

A Qualitative Study on the Importance and Value of Doctor-Patient Relationship in Iran: Physicians' Views

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Abstract

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BACKGROUND: Doctor-patient relationship [DPR] refers to verbal and non-verbal communication between doctor and patient, which is of great importance in consultation sessions.

AIM: Therefore, the present study attempts to explore the importance and value of DPR in Iran.

MATERIAL AND METHODS: The method used in the study was conventional content analysis. The data were collected from 21 faculty members (FMs) of Shiraz University of Medical Sciences (SUMS), Shiraz, Iran, who participated in three focus group discussions (FGDs). Transcribed data were analysed using Conventional Content Analysis (CCA) which identified condensed meaning units, subthemes, and themes.

RESULTS: Four themes were extracted from 198 meaning units, 87 condensed meaning units, and 17 subthemes. These included gateway [the role of DPR]; nonlinearity [the nature of DPR]; distortion (quality of DPR in the context); and dysfunctional system (weakness in health system). Generally, results showed DPR to be the gateway to consultations based on non-verbal communication and doctor empathy. The study showed distorted DPR which was due to the dysfunctionality of the health care system.

CONCLUSION: As indicated DPR plays an important role in medical contexts, but if distorted it leads to an unsuccessful outcome. Therefore, to promote DPR, it is necessary to reinforce its structure. Thus, the infrastructure has to be modified and developed at all levels.

Introduction

DPR is an important topic for discussion [1] [2] [3]. It includes verbal and non-verbal communication between doctor and patient [4] [5], which lead to a bilateral exchange of views. Each clinical communication has three aims including a good personal relationship, exchanging information and making decisions [4]. Thus DPR plays an important role in healthcare systems [6].

Scholars have presented different DPR, having three diverse models with three features. These include activity-passivity, guidance-cooperation and mutual participation [4]. According to scholars, DPR is situational, and each of its three models is only suitable for a particular condition. Also, Emanuel

and Emanuel have presented additional models which are paternalistic, informative, interpretive, and deliberative. They believed that in the deliberative model physician helps patients explore health-related values and choose a treatment based on these values, which is best suited for DPR [7]. At the same time, there are two models of medical encounter including socioemotional and task-oriented versions. Satisfaction is considered a socioemotional result and recall and compliance are regarded as task-related outcomes [8].

Generally, these models could be classified into two groups including physician-centred and patient-centred models. The physician-centred model is recognized by the domination of physicians with the exchange of biomedical information, whereby the patient input in medical dialogue is the least [9] [10],

asymmetrical and dominated by the power of the physicians [11] based on absolute knowledge and medical standards [10]. This view legitimates asymmetrical power relationship. However, in a patient-centred model doctor communicates with the patient according to his or her views and values [12] [13] [14] [15] [16]. This view is based on an equal power relationship.

In the sociology of medicine, there are two rival approaches. On the one hand, there is a Parsonian view which legitimises the asymmetrical power relationship [17] [18]. Parsons theory of social system is based on a phrase of sick role [19] [20]. A sick role is a functionalist approach of medical institutions [21] [22], where illness and disability are defined as social deviance [19] [23] and abolished on patients' gaining ability to return to society [24].

On the other hand, there is critical sociology which theoretically criticises modern medicine by focusing on the critical point of DPR [10] [25] [26] [27] [28]. Michel Foucault is a pioneer sociologist who has criticised the knowledge-power discourse of modern medicine [29]. In his writing on *The Birth of Clinic* he indicated that the clinic is constantly praised for its empiricism, the modesty of its attention, and the care with which it silently allows things surface to the observing eye without being disturbed by discourse which owes its real importance to being a reorganization in depth, not only in medical context but because of its most likely impact on discussion about disease [30]. Jürgen Habermas is another critical sociologist whose theory criticises the medicine as a symbol of the modern institution and expert power [31].

Generally, these two rival theories view medicine from different aspects. The important point is that DPR is of pivotal importance in, where it plays a crucial role in medicine by its specific impact on doctor-patient satisfaction [32] [33] [34] and promoting the efficiency of consultation, a milestone in the present study. Despite its significance, this issue has been neglected in Iran and has only been the subject of a doctoral dissertation prepared in teaching hospitals affiliated with SUMS [1] [3] [9]. Additionally, the past few years have witnessed some critical discussions about the relationship and communication problems regarding doctor-patient interaction in Iran's public sphere, a reality that reflects the importance of present investigation.

Methods

The data of this qualitative research were collected from April to September 2014. The Department of Ethics and Philosophy of Medicine at Shiraz University of Medical Sciences [SUMS] invited

40 academics to discuss DPR. The data for this study were collected from target groups between April to September 2014. The method used for sample collection was heterogeneous sampling or maximum variation sampling because the study intended to detect high variations in perspectives. The participant received letters of invitation to the study and briefed on the research objectives. The inclusion criteria were more than 3 years of teaching and clinical experience in different medical fields, being members of the university during this study, and not being retired or from outside.

The focus group discussion [FGD] method was used for the collection of data. The reason for using this technique was access to heterogeneous perspectives and collective opinions of the participants. FGD included a moderator and a note taker who recorded the points discussed. The moderator brought up the questions which were then discussed and answered by the participants. Two fundamental questions raised in the discussion group were as follows: [1] *How important is the communication between physicians and patient?* [2] *What is the situation of doctor-patient communication in Iran?* The moderator led the participants to the issue concerned whenever they deviated from the main topics. Before starting discussions and for ethical considerations, the verbal consent of the participants was obtained regarding the digital recording of the topics under discussion.

Based on saturation criteria, three focus group discussions attended by 21 participants were concluded with the aim of obtaining maximum information. Of three focus groups, two lasting 1.15 and 1.25 hour were held in the department of medical ethics, and one, lasting 1.05 hour, in the conference room of Nemazi hospital.

The information obtained was transcribed and analysed using Conventional Content Analysis [CCA]. As a whole, there are three methods for content analysis. These are conventional, directed, and summative approaches. In the conventional method, the researcher analyses the data, regardless of the previously determined theoretical framework about the subject [34]. The coding of data was performed by the constant back and forth movement across the data and by interpreting the statements made by the participants. This was a continuous process and performed by back and forth movement of analysts between data, concepts and extracted codes. The concepts and codings were directly extracted from the data. The greater the level of movement toward pivotal codes, the larger was the level of data segregation. Thus data were interpreted to explore condensed meaning units [brief meaning of the interpretation], sub-themes [the initial abstracted concept that explored the related condensed meaning units], and themes [an abstracted concept about some subthemes]. Accordingly, all concepts obtained from research data, through back and forth movement, had

the highest level of categorisation.

The present research was validated by member check method [35] whereby participants were informed about the extracted concepts, and their approval constituted the authenticity of the research. The credit-rating or trustworthiness was another issue which attracted the attention of participants. This was observed during the study by maintaining subjectivity and reflexivity, adequacy of data, and efficiency of interpretation strategies [36]. The selection of conventional content analysis and considering the research objective formed the basis for stepwise collection and analysis of data. The credibility of coworkers was also considered about research design, methodology and analysis of data. The credibility was ensured by members check and peer debriefing, transferability by thick description, and conformability through reflexivity. Also, reflexivity was observed with drawing attention to the production of knowledge and minimising the prejudgments of researchers.

The present study was based on ethical research code of the Helsinki declaration and conducted according to the ethical committee of SUMS. Also, alongside obtaining the consent of participants to take part in the study, attempts were made to observe the anonymity of participants, including all stages from data collection to the final research report.

Results

Twenty-one physicians with 11 specialities participated in this study (Table 1).

Table 1: Participants' characteristics

Field of Specialty	Number of participants [s]	Number of focus groups
Surgery	1	1
Psychiatry	5	1-2-3
Internal Medicine	1	2
Gynaecology	2	2
Dentistry	3	2
Endocrinology	1	2
Pathology	2	1,2,3
Psychology	2	1,3
Radiology	1	1
Anesthesiology	1	1
Nephrology	2	3

The results of 198 meaning units, 87 condensed meaning units, 17 subthemes and 4 themes are demonstrated in Table 2.

Generally, results showed that DPR is an important part of medical care. All participants agreed that a proper DPR should lead to mutual satisfaction in both parties. Thus, the doctor feels that his/her treatment is on the right path. At the same time, patients feel that they have achieved their goals in the consultation. Furthermore, because of mutual

understanding, the patient feels that the consultation has been effective. All participants emphasised the importance of DPR. As shown in Table 2 four themes extracted from the coding processes include *gateway*, *nonlinearity*, *distortion*, and *dysfunctional system*.

Table 2: Conventional content analysis of the doctor-patient interaction

Meaning unit	Condensed meaning unit	Subtheme	Theme
I think interaction is the key to treatment domain. We communicate to enter this domain by asking questions.	Interaction is the key	Speciality of DPR	Gateway
Physical examination needs to be more interactive than communicative.	Importance of interaction		
In Psychiatry, interaction is the key. A good relationship means good interaction.	Good DPR is equal to good interaction		
I have two Iraqi patients are unable to communicate in the Persian language, and I do not speak Arabic either. But we have complete trust in each other.	Trust is created with unknown events	The unplanned trait of relationship	Nonlinearity
We have a good relationship with each other which leads to empathy .But most of the times we do not know how this form of communication has happened and why it has evolved	Both parties do not know how good relationship and empathy occur	Humanistic DPR	
By nodding your head or saying um... and with eye contact, the patient feels that the doctor understands him/her and has no feeling of being ignored.	Nonverbal communication has important role		
Even today, there are still some physicians, even with good reputations, who do not even talk to their patients	Silent doctors	DPR without meaning	Distorted DPR
A mechanical relationship means that no attention is paid to the patient's psyche; the person in front of you is a human being whose soul and psyche should be taken into account	Non-humanistic relationship		
The doctor performs an examination and then decides without any communication	Treatment without communication	One-dimensional relationship	
Some doctors are inclined to ask questions, and when a person sits in front of them, they start asking questions in an interrogative tone.	Interrogator relationship		
At present, there is no course or workshop for medical ethics, and even now, such courses are not offered during our residency period!	Education in DPR and ethical issues are ignored	Malfunction and dysfunction of medical education.	Dysfunctional system
In the clinics, students learn from their academics how to give consultation without having to communicate	Passive DPR Hidden curriculum.		
There is no control over doctors. Some specialists work late until 2 AM. I know a surgeon specialist in Tehran who has employed 10 surgeons to work for him anonymously.	Doctors are not controlled and supervised.	A system without monitoring and controlling	
We do not have any screening plan for selecting medical students.	Lack of monitoring and controlling.		
The biggest obstacle is the system. Our flawed health system forces the attending physicians to visit 50-60 patients per day.	There is no balance between the number of patients and doctors.	Irresponsive system	
When I have to visit 100 patients in a Hospital, I cannot even understand what the thirtieth or the fortieth patient is saying, or I simply refer him/her to my residents.	The high volume of patients and weak communication.		

Gateway refers to the importance of DPR in good treatment. Without the gateway, an inefficient treatment is natural because the doctor cannot enter the private domain of a patient. Thus, for better treatment, a physician needs to communicate with the patient. He needs to ask about the history of illness and its signs. Also, a successful treatment hinges on a complete knowledge about the patient, which is achieved by an active DPR. Thus, DPR is a gateway of medicine

"I think interaction is the key to treatment domain. We communicate to enter this domain by asking questions. Physical examination needs to be more interactive than communicative. The dialogue should be done in the second stage, after gaining the patient trust in a way he/she accepts the physician" (Surgeon of FGD 1).

This interaction is a stepping stone, which if not present the treatment will not be successful.

"In our field, interaction is the key. A good relationship means good interaction. The first step in DPR should be based on a good Rapport. It means

that the doctor has to have a warm, empathic relationship with patients. He/she has to sense the patient's problem and needs" (Psychologist of FGD 2).

As these statements show, DPR is the key or the gateway of interaction. It means that without good relationship doctor cannot have an effective treatment, and will not gain the patient's trust.

DPR is not a linear path which can be planned. It is an ongoing and nonlinear process. It is a flexible and complex phenomenon due to its humanistic structure. Generally, an important trait of DPR is non-verbal communication that causes nonlinearity in a relationship. The initial eye contact is very meaningful that tells both parties how this interaction will continue. Meanwhile, greeting, posture and doctor's tone of voice are the non-verbal communications that produce a communicative package. Undoubtedly, the first eye contact plays an important role and establishes the quality of the relationship.

"During the initial eye contact empathy is shaped, then the next interaction occurs that opens the path of diagnosis and progressive treatment" (Psychiatric of FGD 2).

Thus, a good DPR is heavily dependent on the first interaction. In this stage oral communication does not have any significant role.

"By nodding your head or saying um... and with eye contact, the patient feels that doctor understands him/her and does not have the feeling that he/she is talking to a wall" (Psychologist of FGD 1).

Non-verbal communication and empathy lead to the nonlinearity of communication. This means that both parties had not decided on how to communicate with each other beforehand.

"I have two Iraqi patients who were unable to communicate in the Persian language, and I do not speak Arabic either. But we have complete trust in each other. We liked each other which led to empathy. However, most of the times we didn't know how this form of communication had happened and why it developed" (Surgeon of FGD1).

Another theme is called distortion which is related to the quality of DPR in the context of this study. All participants were concerned about the quality of DPR in Iran. They believed that DPR is flawed and derogatory to patients. A distorted relationship is one-sided and regulated by the doctor's personal experiences, without verbal and non-verbal communication that does lead to a mutual understanding. Such a relationship would ignore the scientific principles of diagnosis and treatment. The doctor, instead of engaging in a dialogue or any verbal or active non-verbal interaction, finalises the consultation within several minutes. The statements have shown that a distorted DPR, within the context of

this study, had turned into a *norm*, where the doctor may even conduct his consultation without any verbal communication at all:

"Nowadays, there are still some physicians, even those with good reputations who do not even talk to their patients (Infectious infant specialist of FGD 3) As witnessed, in the governmental system,, verbal communication has sharply declined and it has leaned towards a situation where the doctor performs an examination and then makes a decision without any type of communication" (Psychiatric of FGD 3).

"Don't even talk" indicates a total absence of verbal communication between the doctor and patient. In such situation, diagnosis and treatment are mainly based on the doctor's experiences or laboratory data. In extreme cases, the patient may feel that the doctor does not consider him/her as a human being in need of treatment. A distorted relationship is mechanical and passive in which no interaction takes place. Also, the doctor would not gain any understanding of the patient's perception of the illness, and thus, the patient feels that part of his/her existence has been ignored. As such, the interaction is governed by an instrumental relationship.

"A mechanical relationship means that no attention is paid to patient's psyche; the person in front of you is called a human being whose soul and psyche should also be taken into account. By considering psychological issues, the doctor can treat many of his physiological problems, and the psychological aspects should not be ignored or suppressed, or treat the patient as an object. Treating a patient is not like repairing a car. The doctors do not look at their patients, but they only look at the lab tests papers" (Psychiatric of FGD 2).

So, a distorted relationship deviates from its natural pathway for transferring the meanings, and thus it cannot contribute to a common understanding of the disease, its diagnosis and possible treatment. Under such circumstances, diagnostic and therapeutic purposes are ignored. Another characteristic of a distorted DPR is inequality, where the doctor makes a one-sided diagnosis and prescribes a treatment, while the patient leaves the office without any interaction. There is even a higher level of inequality in doctors' conduct and their patterns of questioning, shaping an interrogator style of dialogue:

"He is not supposed to act like an interrogator! Some doctors are just like that, and when a person sits in front of them, they start asking questions in such atone" (Psychiatric of FGD 1).

In an interrogative interaction, the patient faces a multitude of closed questions which should be answered with Yes/No. If the patient wishes to change the direction of the consultation, for example by asking a question about diagnosis or therapy, the question is simply suppressed and ignored. As such, either the doctor prevaricates, or if the patient insists,

he/she may receive an unpleasant answer. Beside, dissatisfaction and ineffectiveness, the main outcome of distorted DPR is patient' deception.

"Deception frequently happens, specifically in the field of Gynecology which includes differential diagnosis. The patients who come to us are young and healthy and do not have any medical problem. Despite this, deception is frequently taking place" (Specialist in OB-GYN of FGD2).

The dysfunctional system refers to the weakness of the healthcare network in the systematic management of DPR. All participants agreed that there is a structural failure in managing the medical institutions which have led to distorted DPR. Healthcare system is lacking strategy regarding macro and middle levels of medical systems in providing a theoretical framework for a good DPR. Due to a large number of referrals, doctors are forced to give consultation to many patients considering standard protocols.

"When I have to visit 100 patients in the Hospital, I cannot even understand what the thirtieth or fortieth patient is saying, or I simply refer him to my resident. How much strength should I have to visit 100 patients!?" (Nephrologist of FGD 3).

This problem is not only related to admitting patients, but there is a similar situation in the clinic. For instance, a psychotherapist has to spend at least thirty minutes with each patient, but those in charge have different expectations.

"The biggest obstacle is the system. Our flawed health system forces the attending physicians to visit 50-60 patients, while everything is dependent on interaction, and if non-existent, even in case of emergency, no matter how much I try to help, it won't work" (Psychiatric of FGD 1).

Also, the health system focuses on the number of services, merely by increasing the number of consultations. In such a situation, the criterion for professors is simply promotion and the number of papers they have published, while their performance is not evaluated.

"In Professors' Promotion Form, there's no item for quality, and the whole story is about the number of published papers. The best academic that I've seen with numerous papers receive half a dozen of patients in his room, and never allows them to talk, and for the sake of his promotion, quality was not considered, and the only thing which was important was the number of published papers! I wonder how much these papers are going to help patients in reality" (Internist of FGD 2).

Another characteristic of the dysfunctional system is poor control/supervision, or even lack of surveillance overtreatment, which adversely affects DPR processes. Lack of control and supervision on physicians' work seems to be intentional with its

benefits.

"...I just wanted to say that we are not satisfied ourselves, because there is not even a system to put us within a framework, and this is a serious obstacle" (Surgeon of FGD 1).

Dysfunctional system neglects to teach ethics and philosophy of medicine. In this structure, DPR skills are not taught, and ethical problems are not explored.

"During our time, there was no course or workshop for medical ethics, and even now it is missing during our residency period! So, teaching such issues is not important, and professors do not expect students to know about them. The only important thing is the lab test results and medical procedures, and not the way you treat the patient". (Psychiatric of FGD 2).

Finally, there is no effective screening system to select medical students.

"Here, no attention is paid to medical students when they are accepted; most of them should not even be allowed to choose medicine as their major in the first place and are fit for other majors" [1].

Discussion

This study aimed to explore the condition of DPR according to views of FMs. Results showed that DPR is the key to successful diagnosis and treatment. It plays an important role in medical interactions where if not present physicians cannot provide appropriate treatment and enter into the patient's private domain. Also, DPR is a nonlinear phenomenon which presents interaction between two human beings. Nonlinearity means that both parties do not know how and where the interaction begins and how it continues. This also means that interaction is heavily dependent on non-verbal communication specifically the eye contact and empathy. Despite the importance of DPR and its characteristics, the unequal and distorted DPR has become the norm. Distorted DPR is more related to the dysfunctionality of health care system which is due to lack of strategy about a successful DPR.

Our study showed that a good DPR has two main components which are non-verbal communication and empathy. As Friedman mentioned, non-verbal communication through touch, facial expression, voice tone, etc. is essential for a successful patient-physician interaction [38]. Also, non-verbal mode characterised by nodding, forward lean, direct body orientation, uncrossed legs and arms, arm symmetry, and less mutual gaze is shown to be positively associated with outcomes of DPR [39].

Regarding the distorted DPR, our findings were confirmed by other studies [1] [40]. However, there are different perspectives about distorted DPR. Sadati et al. showed that the asymmetrical power relationship is related to modern medicine discourse [1], the domination of paraclinical standards [10], and dysfunctional healthcare system [3]. Additionally, Mishler's classic study showed that this form of interaction is related to the separation between the voice of medicine and the voice of lifeworld [36]. Barry et al. showed that type of illness could affect the quality of DPR [38]. This study showed that asymmetrical and distorted DPR is due to the dysfunctionality of health care system which is in line with Sadati et al., a study [41], a situation leading to several interactional problems in DPR. [42].

Our study revealed that dysfunctionality of health care system plays a pivotal role in the formation of distorted DPR. Thus, distorted DPR is related to the nature of modern medicine and its voice, but it is also associated with the health care system approach to DPR. When the health care system does not have any strategy to address this issue, medical students have no clue as to how to initiate a good relationship. Also, due to lack of active surveillance in the system, doctors do whatever they wish.

According to our results and concerning functionalist theory or Parsonian theory a poor form of DPR is due to the dysfunctionality of the system. In this context, we are witnessing a hidden conflict between the structure and the agency. Also, the agencies are tremendously powerful because there are no plans to manage, control and survey the inherently fragile structure. According to the critical theory, we can say that the powerful discourse of modern medicine is naturally suppressive and leads to distorted DPR. According to the results of other studies [1] [41], an asymmetrical power relationship is expected that includes different shapes and forms of suppression.

In conclusion, the results of this study showed that the gateway to a successful diagnosis and treatment is active DPR, which is a nonlinear phenomenon and related to non-verbal communication and doctor's empathy. In this context, the dysfunctionality of the healthcare system leads to distorted DPR. Knowing that the system suffers from this problem, there is as yet no strategy to deal with this issue. Therefore, if a powerful and strengthened DPR is desired, appropriate measures should be taken to reinforce its structure. This can be achieved by modifying and redeveloping the underlying infrastructure. Finally, system surveillance has to be promoted in addition to the fundamental revision of medical ethics.

Limitation and recommendation: The main limitation of this study was that it only presented the subject from a physician's perspective. Thus, future

studies are warranted with a variety of views including patients, doctors of private hospitals, nurses and other caregivers of the health system. Also quantitative studies on this subject are proposed.

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