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The selected aspects of doctor–patient relationship in the opinion of final year medical students

The doctor–patient relationship is manifested on numerous levels. It comprises an interpersonal structure of the diagnostic and treatment process. The form and character of this interaction influences the patient's cooperation with a doctor and frequently it impinges on its therapeutic effects. To exemplify the issue, let us refer to the medical interview. It is the key element common to all medical specializations. An appropriately conducted medical interview lies beneath the proper diagnosis or at least the formulation of a suspicion.

The doctor–patient relations are influenced by various factors both connected with the medic and with the patient; nevertheless, it is the doctor who must initiate it and determine its character. However, it must be borne in mind that doctors are affected by many factors which can modify the quality of the discussed relation. The time of medical studies is a period when the future doctors' behaviours and viewpoints are moulded. The ability of communicating with patients, understanding their problems – both when it comes to the medical and existential aspect – is largely interwoven with the knowledge and sill that students gain during the training at Medical Faculties.

The doctors working with medical students are the ones to set the pattern. Therefore, during the studies it is not only the theoretical knowledge that is acquired, they also constitute the time of the formation of doctor–patient interaction patterns (5). In the contemporary medical literature a need is becoming more and more conspicuous to perform further research on the formation of doctor–patient relationship in the students' consciousness (6). Our research sheds light on the scheme of this formation relying on the analysis of the survey completed by the final year students.

We have embarked on a task of examining the indicators of doctor–patient relationships in a group of students about to graduate from the Medical Faculty and Dentistry Division of Medical University of Lublin in order to compare these results with the ones existing in the ethical tradition and the patterns of doctors' behaviour during the medical practices. The examination outcome may appear constructive as far as the modification of the curricula of medical studies in Poland is concerned.

MATERIAL AND METHODS

The examination was carried out on a group of the final year medical students: 6th year of Medical Faculty and 5th year of Dentistry Division of the Medical University in Lublin during the summer term of the 2004/2005 academic year. The surveyed group totalled 216 persons.

The examination was carried out in the form of a questionnaire of our own design, based on Likert scale including some suggested answers. Likert scale used in the examination was a seven-level scale of the following characteristics: 7 – Strongly agree, 6 – Agree, 5 – Rather agree, 4 – Neither agree nor disagree – I have no opinion, 3 – Rather disagree, 2 – Disagree, 1 – Strongly disagree. The students were asked the following question: 'What factors will you take into account in the first place when dealing with patients?', and were supplied with possible answer variants. The respondents' task was to determine the degree of the correspondence of their opinions to the given answer variants following Likert scale.

RESULTS

The degree of correspondence of students' opinions to the given variants of answers to the question of what factors they will take into account in the first place when dealing with patients is presented on the following charts.

DISCUSSION

In the conducted survey, the students unequivocally decided that when dealing with a patient, doctors should first of all use their own knowledge and professional experience (average 6.49) and take into account the pain felt by the patient (average 5.98). Age was less definitely pointed to by the survey participants as the element which is crucial when taking therapeutic decisions (average 5.08; 19% of the surveyed did not include patient's age among the most important variables for medical decision-making). Interesting results came from the question of the significance of sex as the variable that students will stress when dealing with patients (Fig. 1). The opponents of giving privilege to sex in doctor–patient relationships (46%) equalled the number of the supporters of the use of the variable in taking therapeutic decisions (also 46%). The reason for such a result might have been, on the one hand, the more general type of question for the factors that the respondents would refer to when handling patients, without defining the specific group or medical specialization in which the doctor–patient interaction takes place. On the other hand, when considering the students' unanimousness when it comes to the weight of professional experience, medical knowledge and pain felt by the patient and the relative lack of unanimousness as far as age and sex are concerned, one may reckon that most probably the final year students' way of thinking is not yet rooted inside the clinical 'mainstream'. A practising doctor takes it for granted that he or she must establish patient's sex and age as a starting point in search of appropriate, pathologically recognizable disease and match the observable symptoms to it. The probability of the occurrence of certain diseases with definite age groups and sexes very often plays a decisive role in directing the medical approach (3, 7).

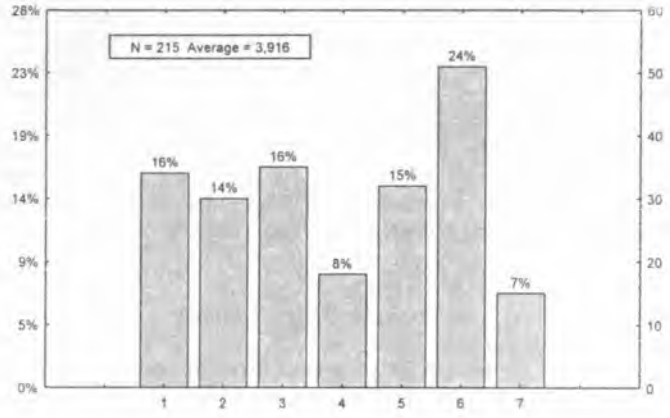

Fig. 1. What factors will you take into account in the first place when dealing with patients? Answer variant: patient's sex. Likert scale: 7 – strongly agree, 6 – agree, 5 – rather agree, 4 – neither agree nor disagree – I have no opinion, 3 – rather disagree, 2 – disagree, 1 – strongly disagree

The deontological rather than clinical orientation prevails throughout the answers given by the surveyed students. Deontological standards contained in the Code of Medical Ethics instruct a

doctor to perform their duties with the respect for the human being, regardless of age, sex, race, genetic heritage, nationality, religious affiliations, social standing, financial position and other conditions (4). The influence of the deontological trend (2) becomes clearly conspicuous in the answers to the question of the significance of the patient's level of education, current occupation, as well as financial position. From among all the respondents (Fig. 2), no less than 60% declared that it will be of utmost priority when taking care of a patient not to take into consideration their level of education; 53% is determined not to take into consideration the patient's occupation; and 50% refused to take into consideration the patient's financial position. Clinical thinking departs from general expressions – not denying their express legitimacy – however, giving priority to tangible socio-demographic data. The patient's level of education very often determines the level of doctor–patient relationship, mainly whether it will be a partnership or a paternal attitude. The consideration of patient's occupation in each case serves the risk assessment when it comes to the occurrence of certain diseases (e.g. all occupational diseases). Patient's financial position is also a decisive factor when taking medical decisions in clinical conditions. Whether the patient can afford the prescribed medicine or not will determine further success of the out-clinic therapy. The influence of deontological standards also came into view in students' conviction that the patient's political opinions (89%) and religious affiliations (68%) should escape doctor's consideration when dealing with patients.

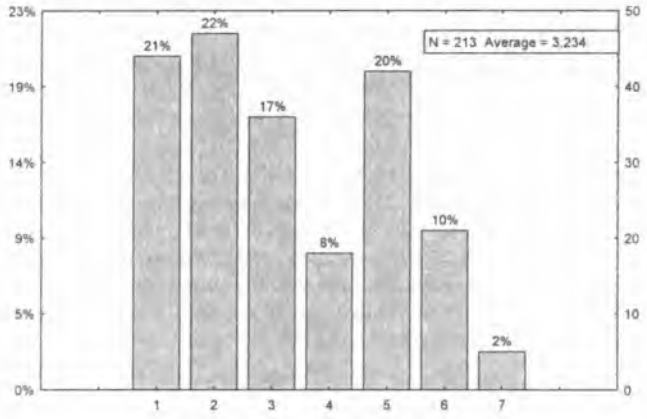

Fig. 2. What factors will you take into account in the first place when dealing with patients? Answer variant: patient's level of education. Likert scale: 7 – strongly agree, 6 – agree, 5 – rather agree, 4 – neither agree nor disagree – I have no opinion, 3 – rather disagree, 2 – disagree, 1 – strongly disagree

Besides, we established that some students followed the conviction that the significance of the degree of responsibility that patients bear for the progress of a disease should be perceived as a medical decision-making factor (Fig. 3). In some contemporary 'distributive' healthcare systems, more attention is drawn to the increased threat that various 'unhealthy' behaviours seem to pose. For instance, in the American healthcare model there is a solution that entails the increased healthcare contributions of those who are habitual smokers. In case of patients who consciously take risky activities (e.g. smoking, excessive drinking), there is a probability that other society members, who are provided with the medical protection of the same healthcare system, will be obliged to incur greater financial burden when it comes to healthcare premiums in order to make up for the general increase in the cost of treatment of, for example, lung cancer. In relation to the ethical principle of justice, such a necessity of extra financial contributions in favour of such risk-takers is not fully justifiable. Nevertheless, there is a problem of unequivocal declaration of what

diseases the given social factors dependent on risky behaviours may lie behind, and this is not at all easy to ascertain (1).

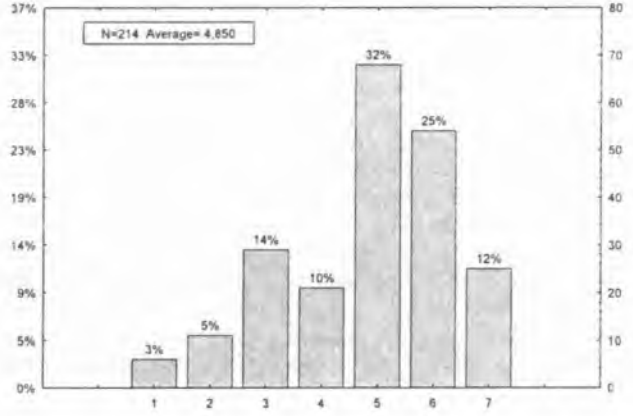

Fig. 3. What factors will you take into account in the first place when dealing with patients? Answer variant: degree of patient's responsibility for the development of their disease (e.g. unhealthy lifestyle, bad habits, etc.). Likert scale: 7 – strongly agree, 6 – agree, 5 – rather agree, 4 – neither agree nor disagree – I have no opinion, 3 – rather disagree, 2 – disagree, 1 – strongly disagree

Most students of the surveyed group (57%) are willing to refer to the patient's life motivation when taking therapeutic decisions (Fig. 4). When comparing this result with the answer to the question concerning the significance of the quality of social relation with the patient (family member, colleague, etc.), where the answers were distributed almost evenly among all Likert scale variants (av. 3.43), one can presume that the final year students not yet following the clinical way of thinking and intuitively inclining to the deontological model want to espouse the partnership model rather than the paternal one towards the patients.

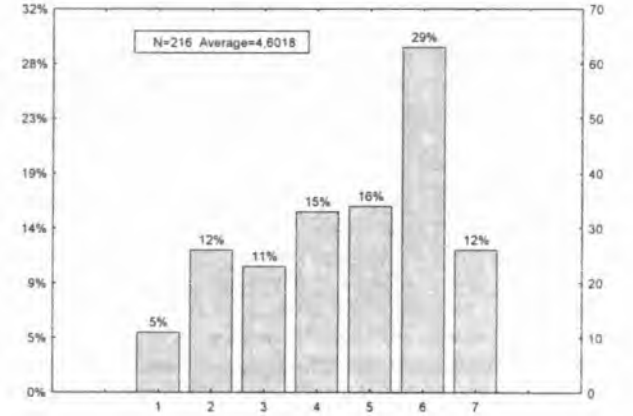

Fig. 4. What factors will you take into account in the first place when dealing with patients? Answer variant: patient's expressed life motivation. Likert scale: 7 – strongly agree, 6 – agree, 5 – rather agree, 4 – neither agree nor disagree – I have no opinion, 3 – rather disagree, 2 – disagree, 1 – strongly disagree

CONCLUSIONS

1. In the consciousness of the surveyed group a dominating model is an apolitical, tolerant doctor, corresponding to the deontology principles.

2. In the consciousness of the surveyed group, a doctor is a person of vast array of medical knowledge and professional experience, sensitive to the suffering of the sick.

3. An idealistic picture of a doctor prevails; the one who forms the relationships with patients relying on the principles of medical deontology and separated from the clinical reality.

4. In the consciousness of the surveyed group of final year students, the partnership model dominates in the doctor–patient relationships.

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SUMMARY

The contemporary medical literature does not fail to notice the necessity of conducting the research on the development of the doctor–patient relationship in the consciousness of students (6). Our examination provides a picture of how such schemes are created on the basis of analyses of the final year students' survey. We decided to examine the doctor–patient relationship indicators in the groups of students about to graduate from the Faculty of Medicine and Dentistry Division of the Medical University in Lublin in order to compare the output with the patterns of doctors' behaviour existing in ethical tradition and medical practice. On the basis of the analysis of a question, following Likert seven-level scale, of what factors the students will take into account in the first place when dealing with patients, we concluded that in the consciousness of final year students the dominating model in the predictable doctor–patient interaction is one of partnership. According to the respondents, a doctor is a person of considerable array of medical knowledge and professional experience, sensitive to the suffering of the sick. An idealistic picture of a doctor prevails; such a doctor forms the relationships with patients in accordance with the principles of medical deontology in separation from the clinical reality.

Wybrane aspekty relacji lekarz–pacjent w opinii studentów ostatnich lat studiów medycznych

We współczesnym piśmiennictwie medycznym dostrzega się potrzebę prowadzenia badań nad kształtowaniem się relacji lekarz–pacjent w świadomości studentów. Nasze badania dają obraz kształtowania się tych schematów na podstawie analizy odpowiedzi na pytania postawione

studentom ostatniego roku studiów. Podjęliśmy się zbadania wyznaczników relacji lekarz–pacjent w grupie studentów kończących studia na Wydziale Lekarskim i Oddziale Stomatologii Akademii Medycznej w Lublinie celem porównania tych wyników z istniejącymi w tradycji etycznej i praktyce medycznej wzorcami postępowania lekarskiego. Opierając się na siedmiostopniowej skali Likerta, na podstawie analizy pytania o to, jakimi czynnikami przede wszystkim będą się studenci kierowali wobec pacjenta, stwierdziliśmy, że w świadomości studentów kończących studia medyczne dominuje model partnerski w projektowanych relacjach lekarz–pacjent. W opinii respondentów lekarz to człowiek przede wszystkim obdarzony wysokim zasobem wiedzy medycznej i doświadczeniem zawodowym, wrażliwy na cierpienie chorego. Dominuje idealistyczna wizja lekarza, który kształtuje relacje z pacjentami w oparciu o zasady deontologii lekarskiej w oderwaniu od realiów klinicznych.