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Perspective

A Letter to the Practitioners Sincerely, the Patients

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One of the most noble and popular reasons healthcare workers enter the profession is to help the sick and dying. The origins of medicine can be attributed to this goal; however, modern medicine can now be described more accurately as "disease-specific" diagnostics and therapeutics [7]. It is very easy to lose site of the individual under all of the patient data, regulations, strict guidelines, and most of all the stress of shift work and disrupted circadian rhythms. It's imperative that we see patients' as individuals rather than a list of symptoms on a chart [1].

A crucial part of making the patient feel valid is effective communication. Oftentimes patients feel stressed, anxious and helpless during their hospital visit and inadequate communication can add to this anxiety [5]. Therefore, good communication is used as an invaluable tool in producing therapeutic effects through comfort [5]. That being said, communication cannot be described as one-dimensional as it extends beyond words. Vocal tones, body language, openness, sincerity, and even concealment affects communication and makes up what we call "bedside manner" [5,6]. A healthcare professional may run into countless obstacles when practicing effective communication, however, caring for a patient involves treating the entire individual, which includes the patient's mental well-being [6].

As the patient meets with the practitioner, it's almost as if they enter into a partnership. Like any relationship, it will take trust, reliance and mutual respect for it to work, and patient-practitioner dynamic is no different [6]. On the contrary, the differences start to settle in when boundaries must be set because after all, it is a professional relationship [7]. The line between caring verses objectivity must be trodden lightly. A common phenomenon that takes place between patients and practitioners are known as transference and counter-transference [14]. Abiding to set boundaries will aid to minimize these experiences.

Another point to take into consideration is the patient's perspectives of the healthcare worker. The practitioner may be viewed as superior due to reasons like the use of medical jargon and authority that may put them in a position of superiority [7]. This relationship can be further complicated by patient's inability to help their situation leaving them depended on the healthcare worker and feeling helpless [7]. It's critical that the practitioner be aware that these feelings may exist and try to limit any feelings of inferiority by establishing a good rapport. Feelings of helplessness can be limited by empowering the patient to be more involved in their care using techniques like shared decision-making and taking into consideration the patient's treatment goals [4].

Relevance

It is very easy to lose site of the individual under mountains of patient data, rules and regulations of institutions combined with the stress of shift work. Although the goal is to make the patient better, one must keep in mind that the patient bares more stress because they are scared, helplessness, and may be suffering from hospital anxiety [7]. Health care workers (HCW) simply get used to this idea of treating patients in a very technical manner simply because they are surrounded by it all the time [1].

Exploring the relationship

In the past, the relationship between HCWs and patients can be described as paternalistic relationship where the HCW had higher social status [16]. For example, "Doctor" was seen as a sacred occupation and every order was followed without question by patients. The current relationship can be described more as a mutuality relationship where majorly of the patients have higher education with a better economic status and more likely to question diagnosis and treatment strategies and have more autonomy over their treatment [16].

Influences

Both the patient and the practitioner can be influenced by external factors. The patient may be influenced by previous experience, the media, family, friends, cultural influences, literature regarding intuitions or particular HCWs. A phenomenon called transference can also take place in which the patient acquiring emotional responses about the practitioner based on past experiences or simply if the practitioner resembles someone in the patient's life [14]. This can cause prejudices either positive or negative about the HCW even before the first interaction [14]. The patient may have certain expectations out of the HCWs such ranging from showing social niceties like proper greetings and avoiding medical jargon to investing time listening to personal issues and how treatments will impact their livelihoods [3]. This can be considered the "ideal practitioner" [3,7] and in many ways, does not actually exists in clinical practice. The same can be said for practitioners where they can be influenced by previous patients, cultural influences, age of the patient, patient's history and similarly a phenomenon called countertransference [14]. Countertransference is when the practitioner forms biases towards patients based on their past experiences or acquiring emotional responses towards patients that may remind them of member in their personal life (i.e. family/friends) whether they may be positive or negative [14]. Practitioners may also have expectations from patients such as taking responsibility, being honest about their illness, regard themselves as in need of care and always cooperating with the practitioner [3,7]. The "ideal patient" if you will and alike with the ideal practitioner, the ideal patient may be very rarely seen [3]. There isn't a perfect solution to this problem but perhaps the realization that one may never get the ideal patient or the practitioner therefore instead of expecting a higher standard, both parties can attempt to be their ideal selves to meet in the middle and minimize any conflict that may arise. From the practitioner's perspective using a "patient centered" approach always keeping the patient in the loop, paraphrasing medical jargon and avoiding any show of superiority [7]. In return the patient can be honest about their illness and be more cooperative with HCWs benefiting both parties and help speed up the diagnosing process.

The psychology

An in depth look into the current relationships between the patient and practitioner.

Dr. Talcott Parsons was an American sociologist and was the first to theorize the role-based approach of the doctor-patient relationship [2]. He described four different relationships that can take place between a patient and a practitioner where each has its own advantages and disadvantages. These include Paternalistic, Mutual, Consumerist and Default relationship [3,4,7].

A paternalistic relationship is when the physician has higher control over the patient, regarded as the traditional form of doctor-patient relationship "Voice of Medicine" [3,4,7]. The patient tends to have more of a passive role and is expected to cooperate with orders and treatment options. This type of relationship uses a "disease centered model" of medicine and focus on reaching a diagnosis, rather than the patient's unique experience of illness [4]. Advantages are that it gives the patients relief from the burden of making hard decisions that can bring added anxiety, furthermore, the confidence that is elicited by the HCW may bring about what is called "medical magic", a placebo effect to the patient that they are in capable hands and their illness will be taken care of [3,4]. The disadvantages that can come from this is possible manipulation and exploitation of the vulnerable and ill with the HCW having ultimate control over decisions [3].

A mutual relationship is seen more as a consultation style where there is active involvement from the patient [3,4,7]. Seen more as equal partners where both parties share power and responsibility; a joint venture [4]. The foundation for this type of relationship is com-

munication and taking an interest in the psycho-social aspect of the illness and eliciting informative answers. The patient has a responsibility to define their problems in an open and full manner and similarly, the practitioner needs to work with the patient to articulate the problem and provide options with full informed consent [4]. Advantages are the patient feels useful and contributed to their diagnoses and the collaborative relationship brings more cooperation and better patient satisfaction [3]. On the contrary, if the communication is not honest, neither party will have mutual trust and may bring about an inadequate diagnosis [3]. Also making decisions can sometimes be overwhelming to a patient bringing added anxiety.

Consumerist relationship can be considered the opposite of paternalistic where the patient may have higher control over the practitioner [3,4,7]. Sometimes considered "Health shopper" exhibiting consumeristic behaviors such as exercising independent judgement, being uncooperative with the HCW and constantly seeking second opinions and referrals that undermine the practitioner [3]. This type of relationship may not be seen very often in clinical practice, but nonetheless does exist. Behaviors such as seeking unnecessary prescriptions, drugs, sick leave or even sick notes can also be considered consumeristic [3,7]. An advantage of this is the patient having their own choice and freedom over their healthcare but when things seem to go wrong or satisfaction is low, the patients are more likely to question physician's authority and neglect any responsibility [3]. This may also bring about inadequate diagnosis due to poor transfer of knowledge and unnecessary spending of medical resources [3].

Relationship of default is assuming a passive role by both the patient and the practitioner [3,4,7]. This type of relationship may come to a dysfunction standstill especially if there are conflicting points of view because neither party is assuming any form of authority. This is commonly seen in older patient populations especially those with language barriers suffering from chronic illness (i.e.: diabetes mellitus and hypertension) in the community setting [7]. The practitioner may be very slow or not try at all in their investigations of the problem because it may not be critical in nature and the patient may either go along or give up in their attempt to fix the problem due to their lack of information and prolonged wait to a diagnosis [7].

A study out of the Oman medical journal showed that doctor-patient relationship is the best predictor of whether the patient will follow HCWs instructions and advice [9]. Martin LR., *et al.* measured the quality of healthcare outcomes dependent on patients' adherence to treatment regimens. They evaluated based on demographic characteristics (age, gender and ethnicity) and found that physician–patient congruence was the only significant predictor of self-reported patient adherence [10]. It also showed that patients who participated in discussions of treatment strategies with their HCW are more likely to adhere to treatments, medications and have better outcomes [10]. In other words, the patient is more likely to adhere to their meds when they are part of the conversation resembling a mutuality relationship.

Practicing a mutual relationship means to have a good rapport between the patient and practitioner and actively involving the patient in the discussion, taking subjective feelings and distresses in to consideration [3,7]. Treating the individual as a whole as oppose to a list of symptoms because many times the subjective information or the mental status may give the most information for the underlying physical symptoms [7]. All things considered, a mutual relationship seems to have the most benefits; but that being said, in a situation of critical care when there may not be enough time to have a proper discussion, a paternalistic relationship may be of more benefit given the vast experience and wealth of knowledge brought about by HCWs to make quick and necessary decisions in time of crisis. Each relationship needs to be used at the right times for them to be beneficial because each have their benefits and drawbacks based on the situation.

Communication

Communication is really the corner stone of all good patient-practitioner relationships. Once patients are admitted into the hospital it's common to feel anxious about tests, treatments and what the future may hold which could be exacerbated with poor communication [5]. It should also be stressed that the manner in which how a healthcare worker communicates is just as important as what is being communicated [5]. Things like body language, vocal tone, and sincerity are all part of good bedside manner. It's easy for patients to feel like they have lost control of their life in the hospital because for even simple everyday things like when to eat, clean and get out of bed is scheduled and dictated by someone else [8].

Why is communication important?

Good communication is the gateway in which a relationship can be built with trust and security [8]. On the first visit, patients share their most personal information with someone they have never met before and sometimes within minutes of meeting are required to disrobe for a physical examination and placed in a vulnerable situation [5]. Communication can be used as an aid to provide feelings of security and is also a way of improving patient satisfaction and compliance [6].

What is good communication?

Communication along with good bedside manner is typically used to reassure and comfort patients while remaining honest about a diagnosis [6]. Things like body language, vocal tones, honesty, sincerity, and even concealment of attitude is part of communication [5,6]. There must be complete transparency between the two parties.

From the HCWs perspective, during the first Interaction one must properly Identify themselves and explain the goal for the interaction [5]. Introducing oneself to not only the patient but family members, addressing patients by their proper suffix unless requested otherwise and limiting medical jargon goes a long way in showing respect and depreciating any from inferiority felt by the patient [5,8]. Using appropriate spacing during the interaction; in other words, creating an appropriate environment such as closing the blinds/curtains or doors prior to performing a physical examination or asking sensitive questions [6]. Communication is an essential part of the Initial interview especially when obtaining a history. It's imperative to maintain objectivity, removing one's own beliefs and values, avoiding judgmental attitudes and prejudices against language, religious or cultural differences, sexual orientations, education or socioeconomic statuses [5,6].

Communication becomes very crucial when providing patients with bad news. It's important to remember that patient will be sensitive to non-verbal communication just as much as verbal (i.e. body language) [5]. When it comes to information involving fear and anxiety patients will look for ques to assess their situation in the practitioner even if it's in other HCWs in the room [7]. It's important to maintain appropriate eye contact, look attentive, be present in the situation, facilitate their participation (let them ask questions) and most of all being empathetic [5,7]. A whole other aspect of communication is listening and receiving information especially crucial when giving bad news [7]. Active listening allows the practitioner to communicate that the patient is being heard. To convey attention, it's important to make proper eye contact, nodding appropriately, and having a posture that is open and inviting [5,7]. Furthermore, listening should be extended beyond the realm of ears, that is to say listen to the patient's body language as that may convey as much if not more information [5]. It's important to assert opinions respectfully but also stating facts openly honestly and candidly which goes a long way in how they are received [5].

Sometimes patients may have inhabited a room for a long time that it may be seen as their second home, therefore territoriality becomes an important factor [15]. Even though it is a hospital room, patients may find solace in in their room and area around them, hence good practice indicates knocking prior to entering and asking permission before moving objects [15].

Finally, a part of good communication is privacy/confidentiality, a core duty of medical practice. It is not just an obligation but a legal responsibility for medical practitioners [11]. Doctor-patient confidentiality doesn't only apply to doctors but to all health care professionals and their patients [11]. There are many levels to confidentiality, for example if the patient wishes exclude family from sensitive information (given the patient is of age), the practitioner must respect those wishes unless the patient becomes incapacitated in which case the information is relayed to the medical proxy (power of attorney) [11]. Confidentiality exist to protect the privacy of patients but it also provides a sense of trust and security so that patients are likely to seek help and share sensitive information without any overwhelming burden [11]. The exception to the rule is when the information is of concern for the safety of others and when it is required by the law although this may differ based on country, region and hospital policies [11].

Maintaining professional boundaries with patients

How far is too far? According to the (CNO) College of Nurses of Ontario and College of psychologist of Ontario it is the HCWs responsibility for effectively establishing and maintaining the limits or boundaries in the patient-practitioner relationship [13]. These include avoiding personal relations with the patient, abstaining from accepting gifts in return for treatment, abstaining from disclosing personal information and engaging in financial transactions unrelated to the provision of care [12]. Professional boundaries also include treating oneself, family or anybody with personal relationship [12]. Even though the skills may be within the practitioner's scope of practice, biases could cloud the professional judgment [12]. The literature suggests including anything that is done for a therapeutic, preventive, palliative, diagnostic, or even cosmetic procedures [12]. The reason behind this is that emotional and clinical objectivity may be compromised and the patient may not receive the best quality treatment, despite best intentions [12]. The exceptions to the rule are for a minor condition or in an emergency situation when another qualified health-care professional is not readily available [12].

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