Understanding Patient Doctor Relationship via a Sample of Iraqi Doctors

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Abstract:

Background: Rapid changes in healthcare delivery system & socio-political climate have resulted in considerable strain on Doctor-patient relationship. Doctors' role is to install positive energy within the patient, through which sick people find relief from suffering. Without it, there continues to be more confusion, fear, and doubt. Future doctor should show compassion, be open, honest, & admits when he is unsure.

Objective: This study aims to understand the social dimensions of Iraqi Doctor misbehavior & mal-communication with patients.

Subjects & Methods: A cross sectional study, with a tool consisting of two sketch Drawings representing an agonizing misbehavior scenario for a female gynecologist encountering a pregnant patient, & a male orthopeditian encountering a disabled male patient. Scenarios were presented to a convenient sample of 155 Iraqi Doctors, pooled during (2012-2014) in Baghdad, striking their feelings, to generate rich comments.

Results: About two thirds of Doctors were females, and the majority was non specialists. Only 7.1% of Doctors (with significant gender difference), offered an excuse for the misbehavior. Around 80% of Doctors expressed patient sympathy. Scenario understanding showed significant Doctors' gender difference. Two thirds of Doctors stated reasons & suggested solutions for the misbehavior. Main reasons stated were: commercialization of medicine (23.8%), loss of today's Doctor humanity (18.1%), and profession power & ability to threat (15.2%).

Conclusion: Although Doctor-patient misbehavior is not un-prevalent, most Iraqi Doctors disagree with it. The majority express professional sympathy. Less than tenth of Doctors stand by misbehavior, trying to give excuses. Commercialization of medicine, loss of Doctor's humanity, professional power, & mal-communication are emerging challenges for future Iraqi Doctor-patient relation

Key words: Doctor Patient relationship, Iraqi Doctor, Commercialization of medicine.

Introduction:

The 21st century nature of patient-physician relationship is far more complex due to preponderance of chronic disease, new medical technologies, shifting reimbursement practices, internet, governmental regulations, rising costs, changing social norms that are constantly molding patient physician behavior [(1)].

Doctor-patient relationship grows over time with mutual trust and understanding, based on shared experiences and respectful dialogue [(2)]. The rapid changes in healthcare delivery system & socio-political climate have resulted in considerable strain on this relationship [(3)]. In the last 30 years, medical care in the west has increasingly emphasized patient autonomy, & decision making [(4)].

Talcott Parsons was the first social scientist to theorize four norms governing the functional sick role: the individual is not responsible for his/her illness, exemption of the sick from normal obligations until he/she is well, illness is undesirable, and the ill should seek professional help [(5)].

The doctor-patient relationship had been found to be associated with patient's satisfaction, treatment adherence, treatment outcome [(6)]. Doctors' role is to install positive energy within the patient, through which sick people find relief from suffering [(7)].

In the 1970s clinical competence emphasis on communication was missing [(8)]. Although effective doctor patient communication is shown to be highly correlated with patient satisfaction, real live experience shows that physician often discourage the voicing of concerns, expectorations, & request for information [(9, 10)].

The exact mechanism for how physician satisfaction is related to patient communication is not known, but physician's satisfaction with their professional life was associated with greater patient trust and confidence [(9)].

Various physician-patient communication components such as empathy, reassurance, patient-centeredness, information sharing, and friendliness have statistically significant positive effects on patient's health [(11)]. Future doctor should show compassion, be open, honest, & admits when he is unsure. He should have a preventive approach, and a broader understanding for patients' emotional, social, mental, spiritual, physical dimensions of human experience (patient centered) [(12)].

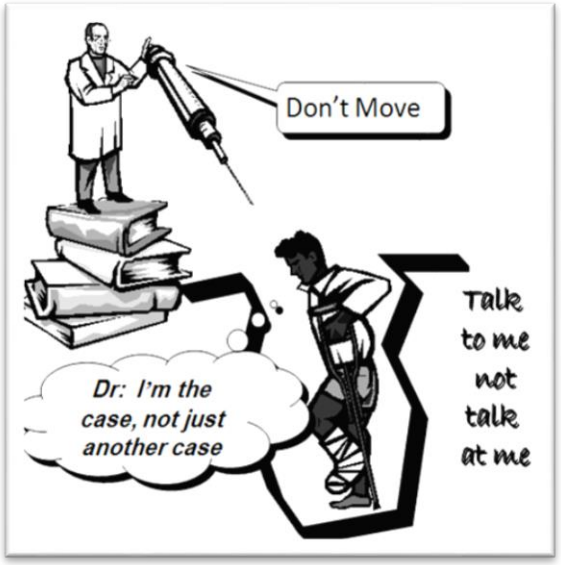
This study aims to understand the social dimensions of Iraqi Doctor misbehavior & mal communication towards his/her patient.

Subjects and method

The tool of this cross-sectional study consists of two sketch Drawings designed by the researcher, using electronic "Microsoft Office Word" clip arts: The first sketch represents a scenario of a female gynecologist encounter with pregnant patient - while doing sonography - in a private hospital. The second sketch represents a scenario of a male orthopedic

surgeon encounter with a disabled male patient, while giving an injection.

The scenarios were designed to reflect an agonizing inhuman defect in the Doctor-patient relation that is expected to strike the feeling of the viewer, and brainstorm him - if he/she is a doctor - to generate rich comments.



Sketches were distributed to collections of in-service Iraqi doctors, whether specialists, postgraduate students or non-specialists. The study sample was pooled from meetings, small conferences, and educational settings during the years 2012-2014 in Baghdad.

In order to neutralize gender effects, female doctors received the females' patient-doctor scenario, while male doctors received the males' patient-doctor scenario. All were asked to write down - in Arabic - their comments (to translate their generated feelings into comments), and return back the plates within ten minutes without giving their names. Presenting an agonizing picture may be more brainstorming than asking a direct question about Doctor-patient relation opinion.

A total non-random convenient sample of 155 doctors was enrolled in the study after returning back their comments. Seven doctors who fail to write comments were excluded, thus the response rate was 96%.

Comments were reviewed systematically by the researcher looking if: The Doctor disagrees with the health provider's behavior in the presented plate and why; whether he excuses the health provider for his/her behavior; if he/she reflects sympathy to the patient in the presented plate. In addition the researcher looked if the Doctor correctly understood the defect in the relation, and if he had a corrective perspective, or offered any positive solution.

Data were presented and analyzed using Microsoft office excel 2010, & SPSS v.20, with a cutoff p value of 0.05 to denote significant results.

Results

Of the 155 Doctors participating in the research, 60% were females, and 44% were in the thirties. Non-specialists constitute the majority sample (87%), (table 1):

Tab 1: Gender, age, & Specialty of Doctors sampled

Respondent Gender	**No. (%)**
Male Doctors	62 (40)
Female Doctors	93 (60)
Total	**155 (100)**
Age Group (yrs)	**No. (%)**
20-29	23 (18)
30-39	56 (44)
40-49	35 (27)
50-59	14 (11)
Total*	**128 (100)**
Mean age (yrs) Age range (yrs)	37±8.15 (24-55)
* 27 Doctors Unrevealed their age	
Doctor specialization	**No. (%)**
Non-specialists	135 (87)
Specialists	20 (13)
Total	**155 (100)**

While almost all Doctors (98.7%) disagreed with the presented Doctor misbehavior, only 7.1% of Doctors (with significant gender difference in favor of male Doctors) offered an excuse for the misbehavior. Around 80% of Doctors expressed sympathy for the scenario patient. Scenario understanding was significantly different between male & females Doctors. As 80.5% of female Doctors & 63% male Doctors understood the scenario properly. Accordingly, about two thirds of the Doctors (with no significant gender difference) stated possible reasons & suggested solutions for the misbehavior problem (table 2). Main reasons for the scenario misbehavior stated by Doctors were financial drive or commercialization medical practice (23.8%), followed by loss of today's Doctor humanity (18.1%), then the profession power & ability to threat (15.2%). Mal-communication & vast social level differences were stated by 13.3% & 11.4% of Doctors respectively (table 3).

Tab 2: Respondents' comments for the presented behavior in Doctor-patient encounter

Respondent comment	**Scenario type (Doctor-Patient)**	**No (%)**	**Yes (%)**	**Total (%)**
Agrees with Doctor misbehavior	Male-male	71 (97.3)	2 (2.7)	73 (100)
	Female-female	82 (100)	0 (0)	82 (100)
	Total	**153 (98.7)**	**2 (1.3)**	**155 (100)**
Excuses Doctor for his misbehavior	Male-male	64 (87.7)	9 (12.3)	73 (100)
	Female-female	80 (97.6)	2 (2.4)	82 (100)
	Total	**144 (92.9)**	**11 (7.1)**	**155 (100)**
Corrected X^2= 4.33 P= 0.038 S				
Expresses sympathy for patient	Male-male	15 (21.5)	58 (79.5)	73 (100)
	Female-female	14 (17.1)	68 (82.9)	82 (100)
	Total	**29 (18.7)**	**126 (81.3)**	**155 (100)**
X^2= 0.31 P= 0.58 NS				
Understands the misbehavior	Male-male	27 (37.0)	46 (63.0)	73 (100)
	Female-female	16 (19.5)	66 (80.5)	82 (100)
	Total	**43 (27.7)**	**112 (72.3)**	**155 (100)**
X^2= 5.88 P= 0.02 S				
Stated reasons, & hence suggested solutions	Male-male	27 (37.0)	46 (63.0)	73 (100)
	Female-female	23 (28.0)	59 (72.0)	82 (100)
	Total	**50 (32.3)**	**105 (67.7)**	**155 (100)**
X^2= 1.41 P= 0.24 NS				

Tab 3: Main reasons stated for presented Doctor-patient misbehavior

Main reason	No. (%)
Doctor Financial Drive	25 (23.8)
Loss of Doctor humanity	19 (18.1)
Doctor Power & ability to threat	16 (15.2)
Doctor-patient mal-communication	14 (13.3)
Vast differences in social levels	12 (11.4)
Presence of big social distance	07 (06.7)
Patient-Doctor misunderstanding	05 (04.8)
Lack of bilateral trust	03 (02.9)
Busy Doctor (time pressure)	02 (01.9)
Presence of social barrier	02 (01.9)
Total	**105 (100)**

Discussion

Enrolled Doctors in the study covered two generations, ranging from early twenties to mid-fifties, with male to female ratio of 2:3. Specialists constituted 13% of the sample.

All sampled female Doctors, and most of male Doctors considered presented scenarios as misbehavior from the doctor's side. This issue is expected as an essential part of this human profession. Studies show that worst physician perceived insensitive, disrespectful behavior is disinterest in patient as an individual, and impatience in answering a patient's question [13]. Physicians often react negatively to dying patients, patients they do not like, and patient they believe are complainer. Physicians also are subject to personal financial, and personal interests in patient care [5].

In addition, less than tenth of studied sampled offered an excuse for the presented scenario behaviors, with significantly male predominance. This is alarming for the deterioration in issues of warmth & human care. It is unusual for a Doctor to through his human role, and enroll in misbehavior with his patient, but studies show physicians and other providers to react less favorably with patients who are held responsible for their illness, than to "innocent" patients [5]. Justifications from Doctors for misbehavior may emerge from physicians lacking the social skills to truly engage patients in mutually satisfying relationship [2].

Medical education, and social role expectations, impart normative socialization to physician, to act in the interest of the patient, rather than their own material interests [5].

Majority of Doctors (under this study), expressed sympathy for the presented patient. This human feeling is professional, although traditional Iraqi Medical training neglected the importance of empathy, and rapport-building skills, focusing on curing the patient with the right diagnosis and Drugs.

On the other hand, female Doctors significantly understood the misbehavior more than male Doctors did. This in expected from the sensitive delicate gender, especially if exposed to what strikes their feelings.

To boost Doctor-patient relation understanding, physicians must be equipped with knowledge and skills from the behavioral and social sciences needed, to recognize, understand, and effectively respond to patients as individuals [11]. Unfortunately, in Iraqi medical schools, medical sociology is taught only to community medicine postgraduates, who are not in direct contact with patients, leaving the clinical sciences' candidates, which are in most need.

Consequences of misbehavior would be expected to be malpractice suits, or patients' violence. Reasons that instigate patients to file malpractice claims include: deserting the patient, devaluing patient, delivering information poorly, failing to understand the patient [9].

Most Doctors in the study were ready to suggest solutions for the presented Doctor-patient misbehavior. Suggestion & solutions were rich, thanks to the brain storming effect of the presented agonizing pictures. Main stated reason for the misbehavior was the effect of financial pressure on the health provider, or the commercialization of medicine.

Growing studies on cost containment showed that Patient is interested in maximizing consumption of health, and the physician is interested in maximizing income. Studies documented that patients without health insurance have less access to doctors, and receive less care from them when they have access [5]. Consultations delivered by profit, & quantity driven medical practices fail to provide sufficient time for the development of a familiarity [3].

There is a need for an in-depth understanding of consumer (patient) perspectives [12].The term "patient" and not "customer" or "client" best portrays

the relationship nature [3]. Marxist sociologists interpreted the relationship within the context of capitalism, where profit maximization drives the innovation of technologies and drugs and constrains physicians' decision-making [5].

Next important reason mentioned that destroys the Doctor-patient relation is Doctor's humanity loss, especially if associated with poor Doctor-patient communication. Literature highlighted the importance of communication and the role of good doctor patient relationship in buffering against patients dissatisfaction [9].

Adding to the problem is the power & ability of the medical provider to threat. Professionalization grants physicians a monopoly on the definition of health and illness [5].

The vast differences in social level between a lay & a professional, creating big social distance, and initiating social barriers in the relation, were other reasons mentioned by sampled Doctors. Accordingly radical de-professionalization is required, to minimize the social distance between doctors and patients [5]. De-professionalization is not eliminating the skills of the doctors, but the privilege, power, and monopolization of medical knowledge [5].

The misbehavior may arise from misunderstanding, & lack of bilateral trust. For the relation to work, patients need to trust doctors' competence & professionalism. Trust also a factor ensuring compliance. It is unrealistic to expect patients to have blind trust in doctors. [14].

Time pressure on a busy Doctor was also stated as a reason for misbehavoir. There is a fear that health care system in its push for greater efficiency has become dangerously close to the edge when it comes to time [8]. Studies show that when physicians spend more time discussing with patients concerns about their disease, they prescribed fewer Drugs [11].

In a study on pregnant patients, nearly half women surveyed reported lack of time to ask health professionals questions [15]. Literature shows average medical encounter lasts 9.4 minutes in UK, & 14.5 minutes in Canada [16].

In conclusion, although Doctor-patient misbehavior is not un-prevalent, most Doctors disagree with it, and the majority express professional sympathy. Less than tenth of Doctors stood by misbehavior, trying to give excuses for this unprofessional act. Commercialization of medicine, loss of Doctor's humanity, professional power, & mal-communication are emerging as challenges for future Iraqi Doctor-patient relation.

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