

# The patient-doctor relationship – a psychological perspective

## Relacja lekarz–pacjent – perspektywa psychologiczna

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**Słowa kluczowe:** relacja lekarz–pacjent, zalecenia lekarskie, modele współpracy.

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### Abstract

This review of available literature aims to present models of co-operation between the patient and the doctor, the consequences of employing these models, and the ways of building relationships. In order to ensure a comprehensive view of this issue and trace the dynamics of changes in this area, we decided to review the relevant literature published since the 1950s. The databases we queried contained academic opinion papers, reports of empirical studies, and publications in psychology of health. Used databases: Academic Search Complete, eBook Academic Collection, Health Source: Nursing/Academic Edition, MEDLINE, PsycARTICLES, and PsycINFO. The analysis focused on the association between the models of patient-doctor relationship and adherence to treatment (adherence or compliance; adherence to treatment). The paper contains descriptions of how models have changed, followed by a detailed characterisation of the paternalistic and partnership-based approaches, also with regard to possible effects on the patient's willingness to adhere to medical instructions.

### Streszczenie

Celem niniejszego przeglądu dostępnej literatury jest przedstawienie modeli współpracy między pacjentem i lekarzem, konsekwencji ich stosowania i sposobów budowania relacji. W celu jak najszerszego spojrzenia na zagadnienie i uwidocznienia dynamiki zmian tego obszaru zdecydowano się na przegląd literatury od lat 50. ubiegłego wieku. Bazy, jakie przeszukiwano, zawierały zarówno poglądowe artykuły naukowe, badania empiryczne, jak i publikacje z zakresu psychologii zdrowia. Były to: Academic Search Complite, eBook Academic Collection, Health Source Nursing/Academin Edition, MEDLINE, PsycARTICLES, PsycINFO. Podczas analizy skupiono się na związku modelu relacji lekarza i pacjenta z realizacją zaleceń lekarskich (*adherence or compliance; adherence to treatment*). W niniejszej pracy można znaleźć opis kształtowania się modeli relacji lekarza i pacjenta w ciągu ostatnich 60 lat. Następnie szczegółowo scharakteryzowane są podejścia paternalistyczne i partnerskie z uwzględnieniem możliwego wpływu na chęć realizowania zaleceń lekarskich przez pacjenta.

### Psychology in a health context

The biomedical model is now being extended to include behavioural, social, and psychological paradigms [1]. In this way, health can be construed holistically, and the individual can be viewed as an element of multiple systems that form a hierarchy among themselves and remain in a state of dynamic balance owing to the flow of information [2].

Contemporary conceptualisations of the health sciences are not limited to a patient's somatic sphere. The biological realm is increasingly being expanded

to include the mental realm. Overall, the health sciences, through the influence of psychology, have been enriched by evidence-based theoretical concepts and the possibility of practical application of psychological knowledge, as in the development of models of health [3]. With regard to health issues, this change is reflected in studies of pro-health behaviours and their structure, and potentially changing such behaviours [4]. Moreover, thanks to analyses of and work on illness as a process or health-oriented prophylaxis, it is possible to propose realistic solutions that health care practitioners can use in their work [5]. Studies are also

carried out to investigate the reasons behind continued adherence to treatment, which has a considerable effect on the outcomes of treatment in various conditions, including mental disorders [6].

According to the psychological conceptions of human personality, two models of health can be derived: a realistic-adaptive model, which contains theories of self-regulation and adaptation, and a postulative model, which presumes the existence of an ideal personality as a result of the process of self-realisation. Such constructs of the conception of health facilitate understanding of issues in clinical psychology and are thus of key importance for the essence of the diagnosis of health, severity of a mental disorder, or the advisability of a treatment [4].

Another area of interest for clinical psychology is the study of relations between health-related behaviours and quality of life, a patient's well-being, and health itself. The implementation of programmes for the prophylaxis, interventions, or changes in health-related behaviours is practical action that is not only of relevance to health-care professionals, in a broad sense of this term, but are also part of a state's policy on public health [7]. The influence of the relationship on the patient's state of health and treatment efficacy is also studied.

The relationship that develops between the patient and the clinician may play a key role in health care as it influences the course and outcomes of treatment [8].

### Forms of patient-doctor contact – a historical outline

The 20<sup>th</sup> century was an era of dynamic changes in broadly construed medical sciences. The medical profession is now respected and economically feasible, but just 100 years ago doctors did not enjoy a high social status [9]. Patients come from all walks of life and social strata, which has led to doctors developing the ability to communicate effectively with representatives of different levels of society.

The early model of the doctor-patient interaction was that of Parson [10], based on skill-dependent division of roles, where the role of the doctor was characterised by professionalism, good will, and an objective approach. The role of the patient was to show full compliance with the demands of the treatment process. For this model to function, the patient must recognise the supremacy of the expert. Only then is it possible to develop a satisfactory therapeutic relationship [11].

Realising that there were gaps in this model, Szasz and Hollender [12] proposed to complement it with a more individualised view of the patient depending on his or her readiness to actively participate in the treatment. Thus, the authors distinguished three types: activity-passivity, direction-cooperation, and mutual participation [13].

Sociologists critical of the functionalist model presented their proposal based on the assumption of conflict theory. Freidson [14] noticed that the behaviour of the doctor and patient in mutual interaction depends on their position in the social structure. The two partners in the relationship have completely different perspectives (potential conflict). According to this proposal, the doctor achieves a higher position by virtue of having power and access to the suggested medical services [15]. In the wake of Freidson's ideas, Navarro [16] and Waitzkin (1983 after: [17]) see a conflict also in the area of potential material benefits. The proponents of this view are afraid that effective communication between a doctor and a patient who is poor, uneducated, or socially ill-adapted is not possible [9].

A gradual shift of responsibility in the doctor-patient relationship is visible in a proposal known as symbolic interactionism. Bloom [18] assumes that, as a result of mutual negotiations, it is possible to jointly define the problem (diagnosis) and develop a way to help (treatment process). A necessary condition for arriving at a joint opinion is the possession of comparable knowledge of the subject matter so that the competent patient can fully understand the opinion of the specialist [13].

Another classification of the patient-doctor relationship found in the literature distinguishes the following types (Emanuel, Emanuel 1992, after: [11]):

1. Paternalistic relation (stemming from the parent-child relationship; the doctor takes decisions regarding treatment, and the patient is urged to agree).
2. Informative relation (the doctor-specialist provides all information and the patient is able to make an informed decision on the basis of the information).
3. Interpretive relation (the specialist describes in detail the patient's condition and treatment, thanks to which the now-competent patient can make a decision).
4. Joint debate (the doctor and patient engage in a dialogue in an atmosphere of collaboration and choose the most appropriate treatment).

Viewing the doctor-patient relationship in the context of the interest of a consumer of medical services forces the patient to adopt an active attitude. This is a consumerist ideology where the beneficiary (patient) can make informed choices on the medical service market. The doctor assumes the role of an advisor and co-decision-maker [19].

An active, informed patient can take care of his or her own pro-health behaviour, undergo prophylactic examinations, and decide to commence treatment. The doctor has a supportive function. This requires that both parties be treated as equal partners.

An analysis of changes in the patient-doctor relationship in Poland has to take into account socio-political changes. In the socialist period, the position of the patient was limited by administrative solutions,

such as the inability to choose a doctor for oneself because of the strict zoning system. Following the systemic transition, the gradual adoption of free-market solutions was possible, which necessarily involved the emergence of competition in offering the best possible medical services. A collection of patients' rights [20] was introduced in 1991, including granting the patient access to information about him/herself or the possibility of choosing a treatment [13]. At present, the effect of a partnership-based relation on continuing treatment or following discharge instructions is increasingly a topic of interest for health care practitioners and health psychologists alike [7].

### **The paternalistic approach and its consequences for compliance with medical instructions**

A health psychologist views the patient-doctor encounter in terms of mutual expectations, needs, and interpersonal styles of both parties to the interaction. Current knowledge tells us that these aspects have an effect on the course of treatment-oriented actions [21].

The paternalistic model, which presumes an unequal standing of the specialist and patient, may engender a number of complex reasons for poor adherence to treatment.

When the doctor uses medical jargon to deliver instructions, the patient may not understand what is being said. As a result, the patient will probably not remember the instructions and, consequently, be able to follow them. An additional factor in this form of doctor-patient contact is the superior position of the doctor, who takes decisions regarding treatment, which the patient ought to obey. Consequently, it is possible that trust will not develop in this kind of relationship [22].

It is only in isolated cases that the distrustful patient will manage to weigh the potential benefits and disadvantages of the recommended course of treatment and will make an informed decision on whether to follow this "directive" [23]. When the patient begins to consider the advisability of a medical instruction, there is a risk that it will not be respected.

Doubts may arise when the patient does not trust the doctor's competences (i.e. does not regard the doctor as a specialist, also in communication), or when a medical instruction is difficult to implement and disturbs normal activity, forcing the patient to change well-established habits [4], such as the need to wear an orthopaedic brace 21 h a day over several years.

Bensig and Verhaak [24] demonstrated an association between treatment outcomes on the one hand and the course of patient-doctor communication and the patient's emotional state on the other. If the patient is anxious and tends to worry, this may have negative consequences for the outcomes and duration of recovery.

### **Roadblocks to interpersonal communication**

The relevant literature includes presentations of theoretical models that shed light on communication difficulties. The classification proposed by Thomas Gordon may serve as an example (1955 after: [25]) (Table 1).

### **The partnership-based approach and its influence on treatment**

Health goals can be viewed in an interpersonal dimension. In this view, they involve the development of a mutual relation and building space to communicate intentions and needs, with an emphasis on the speaker's competence [4]. An interpersonal approach provides the space to employ psychological means in order to facilitate the institution of a desirable health behaviour for both parties and at the same time lessen the frustration on the part of the doctor, who is afraid that the interventions he or she advises will not be implemented [25].

It can be stated that there is a direct relation between a patient's mental state and treatment outcomes. Actually, "Psychologia zdrowia" [Psychology of Health] by Prof. Heszen and Prof. Sęk contains the following statement: *Thus, it may be supposed that emotional factors mediate the relation between the characteristics of a patient's rapport with the doctor and treatment outcomes* (p. 249 [4]). Hence, by taking care to promote an atmosphere of trust and hope between the doctor and the patient, we are actually trying to ensure good efficacy of the treatment we advise [26].

Patients view doctors as more competent when doctors devote enough time to them, ask their opinion, and show a willingness to help patients cope with their illness. This kind of approach instils trust (Bensira 1980, after: Bishop 2000) [27].

### **The importance of perceived control in a stressful situation in the doctor-patient relationship**

Patients are more likely to agree to suggested treatment if they feel in control of the situation in the patient-doctor relationship [28].

By giving the patient a sense of being able to influence the situation, e.g. by pointing out possibilities for obtaining information or showing treatment options, we increase the patient's sense of perceived control and, at the same time, decrease stress levels [27]. If mutual partnership is maintained during the doctor-patient interaction, the patient will be able to really influence the situation and make decisions about him/herself [29].

### **The effect of positive affect on coping with illness**

Research shows that an optimistic frame of mind and a sense of perceived control have a protective ef-

**Table 1.** Patient – doctor possible communication difficulties

No.	Potential roadblock	Sample message	Possible negative effect on the patient
1	Ordering, directing, commanding	P: I don't like these drugs, I don't think they're helping me D: Please continue taking them, it is me who will assess their effectiveness	A sense of inferiority, disruption of further communication
2	Warning, commanding	P: I wonder if I will ever be healthy again D: If there's no trust inside you, you will never be healthy	Making the patient unwilling to ask more questions
3	Moralising, preaching	P: I am afraid of taking antidepressants, I've never taken psychiatric medication D: You should take them for the sake of your husband	Telling the patient what they should be feeling, producing a sense of inferiority
4	Name-calling, labelling	P: I'd like to shave on my own D: Don't be such a superhero. Can't you accept that someone has to take care of you?	Producing a sense of inferiority in the patient and using a defensive attitude
5	Judging, blaming	P: I am sorry that my lipid profile has deteriorated D: Well, that's no wonder since you've been doing nothing but sitting on the couch	Making the patient feel that they are under attack. Counter-criticism of the doctor is a possible outcome
6	Disapproving, opposing, lecturing	P: I am afraid of taking sleep medicines D: You have a misconception about these medicines and I have to explain it all to you again	Producing a sense of inferiority in the patient and using a defensive attitude
7	Approving, supporting, praising (insincerely/ineptly)	P: I'm upset because my husband needs continuous care D: That's normal, he has Alzheimer's	Making the patient suspicious of being manipulated or embarrassed
8	Analysing, interpreting (excessively)	P: I've been feeling worse and worse D: You're saying all those things to get out of today's exercises	Making the patient feel "exposed" and ashamed
9	Reassuring, sympathising (ineptly)	P: I'd like to get home again D: You've got nothing there and here everyone likes you	A sense of the problem being downplayed, making the patient feel misunderstood
10	Ignoring, distracting, interrupting	P: I am afraid I'll die D: I'll take your pulse now	A sense of the problem being ignored
11	Questioning, probing	P: The nurses are ignoring me D: Why are you telling me this? Have you used the bell	A sense of lack of understanding and lack of willingness to help
12	Advising, suggesting specific solutions	P: I have a headache after this session D: You need to take the medicine, lie down and make yourself a compress. That helps everyone	A sense of lack of understanding and not being approached on an individual basis

*P – Patient, D – doctor/another health care professional, such as a physiotherapist.*

fect on mental and physical health. Positive emotions can contribute to improving one's health and maintaining physical well-being [30]. Compliance with medical instructions is influenced by an optimistic belief in the efficacy of the doctor's actions and in one's ability to act in line with certain indications [31].

Falkman and Moskowitz (2000, after: [32]) claim that positive affect can act as a kind of buffer against the undesirable consequences of stress. In an encounter with the patient, the doctor should take care to ensure a balance of negative and positive emotions, so

that the doctor can simultaneously have control over the broadly construed condition of his/her patient, including, for example, tension or cognitive abilities [33]. If the patient experiences positive emotions during an office visit, he or she will be more likely to interpret a stressful situation as a challenge. To achieve this, the doctor needs to ensure that the patient has understood the description of his or her condition and the advice he or she should follow [34].

Analysing a problem situation in the setting of positive affect: excitement, joy and trust promote the for-

mation of a positive opinion about the solution to the stressful situation (Lazarus, Falkman 1984, after: [30]).

### The Six-Step Method is helpful in forming a collaborative relationship with the patient

A study by Prof. Heszen-Niedołek *et al.* (1992 after: [4]) showed that a patient's satisfaction with encounters with a doctor depends on a harmonious exchange of information and a positive attitude of both parties. Of use in developing and maintaining a partnership-based relationship is a model developed by Gorgon and Sterling [25].

#### 1. Defining one's needs without suggesting solutions

We pay attention to the goals and values of the patient as well as the doctor. A key skill on the part of the health care professional is that of active listening to show acceptance and understanding of the patient's fears.

#### 2. Searching for possible solutions

At this stage, when the patient and the doctor together generate ideas, creativity is very important. For the time being, solutions are not evaluated, just produced.

#### 3. Assessment of solutions

The collaborating parties assess the suggestions with regard to possible results or risks associated with a given treatment. Allowing the patient to give an opinion about the treatment increases his or her sense of control of the situation.

#### 4. Adopting a solution accepted by both parties

When the patient accepts a solution that has been developed in a collaborative setting, there is no sense of imposition. If a proposal appears satisfactory to both parties, it is important to formulate it in a clear and unequivocal manner.

#### 5. Implementing the agreement

Of importance here are reliable division of work among those involved in implementation of the plan and assigning specific tasks to be carried out.

#### 6. Assessment of the outcomes of the agreement

It is important that the doctor and patient should have space for evaluating their joint decisions. Thanks to that, should circumstances change, there will be no danger of the mutual agreement on treatment being cancelled. It will only be updated.

Seeking inspiration in the collaborative model presented above, the doctor takes care to maintain a partnership-based relationship with the patient. This increases the likelihood of compliance with the doctor's instructions, thus increasing the probability of effective treatment.

### Conclusions

Health psychology is a new science exploring health-related human behaviour: prophylaxis or structuring and changing pro-health behaviours. In the relevant world literature, various models of the doctor-patient relationship have been discussed since

the 1950s. Following the dynamics of development of relationships, two principal models of collaboration are now indicated: paternalistic and partnership-based. Maintaining positive affect during an office visit combined with indicating to the patient areas that he/she can control may improve compliance and, accordingly, have a positive effect on treatment. The Six-Step Model may help implement the partnership-based model of collaboration with the patient.

### Conflict of interest

The authors declare no conflict of interest.

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