ASSESSMENT OF DOCTOR-PATIENT RELATIONSHIP IN ARAB ORGANIZATION FOR INDUSTRIALIZATION HOSPITAL AND AL KHABIRY HEALTH CARE CENTER IN MAADI

Thesis

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بسم الله الرحمن الرحيم

﴿وأنزل اللـه عليـك الكتــاب
والحكمة وعَلَّمَكَ مَا لَمْ تَكُن تَعْلَمُ
وكَانَ فَضْلُ اللَّهِ عَلَيْكَ عَظِيماً﴾

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LIST OF ABBREVIATIONS

i. AOI	Arab Organization for Industrialization Hospital
ii. CDC	Centers for Disease Control and Prevention
iii. DM	Diabetes Mellitus
iv. FDA	Food and Drug Administration
v. ICD	International Code of Diseases
vi. ICU	Intensive care units
vii.NORPEQ	Nordic Patient Experiences Questionnaire
viii. PCMH	Patient-Centered Medical Home
ix. SD	Standard deviation
x. SES	Socioeconomic status
xi. SOC	Standard Occupational System
xii. UK	United Kingdom
xiii. US	United States of America
xiv. WHO	World Health Organization

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INTRODUCTION

One of the principles of family medicine adopted by the College of Family Practice of Canada is that "the patient-physician is central to the role of the family physicians", family physicians around the world thus should make an initiative to make themselves the advocates for improving doctor patient relationship in medical care. Extra effort to improve communication and relationship with patients would help to reduce complaints, improve compliance and reduce unnecessary investigation. To this end, family medicine academics should take the first step to study this area of medicine which is currently under-researched ***(CFPC, 2000)***.

The relationship between patients and physicians remains fundamental to the delivery of care despite all the changes in the health care system. Patient–physician relationship model is a complex system operates in the routine practice of medicine. Both patients and physicians have personal beliefs, fears and attitudes that shape their expectations for a medical encounter. Their beliefs engender a pre-visit level of trust that exists before they walk in to the examination room ***(Gallagher and Levinson, 2007)***.

In turn, expectations and pre-visit trust both influence what transpires during the visit, including the nature of the questions patient asks, the negotiation between patients and physicians, the process of decision making and the emotions both patients and physicians experience ***(Henry, 2003)***.

The interaction and communication during the visit shape outcomes, including the post-visit level of trust, the likelihood that the

patient will follow treatment recommendations, patient satisfaction, actual biological outcomes, the potential for malpractice legation in case of a bad medical outcome and physician satisfaction. Subsequently, this outcome incorporated in to both patients and physicians pre-visit beliefs and trust in future encounters ***(Pearson and Raeke, 2000)***.

Increases in competition among health care services have led organisations to consider marketing strategies and alternative methods to maintain patients and increase the number of patients they serve ***(O'Conner and Shewchuck, 1995).*** To achieve this objective, patient satisfaction with the health service provision, namely the quality of the interaction with the doctor, has been described as a critical factor to consider ***(Hausman, 2004).*** However, given the association between satisfaction, health outcomes and the adherence to therapeutic suggestions ***(DiMatteo et al., 1980; Bartlett et al., 1984),*** the relevance of satisfaction appears to go beyond benefits for individual health service providers. A lack of adherence, or non-compliance, can lead to death and significant health care costs ***(Mojtabai and Olfson, 2003).*** Another concept shown to reduce health care costs and increase health outcomes is patient participation ***(Vernarec, 1999).***

The identification of customers as 'partial employees' ***(Bowen, 1986),*** interlinked with the cocreation paradigm, has recognized the customer as a means for value enhancement and to increase productivity ***(Lovelock and Young, 1979),*** thereby including the customer in the creation of the service delivery. For customers to positively experience intangible services, ***Bowen (1986)*** acknowledges that equipping service providers with interpersonal skills can influence satisfaction. In addition, building long-term relationships with customers is considered essential for the economic survival of most service firms today ***(Berry, 1995;***

Heskett et al., 1994). As such, the physician is the key in maintaining and enhancing relationships with patients.

Medical service is defined by ***Orava and Tuominen (2002)*** as "a health care service intended to influence a person's health, directly or indirectly, through procedures executed by medically educated personnel". It is characterised by a high level of interaction between the doctor and patient ***(Lovelock and Young, 1979),*** and has been shown to include (1) one-on-one interactions (2) frequent encounters with the same physician (3) intimate exchanges (4) variability across encounters and (5) the requirement of patient cooperation to achieve successful health outcomes ***(Hausmann, 2004; Johnson and Zinkhan, 1991; Waitzkin, 1985)***.

Research hypothesis:

Dr-patient relationship in AOI hospital is better than in ALkhabiry health care center and patients will be more satisfied with the hospital environment.

The study question was: is their difference regarding doctor patient relationship in both places (AOI hospital and AlKhabiry center) and its relation with different aspects of patient satisfaction

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AIM OF THE WORK

To assess and compare doctor-patient relationship among patients attending outpatient's clinics in internal medicine, gynecology and obstetrics and pediatrics departments in Arab Organization for Industrialization Hospital and in AL Khabiry primary health care center in Maadi district.

DOCTOR PATIENT RELATIONSHIP

The primary goal of any health care delivery system is to provide the best possible care to its patients. In this modern era, where it is the right of every patient to demand best possible care in medical facilities, it is also the duty of every medical staff member to deliver his optimum efforts to the entire satisfaction of the patient. The core axis around which the whole health care system revolves is the relationship between patients and doctors. Without an intact doctor patient relationship, no health system can work ***(Barbour & Lammers, 2007)***.

Moreover, this relationship is tied by communication. Doctors need information from patients to determine an accurate diagnosis and effective treatment plan, and patients need information about their medical problem and the rationale and procedures for its treatment. So, for any health care system to work properly, communication between doctors and patients needs to be effective and precise ***(Bradley et al., 2001)***.

The doctor patient relationship is the core of clinical medicine. The doctor must have knowledge and skills to practice medicine safely, but the relationship he or she has with each patient will also affect outcomes. An effective relationship will help the patient feel better and be healthier, and will usually result in improved job satisfaction for the doctor ***(Kaplan et al, 1996)***.

In spite of the scientific developments, the doctor-patient relationship has been described as “an unchanging event in medicine”, preserved mainly by the “unchanging goals of medicine”. Medicine is

fundamentally a human activity aimed at helping the sick and disabled, through healing, alleviation of suffering, and caring for people with respect and dignity ***(Siegler, 2000)***.

The quality of the relationship between a doctor and a patient is a key factor in the effectiveness of care. Good doctor-patient communication is associated with a higher level of patient satisfaction and better compliance. Furthermore, optimizing doctor-patient communication can lead to better patient health and outcomes ***(Jensen et al., 2010)***.

Available evidence suggests that low-income populations and people without health insurance report lower communication satisfaction and a reduced access to care ***(DeVoe et al., 2009)***.

The doctor-patient relationship can be seen as a specialized form of human relationship, and work in other disciplines has distinguished between the dynamic interactive aspects of relationships and the mental associations made by people 'in' relationships, which are 'historically derived representations of experience' ***(Duck, 1998)***.

Broadly speaking, the doctor-patient relationship can be viewed as either a process or an outcome, and opinion on which is most appropriate is divided. Although the purpose or function of the relationship is likely to vary according to the perspective of the observer, clinical imperatives emphasise its value as a component of the care process that might improve health outcomes. A better understanding of those aspects of doctor-patient relationships that affect patient care is required, because it has implications for how doctors are trained and health care is organized. If continuity, for example, makes a unique contribution to doctor-patient relationships, then it may be unwise to pay excessive attention to doctors'

communication skills in isolated consultations; instead greater emphasis on organizational systems that promote continuity may be appropriate ***(Dowrick, 1997)***.

➢ Historical background:

Parsons, (1951) was one of the earliest sociologists to examine the relationship between doctors and patients. His interest arose from a broader theoretical concern with how society is able to function smoothly and respond to problems of deviance. Parsons regarded social functioning as partly achieved through the existence of institutionalized roles with socially prescribed patterns of behavior. All people, therefore, all aware how people are likely to behave when they occupy the role of father, teacher, shop assistant, and so on, and of their expectations of others when occupying the complementary role of child, pupil or customer.

Parsons viewed the role of the doctor as complementary to the role of patient. Just as the patient is expected to cooperate fully with the doctor, doctors are expected to apply their specialist knowledge and skills for the benefit of the patient, and to act for the welfare of the patient and community rather than in their own self-interest. Doctors are also expected to be objective and emotionally detached, and to be guided by the rules of professional practice (tab.1) ***(Cerný, 2007)***.

Table (1): Parsons' analysis of the roles of patients and doctors

Patient: sick role	Doctor: professional role
Obligations and privileges: 1. Must want to get well as quickly as possible	**Expected to:** 1. Apply a high degree of skill and knowledge to the problems of illness
2. Should seek professional medical advice and co-operate with the doctor	2. Act for welfare of patient and community rather than for own self-interest, desire for money, advancement, etc
3. Allowed (and may be expected) to shed some normal activities and responsibilities (e.g. employment and household tasks)	3. Be objective and emotionally detached (i.e. should not judge patients' behaviour in terms of personal value system or become emotionally involved with them)
4. Regarded as being in need of care and unable to get better by his or her own decisions and will	4. Be guided by rules of professional practice
	Rights: 1 Granted right to examine patients physically and to enquire into intimate areas of physical and personal life
	2. Granted considerable autonomy in professional practice
	3. Occupies position of authority in relation to the patient

(Parsons, 1951)

Generally speaking, there are two dominant approaches towards the study of medicine: the medical one and what ***Cerný, (2007)*** calls the "sociolinguistic" one. Because some studies have proven that both doctors and patients are dissatisfied with each other, and because this dissatisfaction is mostly connected with the quality of talk between them, the medical approach is usually concerned with doctors and how they should be educated in order to improve their services. Its aim is a more effective health care delivery.

The "sociolinguistic" approach, on the other hand, is concerned with "studying language in real-life situations", emphasizes the roles of both participants, and prefers qualitative analysis, including time-consuming transcriptions. The sociolinguistic approach studies