The Complicated Doctor-Patient Relationship: Part 2

DPMs should not treat foot problems… they should treat people with foot problems.

BY KENNETH REHM, DPM

Editor's Note: *This is part 2 of a two-part article. In part 1 the author discussed the two basic approaches to the practice of medicine; the four pillars of physician engagement; and the vital importance of empathy-driven behavior. Part 2 further explores these concepts and also shines a light on how current medical education is failing to educate students on interpersonal skills and patient relations.*

Patient-Centered Communication

It is fair to say that all communication skills require the basics. It bears repeating that using clear and understandable words that are kind and comforting—but that still impart exact meaning that corresponds to the patient's level of understanding and acceptance—is at the very heart of good doctor/patient communication. The choice of words and the tone of voice used offers support and can validate patients' feelings and concerns. In conversation with patients, when the doctor is able to offer self-disclosure and verbally relate to the patient's narrative, the patient will be more open to offer information that lies below the surface, which often offers the most meaningful insights. These skills can be learned, and it is incumbent upon every clinician to develop these abilities.

Patient-centered communication offers myriad benefits. Research[1] has shown positive impact on the patient's relationship with the provider, along with improved patient satisfaction and well-being. It is associated with lower levels of emotional distress and anxiety, and improved quality of life. Patients having a more participatory role in their care are more satisfied with their care; have less angst regarding their diagnoses; and have a healthy feeling that they have some control over their lives and are not simply victims of their disease.

Regarding the use of technology and its relation to patient-centered communication, it must be noted that while there are some benefits to using computers in medical consultations, they can have deleterious effects on the doctor-patient relationship. Many physicians feel challenged and limited regarding their ability to concentrate on the patient and the computer at the same time, especially when the computer requires answers to questions not directly related to why the patient is there for the visit. Listening to patients and answering their questions doesn't always blend easily with having the computer as a main focus during the visit. And we need to remember that one of the important causes of medical errors and unintentional harm to patients is ineffective communication.

Today's Students

To yearn for the warm and trusting relationship between doctor and patient of yesteryear almost seems futile. This precious memory will continue on the back of a total metamorphosis of the healthcare system. Medical school curriculums, for example, are shifting dramatically to accommodate the rapidly changing student population. While school curriculums need to undergo measured adaptation to advances in science and medicine, some of these changes may not be conducive to developing the interpersonal, social and communication skills that would foster excellent doctor-patient relationships. There is concern that some of these innovations will set the stage for detrimental outcomes in the future practice of medicine.[2]

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For example, though the COVID-19 pandemic is (presumably) a thing of the past, it has caused a disruption in medical education and forced a transition for many courses to online platforms. Another innovation is

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the so-called "flipped classroom",[3] where the classroom is used NOT to hear a lecture, but to perform hands-on learning exercises and discuss a lecture that was previously reviewed as a homework assignment. The student then comes to class with a basis of knowledge and, through dialogue and interpersonal exchange, can view the subject matter from different points of view, with the goal being to better internalize the information and form an airplane view of the subject more quickly. This may sound like a beneficial innovation, but it turns out that the current fervor is not commensurate with the amount of scientific evidence in its favor, and does not support a justification for its further implementation.[4]

Medical schools are disinclined to educate students on interpersonal skills and patient relations. Though this has long been an ongoing reality, today's students seem particularly in need of this sort of education. Analysis of today's students reveals that they score higher on assertiveness, self-liking, narcissistic traits, and high expecta-

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tions, along with unfortunately high levels of stress, anxiety, and poor mental health.[2] Students are presenting with inadequate time management skills, lack of preparedness and increased psychological stress, each resulting in a failure to accomplish learning tasks and concomitant responsibilities. These factors definitely contribute to a negative impact on the learning process. In order to maintain the highest standards in medical education, these challenges need to be addressed, no matter what instructional method is used.[4] Imagine how these problems, if left unresolved, might translate to a failure in the ability to engage with patients on the many levels needed to participate in an effective doctor-patient relationship.

Additional Shifts

In recent years, there are additional shifts in the culture of medical practice that have aligned to undermine, devalue and diminish the doctor-patient relationship. One such example is the demise of the private practitioner in private practice and the rise in popularity of managed care organizations (MCO) and federally funded clinics, employing physicians that are obligated, or financially incentivized, to perform on par with corporate benchmarks, such as complying with restrictions involving doctor-patient conversations;[5] guidelines regarding to whom and when a referral to a specialist, or outside provider, can be made; the number of patients that are expected to be seen in a day; and how much time is available for the doctor to spend with a patient, among other managed care protocols.

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The MCO "time crunch", in particular, has made a mockery of the doctor-patient relationship. Some managed care organizations have allotted only 10 minutes per patient per complaint.[6,7] In this appointment, only one complaint can be evaluated; and other 10-minute appointments will be required to deal with each additional complaint. The patient here is forced to know enough about medicine and about which complaints need to be discussed first, and how to offer the proper information regarding this complaint such that it is meaningful to the doctor. Surely there is not enough time for the physician to do a complete investigation and assessment. What a dilemma! Besides, one complaint may shed some light on another. This scenario creates immense psychological stress and tension (on both ends of the stethoscope) that can destroy any meaningful doctor-patient relationship. This assembly-line approach might be cost-effective but it is, in this author's opinion, very destructive to our whole healthcare system, and is not conducive to real healthcare.

We mentioned the difficulty of trying to juggle computer usage and interpersonal relating during the patient visit. Over the past 30-plus years, the use of computers and electronic medical records have become the prevailing norm in the practice of medicine across all medical specialties. The management of medical visits has become, for the most part, dependent on technology-mediated approaches. These might assist the physician in gaining data-driven facts, but leaves the information that would be gathered through conversation and intuition, guided by experience, untapped. Thus the patient does not have the opportunity to develop a close bond with—and therefore trust in—the doctor, and not enough information becomes available to the doctor in the process. In this scenario, the patient would not feel that "he or she (referring to their doctor) really understands my situation.". Only through appropriate discussion, focused bilateral self-disclosure and motivational interviewing techniques can the necessary repose be accomplished.[8] When the patient walks out of the office, they feel a void, leaving them second-guessing, which creates a sometimes subtle, and sometimes overt, sense of insecurity and anxiety and a lack of appreciation of the doctor's training, skill, knowledge and ability to handle the problem at hand. These regrettable types of physician visits are becoming more and more common in our current healthcare arena.[9]

Summary

In summary, this paper discussed the doctor patient-relationship, and attempted to lay the groundwork for its relevance to healthcare—regardless of what system is in place, what advances in technology arise, and however times have changed. One's healthcare is a very personal, complicated, intimidating and frightening arena to most. In order for people to have an optimal healing and healthcare experience, they need to feel part of the process and have some control over this very important part of their life. The doctor must understand this while guiding the patient through this wooded jungle and

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owning the responsibility for an efficacious experience. And remember: the foot is attached to the rest of the body, and the doctor is not treating a foot problem, but a person who has a problem with their foot.

In conclusion, we will never go back to the "old fashioned" ways. But let's move forward, creating a new paradigm, merging what works and is good from the past and the present with our vision of a future that we want to have; and one that works for everybody. It's not going to be easy, but we need to be creative and diligent and I believe we can have it all and still uphold the patient as our highest priority……If we really want to. **PM**

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