TEACHING AND LEARNING ETHICS

Patient–physician relationship in the aftermath of war

V Stambolović, M Đurić, D Đonić, J Kelečević, Z Rakočević

J Med Ethics 2006;32:739–742. doi: 10.1136/jme.2003.005942

During the period of conflict that led to the dissolution of the former Yugoslavia, the Serbian healthcare system suffered greatly; as a result, relationships between physicians and their patients reached an all-time low. After cessation of the various wars, a group of medical students attempted to assess the state of the patient–physician relationship in Serbia. Their study showed a relationship characterised by very meek patients and rather arrogant physicians. Empowered by their engagement, the medical students constructed a set of standards for achieving a proper patient–physician relationship; physicians should be capable of hearing and understanding patients, with the result that the ensuing empowerment can enable patients and physicians to create a tool for changing the relationship between both parties.

experienced in Serbia during the break-up of the former Yugoslavia.

Serbia was led into regression by the combined influence of nationalism and retrosocialism. This resulted, externally, in wars involving Croatia, Bosnia, Kosovo Albanians and North Atlantic Treaty Organisation forces (with 78 days of bombing). Internally, it led to a psychosocial existence characterised by egocentrism, violence, exploitation and manipulation. During this period, the people of Serbia (except for an extremely rich elite) lived from day to day in extreme poverty and in permanent peril, completely uncertain of their future.¹⁰

Under these circumstances, the healthcare in Serbia regressed as well, almost to the point of collapse. This deterioration was bought about by three specific developments. The first was a lack of funds. At the beginning of the conflict (1991–5), health funds were depleted because the money was spent on the various wars. In the period following the wars (1996–2000), money was directed towards funding the huge security force and the private funds of high-ranking figures in the regime. The second development leading to the collapse of healthcare was connected to changing values. Faced with the shortage of basic medicines and medical supplies, the medical profession was no longer able to adhere to the professional code of ethics and act responsibly in an effort to ensure the health of individual patients and the health of the community. Priority was given to defending the interests of the ruling regime. The third development was the spread of “Eichmannism” among health professionals—deprived of the ability to think and act individually—leading at best to professional cynicism, resignation and the belief that nothing could be done to put things right. As a consequence, patients were exposed to lowered professional standards, various types of extortion, and widespread corruption.¹¹

Regime change in Serbia at the end of 2000 did not bring immediate changes in the healthcare system. The basic contextual characteristics of Serbian society (egocentrism, violence, and various forms of manipulation and exploitation) did not change either. At the same time, however, a desire to get things changed appeared as part of the social context. In that atmosphere, the study of the patient–physician relationship was not based on objective assessment—that is, on analysis of interaction systems.¹² Instead, the action research method was applied with the intention of emphasising awareness raising and empowerment.¹³ Because of the very difficult position of patients, awareness raising and empowerment were emphasised to medical students as the potential agents of change.

The patient–physician relationship depends on the existing level of psychosocial and cultural understanding in the relevant environment.¹ In environments where psychosocial and cultural existence is dominated by values and meanings typical of modernity, the patient–physician relationship is based on discipline and control.² The physician is active, distant, authoritarian and dominant. The patient is treated as being empty, deprived of his or her internal reality—that is, as an entity without subjectivity,³ which is why he or she is passive, dependent and helpless.

In environments which developed features of post-modernity, with emergence of new forms of sociality, emotionality and communality,⁴ there was a change in the patient–physician relationship. The main characteristic of this change was a shift of attention from the biomedical side to the humanistic side of medicine.⁵

The typical example of this change is the concept of patient-centredness which promotes biopsychosocial perspective, sharing power and responsibility, and the therapeutic alliance.⁶

According to some studies, the shift in the patient–physician relationship brought about a positive improvement in the image of physicians⁷ and even in the frequency of malpractice claims.^{8,9}

The quality of the patient–physician relationship can, however, regress from its modern pattern. This can happen in environments where modern medicine is introduced, and in countries which are regressing as a result of political and social turmoil. Political and social turmoil was

See end of article for authors' affiliations

Correspondence to:
Assistant
Professor V Stambolović,
Faculty of Medicine,
University of Belgrade,
Belgrade 11000, Serbia;
vstambol@infosky.net

Received 5 August 2003
Revised 10 November 2003
Accepted 1 December 2003

MATERIALS AND METHODS

Three groups were involved in the process: medical students, patients and teachers. Twenty two medical students from the Belgrade Medical Faculty of the university of Belgrade (Belgrade, Serbia) enrolled in clinical courses in the fifth and sixth academic years were engaged as co-researchers and co-change agents with responsibility for exploring the dominant patient–physician relationship and suggesting standards that might improve that relationship. They were initially involved in the research programme of the Laboratory for Anthropology that aimed to investigate the physician-patient relationship in the current social context.

Teachers included two professors from the Belgrade Medical Faculty (a founder of the Laboratory of Anthropology and a founder and member of the group that designed the local version of the Charter of Patient Rights), two educational assistants from the Laboratory of Anthropology, and four other professionals (a psychodrama analyst, a psychiatrist, an ethnologist and a public health expert) with responsibility for stimulating the development of knowledge about specific aspects of the medical system while promoting the process of student empowerment.

Patients were engaged as co-change agents and as participants in the creation of standards for the patient–physician relationship. They were chosen by students visiting three outpatient university clinics in Belgrade: gynaecology, internal medicine and general surgery. A total of 330 patients were interviewed (181 women (55%) and 149 men (45%); age range 18–60 years). The emphasis of the study was on student insight, activity and change. The university outpatient clinics of gynaecology, internal medicine and general surgery were included as they were the most frequently visited facilities (compared with other outpatient clinics), and the patients were interviewed as they visited the clinics over a period of 10 working days. All patients who made at least four visits to the same physician were interviewed.

The study evolved over three phases. In the first part of the study, after students and faculty teachers discussed the issue of the patient–physician relationship, students visited three outpatient clinics and discussed with patients (awaiting medical consultation) their experiences with the practising physicians. The students were then engaged in four subsequent discussion groups set up to challenge the enculturation by the dominant patient–physician relationship. With the assistance of the psychodrama analyst they presented various types of patient–physician relationships. With the psychiatrist they discussed various "games" and the pathological benefits of the typical patient–physician relationship. With the public health expert the students discussed the often neglected measures that might strengthen both the patient's health and position in his or her relationship with the physician. With the ethnologist the students discussed the cultural dimensions of the disease.

In the second part of the study, students constructed a questionnaire addressing all these entries with faculty teachers. The final version of the questionnaire had four sections (37 questions): patients' knowledge of their rights; patients' opinion regarding the therapeutic behaviour of the attending physician; the ethics of attending physicians; and the reactions of patients to physicians' behaviour. The semi-structured interview was conducted with open-ended questions so the patients' comments could be recorded.

In the third part of the study, the students presented the results of their inquiries to the faculty teachers and subsequently developed standards describing physicians' behaviours towards patients. These standards were printed as a booklet that was later distributed to students of the medical faculty and to patients attending the three outpatient clinics.

RESULTS

Knowledge of patients' rights

Interviewed patients were not aware of their rights as human beings. None of them mentioned the right to human dignity, the right to equality, or the right to freedom from degrading treatment.¹⁴ They were aware of their technical rights—that is, entitlements under their mandatory health insurance. However, the knowledge of interviewed patients was poor with regard to these technical rights. Only 16% of them were aware of their health insurance rights, 32% were partially informed and 51% were not informed. Among informed patients, 21% could cite that they had the "right to free medication", 14% mentioned "the right to free treatment", and 3% knew about "the right to change a doctor"—that is, the right to seek a second opinion. The remaining 62% of informed patients could not cite any particular technical rights.

Patients' opinions of their physicians' therapeutic behaviour

Patients came to the outpatient clinic with definite ideas of what constituted desirable behaviour on the part of the attending physician. For the majority of patients (62%), the most important quality they were expecting from their doctors was professional expertise. Cordiality (warmth, friendliness and empathy) was emphasised by 53% of the patients. In third place was honesty (25%), followed by dedication to their problems, sincere communication, an ability to establish dialogue with them, patience and tidiness.

However, it seemed that patients were not getting what they were looking for. As many as 25% of them complained about the arrogance of their attending physicians, 18% spoke about a lack of kindness, 12% about a lack of interest and 11% about the failure of their physician to engage in conversation regarding their health problems.

Patients reported that their attending physicians were forthright with them: 87% of patients had been clearly informed about their diagnosis and 68% had been informed about the prognosis of their disease. At the same time, only half of the patients had been informed about the advantages of the treatment suggested by their doctor and even fewer (43%) were informed about other treatment options (only 12% of patients had the opportunity to discuss treatment alternatives with their doctor). In addition, more than half of the patients had not been informed about the iatrogenic consequences of taking their drugs. Physicians were also thrifty with regard to information on the length of treatment, with 32% of patients being given no information. Also, almost half of the interviewed patients claimed that they were not given any information regarding the changes in lifestyle they could expect after treatment.

There were more indications of poor communication between interviewed patients and their doctors: 30% of patients complained that they could not understand the doctor's explanation regarding their disease or their treatment owing to the excessive use of medical jargon (Latin terms, abbreviations) by their doctors. Also, 60% of patients reported that they had no opportunity to ask for additional information regarding their condition. Among those who managed to ask for explanations, 46% were left without direct and clear answers.

Fifty one per cent of patients who were interviewed claimed that they were exposed to treatment without any discussion with their doctor regarding its purpose, benefits, modalities and consequences.

Ethics of attending physicians

It is understandable that, in an atmosphere of widespread corruption, 65% of interviewed patients said they had a habit

of giving various presents to their doctors. Most often, they would present a valuable drink (35%), coffee (26%), a box of chocolate or candy (15%), or a kerchief, shawl or valuable pencil sets (23%). A significant number of patients (15%) gave sums of money (“under the table”). According to patients, doctors accepted these offers; 75% of them treated the donating patient much better at the next visit.

Patients had a similar experience with those doctors employed in government institutions who recommended that patients go for treatment to private clinics where they held part-time positions as consultants. Most patients (80%) claimed that the same doctors treated them much better in their private offices.

Two other ethical complaints were reported relatively frequently. The first of these was lack of privacy; 25% of interviewed patients reported that during their medical consultation another person (who was not a member of the medical staff) was present in the doctor’s office. The second complaint concerned the patients’ right to equality; 12% of patients claimed that for various reasons (religious, national, social, gender, age) their doctors were not fully respectful towards them.

Reaction of patients to physicians’ behaviour

Most patients (85%) were not satisfied with the attitude of their attending physicians. Nevertheless, only 7% saw fit to complain: 3% complained of lack of kindness, 3% of lack of expertise and 1% of special treatment given to other patients (admitting patients who jump the queue). Among those who were not satisfied but did not want to complain, 21% explained that they did not consider complaining because their effort would be in vain, 7% reported that they did not know who would listen to them, and 2% resolved the problem by themselves. The remaining 40% did not cite any reasons for their decision to keep their dissatisfaction to themselves.

The sum of the percentage of patients who gave no reasons for their silence (40%) and the percentage who were satisfied with the behaviour of their doctors (15%) was close to the proportion of patients (65%) who reported that they had “connections”—that is, were recommended or were personally acquainted with their attending physician. In other words, patients knew that if they could somehow improve their standing with their doctor, the service they received would be improved: 25% used “connections” to shorten their waiting time in the doctor’s office, whereas 20% of patients felt that having “connections” provided some sort of insurance regarding the quality of the examination and treatment they received. Other major reasons cited were better a relationship with the doctor, and increasing the doctor’s attention and kindness.

The outcome

At the final meeting, students who participated in the study presented a “Proposal of standards of the patient–physician relationship”. Among the 22 proposed standards, 8 deal with patients’ rights (being treated with respect, being informed about alternative treatments, being informed about risks and possible iatrogenic effects, being informed about duration of treatment and duration of rehabilitation, as well as about lifestyle changes after treatment), 8 deal with therapeutic behaviour (stimulating patients to ask questions, making language understandable for patients, direct communication, respectful behaviour, providing detailed information regarding both interventions and treatment, including advantages and disadvantages) and 6 deal with physician ethics (introduction to the patient, careful answering of patient’s questions, stimulating the patient to ask for a second opinion, keeping patient information confidential, rejecting offers of money “under the table”, avoiding referrals to

private institutions if adequate treatment is available in regular outpatient clinics). Each of these standards was additionally explained by a small story depicting the relevant situation.

Subsequent to this study, the *Proposal of standards of the patient–physician relationship* was printed and distributed by the Serbian Anthropological Society.¹⁵

DISCUSSION

Currently, in medical schools in Serbia, attention is mostly oriented towards professional knowledge and skills. Regarding relationships with patients, students mostly accept the stereotypical attitudes which emphasise the important, powerful and prestigious role of doctors.¹⁶ Patients’ rights are neglected.

In the present study, the action research method was used in an attempt to develop another approach for medical students. This approach was to regard the patient as a person and to obtain empowerment with meaning and engagement that evolved out of that encounter.

A medical student is rather low in the hierarchy of any medical institution. That is why students (compared with doctors) have much closer relationships with patients. Students who participated in the study felt that their position enabled them to have a more open dialogue with patients in order to discuss their experiences.

Patients who were interviewed were quite open with the students. This may have been because, on the one hand, the students were not doctors (so there were unlikely to be any repercussions for those patients who spoke truthfully about their experiences in any particular medical institution), while on the other hand, they were going to be doctors in the future.

Another important characteristic of the study was that student engagement in the highly structured environment of the medical school was replaced with the engagement found in real life. This offered another kind of benefit—namely, the benefit of being part of a powerful environment was replaced with the benefit of being an important participant in a socially and medically meaningful enterprise.

Engagement in meaningful enterprise enabled students to produce a tool for change. By devising their *Proposal of standards of the patient–physician relationship*, students empowered themselves, and by distributing it among patients and fellow students they have initiated vortices of thought enabling movement of relationship.¹⁷

Of course, the method used in the study is slow, time consuming, requires dedicated teachers and, at the beginning, involves a small number of students. But, in the rather closed situation in which human relationships, especially physician–patient relationships, are dominated by egocentrism, manipulation and exploitation, it offers a stepping stone to transition and transformation.

CONCLUSIONS

In this study, the patient–physician relationship was explored as a part of the process of change. Medical students who were involved in the study developed an understanding of the explored issue in terms of defining the problem and coming up with the solution. Furthermore, in an open-ended research environment characterised by shared roles, students were engaged in important work and felt that they could make a difference. That creative discovery helped the development of a specific psychosocial space which differed from the dominant environment.

The importance of this change is not quantitative in nature. Twenty two students and nine teachers are a small group. However, by eluding the dominant means of identification and by merging with similar developments, these students’

creative discovery can influence others (both therapists and patients) and may even represent the emergence of new ways of relating in medical institutions.

In the Serbian healthcare system, which is still groping its way towards professionalism, this might prove to be a useful influence.

Authors' affiliations

V Stambolović, M Đurić, D Đonić, Faculty of Medicine, University of Belgrade, Belgrade, Serbia

J Kelečević, University of Alberta, Edmonton, Alberta, Canada

Z Rakočević, Faculty of Stomatology, University of Belgrade, Belgrade, Serbia

Competing interests: None.

REFERENCES

- 1 **Fabrega H Jr.** *Evolution of sickness and healing*. Los Angeles: University of California Press, 1999.
- 2 **Freund PES, McGuire MB.** *Health, illness, and the social body*. Englewood Cliffs, NJ: Prentice Hall, 1991:231–41.
- 3 **Stambolovic V.** Human rights and health within the dominant paradigm. *Soc Sci Med* 1996;**42**:301–3.
- 4 **Williams SJ, Gabe J, Calnan M.** *Health, medicine and society: key theories, future agendas*. London: Routledge, 2000:3.
- 5 **Ong LML, De Haes CJM, Hoos AM, et al.** Doctor-patient communication: a review of the literature. *Soc Sci Med* 1995;**40**:903–18.
- 6 **Mead N, Bower P, Hann M.** The impact of general practitioners' patient-centredness on patients' post-consultation satisfaction and enablement. *Soc Sci Med* 2002;**55**:283–99.
- 7 **Carmel S, Glick SM.** Compassionate physicians: personality traits and prosocial attitudes. *Psychol Rep* 1993;**73**:1362–5.
- 8 **Brennan TA, Mello MM.** Patient safety and medical malpractice: a case study. *Ann Int Med* 2003;**139**:267–73.
- 9 **Levinsone W, Roter DL, Mullooly JP, et al.** Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997;**277**:553–9.
- 10 **Stambolovic V.** The case of Serbia/Yugoslavia: an analysis through spiral dynamics. *Med Confl Surviv* 2002;**18**:59–70.
- 11 **Stambolovic V.** The reform that, alas, succeeded: the case of Serbia. In: Twaddle AC, eds. *Health care reform around the world*. Westport, CT: Auburn House, 2002:150–4.
- 12 **Wasserman RC, Inui TS.** Systematic analysis of clinician-patient interactions: a critique of recent approaches with suggestions for future research. *Med Care* 1983;**21**:279–93.
- 13 **Hart E, Bond M.** *Action research for health and social care*. Milton Keynes, Buckinghamshire: Open University Press, 1999:20–1.
- 14 United Nations General Assembly resolution 217 A (III), Universal Declaration of Human Rights 1948.
- 15 **Srpsko antropolosko društvo.** *Program za podsticanje antropoloskog pristupa u medicini*. Beograd: Srpsko antropolosko društvo, 2000.
- 16 **Mechanic D.** Professional dominance and medicine. *J Health Polit Policy Law* 1991;**16**:3–5.
- 17 **Shainberg D.** Vortices of thought in the implicate order and their release in meditation and dialogue. In: Hiley BJ, Peat DF, eds. *Quantum implications*. London: Routledge, 1994.

International Forum on Quality & Safety in Health Care

18–20 April 2007, Palau de Congressos, Barcelona.

Why attend?

- Join over 1000 healthcare professionals from over 40 countries worldwide
 - Learn from experienced leaders and improvement experts
 - Gain new skills and tools for creating change in your organisation
 - Take home practical solutions for improvement methods
- <http://www.quality.bmjpg.com>