dedicated team to support the treatment team for a challenging patient; in the case of substance abuse, studies have shown that patients in integrated care groups are more likely to remain abstinent compared to those in independent care groups[22] Regard: Use motivational interviewing techniques to evaluate a patient's current willingness to change and to keep a patient's goals central to care
"Difficult" patient	Regard: The patient might dislike the physician; the doctor may dislike the patient	Knowledge: The physician should actively evaluate his or her feelings toward the patient ("autognosis" or self-knowledge), which allows the physician to use his or her own emotional reactions toward the patient as diagnostic information and allows the physician to thoughtfully change interactive styles with the patient to reduce tension[23]
Health literacy	Trust: The patient may not feel as though he or she has a basis on which to evaluate a doctor's competency Knowledge: The doctor may provide educational materials that are above the patient's literacy level[24] Regard: Misinformation may increase the risk of communication failures between the patient and the physician; using jargon may alienate a patient[25]	Knowledge: Physicians should evaluate their patient's health literacy and tailor the discussion to the patient's level[25]; the doctor should have the patient "teach back" the plan to ensure understanding
Family pressure[b]	Trust: A family may question a doctor's competence; the physician may not trust a family member to serve the patient's best interests Knowledge: A family may know a patient better than the doctor does	Trust and knowledge: A doctor and other members of the care team (including nurses and social workers) should keep family members appropriately informed of a patient's status; frequent family meetings can be arranged Regard: Demonstrate caring for the patient

[a]Diseases that are generally considered difficult to treat (eg, substance abuse, substance-induced comorbidity, borderline personality disorder).
[b]Especially if the patient does not have decision-making capacity.

(ie, the perception of the disease as influenced by personal customs and beliefs).[9,10]

WHAT IS PATIENT SATISFACTION AND HOW IS IT AFFECTED BY THE DOCTOR-PATIENT RELATIONSHIP?

Patient satisfaction is defined as "the degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective, or beneficial."[11] Moreover, all 4 elements of the doctor-patient relationship impact patient satisfaction.

Trust. Bennett et al[12] found that, among patients with systemic lupus erythematosus, those who trust and "like" their physician had higher levels of satisfaction. In another study,[13] patients' perceptions of their physician's trustworthiness were the drivers of patient satisfaction.

Knowledge. When doctors discovered patient concerns and addressed patient expectations, patient satisfaction increased as it did when doctors allowed a patient to give information.[14,15]

Regard. Ratings of a physician's friendliness, warmth, emotional support, and caring have been associated with patient satisfaction.[16–18]

Loyalty. Patients feel more satisfied when doctors offer continued support; continuity of care improves patient satisfaction.[13,14]

WHICH FACTORS CAN ADVERSELY INFLUENCE THE DOCTOR-PATIENT RELATIONSHIP?

While the attributes and benefits of a favorable doctor-patient relationship have been characterized, few studies have provided solutions for an impaired relationship. Therefore, we propose 4 categories (patient factors, provider factors, patient-provider mismatch factors, and systemic factors) that can interfere with the doctor-patient relationship.

Tables 2–5 summarize the major factors in each of these categories, list elements of the doctor-patient relationship affected by each factor, and propose possible solutions; however, these tables are by no means an exhaustive accounting of the nuances of the doctor-patient relationship.

Table 3. Provider Factors That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Provider Factors	Strains on Relationship	Solutions
Physician burnout: state of detachment, emotional exhaustion, and lack of work-related fulfillment[26]	Trust: Lack of trust can lead to lower levels of patient satisfaction and to longer recovery times[27]; the behavioral consequences of burnout (eg, ineffective communication) also jeopardize trust and may damage the trust that patients have in a physician's competence Knowledge: Attentive doctors are better able to understand both verbal and nonverbal communication[28]; therefore, burnout, which hinders attentiveness, prevents physicians from appreciating the needs of their patients, thus failing to identify their ailments Regard: It is harder for emotionally exhausted physicians to show affection; when physicians are burned out, their patients are more likely to report that physicians use nonempathic statements[26] Loyalty: Patients are less likely to return to a physician who fails to recognize their needs or who fails to regard them as individuals	Trust, knowledge, regard, and loyalty: All 4 elements are dependent upon physician well-being; strategies that improve a doctor's emotional wellness will optimize the doctor-patient relationship (eg, mindfulness meditation techniques, work-hour restrictions, participation in Balint groups, and programs to promote personal health [eg, exercise, nutrition, and sleep])[27–32]
Doctors in training or in early career	Trust: Patients may not trust a doctor's competence due to his or her young appearance or apparent lack of confidence Loyalty: Patients might be reluctant to receive ongoing care from an inexperienced physician; patients may request care from an attending physician rather than from "a resident"	Trust: Take the time to explain your clinical reasoning to a patient to demonstrate competence Knowledge: Get to know your patient Regard: Demonstrate caring for your patient
Conflict on or with the treatment team	Trust: If a patient is given mixed messages by a team, faith in the team's ability to treat the condition may be lost Knowledge: If team members fail to communicate effectively (eg, during poor "pass-offs"), then the doctor starting a shift may not know the patient sufficiently Regard: Physicians may be distracted by team conflict and be unable to focus on the patient and his or her problem; doctors may displace frustration with the team onto the patient	Trust, knowledge, and regard: Use structured communication formats and regularly scheduled care-team meetings to improve teamwork[33]; include teamwork instruction as part of general medical education[34]

Table 4. Patient/Provider Mismatches That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Patient/Provider Mismatches	Strains on Relationship	Solutions
Language barriers	Trust: Linguistic minorities report worse care than is provided to linguistic majorities[35]; physicians are less likely to share important medical information[36] Knowledge: Doctors and patients may have more difficulty getting to know one another due to language barriers Regard: Doctors are less likely to show empathy for a patient who is not proficient in the physician's language and are less likely to establish rapport[36,37]	Trust: Print educational handouts in the patient's language Knowledge: Use skilled/trained interpreters rather than family members or members of the treatment team who speak "a little" of the patient's language Regard: Encourage a greater expression of empathy
Cultural barriers	Trust: Patients may not trust Western medicine Knowledge: Doctors may not understand the patient's health goals Regard: Physicians may be judgmental about a patient who seeks complementary and alternative medical therapies	Knowledge: Whenever possible, use interpreters who act as cultural ambassadors as well as language interpreters; use frameworks, such as Kleinman's 8 questions,[10] to elicit the patient's explanatory model; encourage physician participation in global health initiatives[38] Regard: Acknowledge and incorporate traditional practices whenever possible[39–41]
Locus of control[a]	Knowledge: Patients may know themselves better than the doctor knows them and therefore know the best treatment Regard: Power struggles may damage rapport	Knowledge and regard: A mutual participation model can be employed[3]

[a]Locus of control (ie, Who is ultimately making the decisions?).

CASE DISCUSSION

The case of Mr A illustrates an exemplary doctor-patient interaction. He had been hospitalized on multiple occasions with complications (eg, hepatitis C, abscesses, and endocarditis) secondary to his underlying disease (intravenous drug abuse). His medical team made an effort to develop their knowledge of the patient and his disease. Consequently, the team was able to recognize and address his underlying problem. Mr A's team demonstrated regard for the patient by making him feel that they were "on his side," and they demonstrated knowledge of his disease, as well of him as a person, resulting in earning his loyalty. Recognizing the gaps in their expertise with regard to addiction management, the medicine team consulted the substance abuse team after Mr A expressed a desire to change his drug use habits in the context of motivational interviewing. Involvement of the substance abuse team is an example of using available resources to overcome the challenge of treating what is generally considered a "frustrating" disease.

Ms B's case is an example of a failure in the doctor-patient relationship. The oncologist started off well by explaining the upcoming diagnostic steps to the patient. The oncologist built trust by explaining the diagnostic procedures that should be performed to better characterize the nature of the cancer,

Table 5. Systemic Factors That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Systemic Factors	Strains on Relationship	Solutions
Time constraints	Trust: Doctors may not have or make the time to explain their reasoning to engender the patient's trust Knowledge: There is less time for the physician and the patient to get to know one another Regard: There is less time to establish rapport Loyalty: Patients are less likely to be loyal to a doctor if they have not developed positive regard	Trust, knowledge, regard, and loyalty: Develop strategies to increase workplace efficiency, leaving time for physicians to explain their reasoning, to know patients, and to establish rapport; by using prescreening forms and questionnaires while the patient is in the waiting room or by using simple technologies (eg, walkie-talkies to communicate with medical assistants and other support staff), more time can be devoted to patient care[42]
Space/room	Knowledge: If the space is not private, physicians may be reluctant to ask certain questions, which limit their ability to know the patient; additionally, patients may be reluctant to confide in doctors if they do not feel the conversation is private Regard: Busy and uncomfortable clinics may make it harder for the doctor and patient to connect	Knowledge: Whenever possible, take the patient into a private room to ask questions
High patient-provider ratio[a]	Knowledge: Patients may feel like they are objects being discussed, rather than as equals participating in their own care; they may not feel as though they know all of the team members and what their roles are Regard: There may be too many people with whom to establish rapport	Trust: Explain each team member's role and how they contribute to the patient's care Knowledge and regard: Whenever possible, limit the number of physicians who round on a patient at one time; in teaching hospitals, where this is not always possible, team members should introduce themselves to the patient outside of rounds to establish rapport and to know the patient
Urgent care setting (eg, emergency department, clinic)	Knowledge: The doctor and the patient may not know each other Regard: The patient and the physician may be less inclined to invest effort in establishing rapport if they know they will not see each other again Loyalty: Clinics may not be set up for longitudinal care (eg, in the emergency department)	Knowledge: The doctor can learn about a patient's history by calling the patient's prior providers and informing the patient that the providers will receive the results of any testing Regard: Take the time to establish rapport and to make the patient feel comfortable whenever possible Loyalty: Set up follow-up appointments with established providers before discharging the patient
Cost	Regard: The patient may harbor resentment about medical bills Loyalty: The patient may be reluctant to see a doctor due to financial concerns	Knowledge: Make the cost of care a part of the routine conversation with the patient; for example, one can discuss a patient's financial concerns, connect a patient to a social worker or to other financial resources, work with a patient on treatment plans he or she feels are affordable, and prescribe generics when available
Documentation burden	Knowledge: Physicians may spend much of the visit making sure all the necessary computer boxes are checked rather than getting to know the patient as a person; having a computer between the patient and the doctor also makes it hard for the patient to feel like he or she knows the doctor Regard: Physicians may spend much of the visit facing the computer screen rather than the patient, which may make the patient feel as though the doctor does not care about him or her as a person; the amount of paperwork and documentation that is often required also enhances physician burnout, making it harder for the physician to demonstrate empathy and caring	Several time-saving strategies can be employed to reduce the amount of time spent on documentation and increase the time available for physicians to spend with patients Embrace technology: personal mobile computers can improve provider efficiency[43] Use dictation software to speed note-writing When appropriate, write a note collaboratively with the patient during the visit; if using this approach, either turn the screen so that the patient can see it as well or arrange seats so that the physician can maintain eye contact with the patient while he or she is typing the notes

[a]Refers specifically to teaching rounds, wherein a large team of providers visits a patient as a group.

thus demonstrating her competence and understanding of Ms B's disease. The oncologist also increased trust by recognizing her own limits by engaging the surgeon's expertise when needed. However, the interaction between the patient and the surgeon illustrated problems that can arise between the physician and the patient. Since the surgeon had never met the patient before, and the surgeon and the patient had not had a chance to establish trust, neither knew each other and neither had the opportunity to establish loyalty. While it may not be possible for a doctor to develop instant trust and loyalty with a patient (although institutional transference may provide a protective umbrella over the relationship), the doctor in the case of Ms B could have made an effort to demonstrate regard for the patient and to display a desire to know the patient. The surgeon could have started off by asking Ms B open-ended questions about her understanding of her disease, as well as of her fears and expectations regarding her health. This questioning would have allowed the surgeon to create a patient-centered interaction by recognizing and addressing Ms B's thoughts, concerns, and values. The mutual participation model would have allowed the surgeon to build knowledge of the patient as a person and show regard for her. Ms B's responses also would have provided the surgeon with information about her level of health literacy, so the surgeon would be better able to target the discussion to her level of understanding.

The surgeon and the oncologist also failed to present a consistent prognosis for Ms B, undermining her trust in the surgeon and the oncologist's competence and transparency. It is worth acknowledging that sometimes it is difficult to balance the 2 seemingly different roles of a physician: a bearer of bad news that may remove hope versus a healer who cares for and sides with the patient. Neither the surgeon nor the oncologist is necessarily inferior in this context. In fact, the surgeon's intentions were good. The surgeon was attempting to ensure that Ms B was fully informed of all the different outcomes of the suggested procedure. There are no current screening tests for esophageal/gastric cancer,

except in a subpopulation of patients with known Barrett's esophagus.[44] By the time most patients present with symptoms, their disease is well advanced, so the surgeon was right in informing Ms B of the potential severity of her disease. Delivering bad news, especially for a disease with a relatively unfavorable prognosis, will almost always upset any patient. However, the surgeon should have pointed out all the possible outcomes, including that of a superficial malignant lesion, and he should not have sounded so certain about resecting a large portion of Ms B's stomach, especially prior to endoscopic exploration and disease staging. While the oncologist's assessment could have been overly optimistic, provision of all the possible outcomes by the oncologist as well as the surgeon would have demonstrated concordance among the physicians, thus allowing Ms B to retain trust in her providers. Additionally, during the initial visit, the surgeon could have simply stated the possibility of the disease's seriousness, rather than bluntly stating that the disease would most likely be the cause of her demise. The surgeon and oncologist could then reveal more details at subsequent visits when some loyalty had been established and when more information about the extent of her disease was known. Delaying such information until the next visit would not alter staging or management of the disease. The surgeon was right to inform Ms B, but in this context, the manner and the quantity of information divulged ultimately affected the doctor-patient relationship.

Further, distance arose when the surgeon turned away from Ms B at the end of the meeting to complete the visit note. As the documentation burden increases, doctors feel increased pressure to attend to the computer during patient visits, causing face-to-face interaction to suffer. Doctors may unintentionally display a profound lack of empathy by looking at the computer screen instead of at the patient, especially when the patient is experiencing strong emotions. This act of turning away created not only a failure of regard, but also of loyalty. The physician is abandoning the patient to suffer alone despite the physician's physical presence. In this vignette, the surgeon should have fully addressed Ms B's emotions before working on the note. In other circumstances, the physician may turn note-writing into a collaborative experience with the patient and encourage the patient to correct or to fill in additional information. If the doctor is writing orders for the patient, it may be useful to explicitly explain to the patient what the physician is doing on the computer so the patient can understand that the physician is using the computer to help to provide better care.

CONCLUSION

As our vignettes intended to illustrate, the doctor-patient relationship is a powerful part of a doctor's visit and can alter health outcomes for patients. Therefore, it is important for physicians to recognize when the relationship is challenged or failing. If the relationship is challenged or failing, physicians should be able to recognize the causes for the disruption in the relationship and implement solutions to improve care.

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