**Dealing with conflict in the doctor-patient relationship: An administrator’s perspective at tertiary health care teaching institution of central, India.**

**Abstract:**Very old patient left medical college and hospital due to doctor patient conflict. Media coverage and defamation of institution were the some of the important outcomes.Despite best intentions, junior doctors cannot meet all patient expectations. Junior doctors encounter difficult behaviour and conflict with some patients or patients' families. Communication and manner are paramount. Throughout negotiation of a solution, junior doctors should use non-confrontational vocabulary. Agreeing, acknowledging the patient’s and family feeling, active listening, **acting as a team and working together without blame or judgment and**demonstrating genuine respect for the patient should weave through all aspects of the doctor-patient relationship and may need to be communicated more explicitly: Let's work through this together step by step.Restricted Consultation, easily accessible laboratory facility, good working environment – emergency triage system, maintenance of confidentiality, separate counselling facilities, and conservation of highest level of health care are utmost important for prevention of doctor-patient conflicts..

Key words: doctor – patient relationship, conflict, junior doctors, strike, managing conflict.

"

**Introduction**:

In the institution such as hospitals, large number of patients, unwarranted entry of relatives of patient1, decentralization of decision making, and multidisciplinary and interdisciplinary team work will increase the interaction needed to accomplish the clinical and management task.2 Learning how to prevent or manage conflict effectively is an important clinical skill for physician. Studies indicate that up to 15% of difficult patient in these encounters may have worse short-term clinical outcomes.2

The doctor–patient relationship in general practice is often viewed by practitioner and patient alike as a long-term ‘personal’ relationship.3 Such a relationship is a key component of patient-centred medicine4 and may have positive health outcomes for patients as it allows a ‘therapeutic’ relationship to develop between general practice(GP) and patient, one in which the GP displays empathy, genuineness and unconditional positive regard to effect therapeutic change in patients.[4](file:///C:\Users\THAKRE\Desktop\DY%20SUPPERINTENDENT\literatur%20conlict\Ending%20the%20doctor%E2%80%93patient%20relationship%20in%20general%20practice%20%20a%20proposed%20model.htm#ref-4) Patient and their relatives may have difficulties in their relationships with physician. This may include ending their relationships with GPs.3 In particular, the questions of why and how junior doctors choose to end their relationship with patients have been the subject of very limited empirical study and there is only a small literature on patients' termination of their relationships with doctors.3, 6-8  It does not limited to individual patient but becomes a generalizable phenomenon expressed by means of strikes.

Doctor and healthcare worker (HCW) strikes are a global phenomenon with the potential to negatively impact on the quality of healthcare services and the doctor-patient relationship. Striking doctors usually have a moral dilemma between adherence to the Hippocratic tenets of the medical profession and fiduciary obligation to patients. In such circumstances the ethical principles of respect for autonomy, justice and beneficence all come into conflict, whereby doctors struggle with their role as ordinary employees who are rightfully entitled to a just wage for just work versus their moral obligations to patients and society.9, 10

It would appear that strikes may have a disproportionate deleterious impact on doctors and other HCWs when compared to patients. Striking HCWs frequently face a loss of income, job insecurity, and emotional distress, plus long hours of work for those who choose not to participate in the strike action. 9, 11,12. However, in our set up no such loss have to bear by doctors on strike.13Most vulnerable and affected are the patient attend outpatient and inpatient department. Little, however, is known about the root causes of conflict and ending of relationships in tertiary health care facility. With this background present case study was carried out to find out the root causes of conflict and solutions for adverse outcome at tertiary care teaching hospital.

**Case example:**

Termination of doctor-patient relationship leads to College complaint and strike of Junior Doctors in tertiary health care institution. This paper addresses a neglected area of medical student education--terminating the doctor-patient relationship. Rich clinical teaching opportunities are lost when educators fail to illustrate the significant emotional aspects of ending this highly personal affect-laden experience. We have tried to explore various issues and outcome of conflict between doctor and patient/patient relatives.

A junior doctor first saw a 74-year-old male for a chest pain in emergency department; relatives of patient expressed concern. Detailed history and examination reveals the patient's slightly increased systolic blood pressure and family history of stroke. Junior doctors highest efforts were to find out probable cause of chest pain which subsequently help in final diagnosis and management of patient. After some discussion and clinical examination; the junior doctor asked patient to go for Electro Cardiogram (ECG).With the help of attendant patient was immediately shifted for the procedure. While investigation there was some technical delay in recording ECG therefore relatives were very much concern and expressed their displeasure. Concern junior doctor counselled relatives of the patient and advised treatment and other lifestyle changes were also suggested, but the patient’s relatives were unnecessary adamant. There was strong altercation between relatives and treating junior doctor. The patient’s relative later requested more referrals to other specialists, but because the patient was now settled, the junior doctor did not make these additional referrals. The patient’s relative stormed inside the hospital and tried to impede hospital service, slamming the door. At a subsequent situation, another junior doctors and relatives of the patient were physically interacted. Immediately hospital security and police performed their roles and issues were sought and settled. The patient’s relative continued to experience issues over time which were addressed in emergency department visits as well as with another junior doctors. The patient’s relative frequently appeared quite angry, loudly accusing the junior doctor of never sending her for tests or referrals, or providing treatment. Recognizing the patient's dissatisfaction and lack of trust in the doctor-patient relationship, the junior doctor suggested to the patient that he find a new family physician. A termination letter was drafted, but it was sent immediately. During that stage relatives were not ready to sign on the document and took that patient to another family physician outside the institution against medical advice. In this case, the College found no deficiency with the junior doctor's medical care and stated there was insufficient evidence to comment on the complaints about the doctor's interpersonal skills. However, junior doctors behaved in an unprofessional way. This could be to just safeguard them from any physical damages. The College did, however, have concerns with the process of communicating the termination of the doctor-patient relationship. It reminded the junior doctor that patients should be notified in a timely fashion. A decision to end the doctor-patient relationship should be communicated in writing and, as appropriate, by direct communication between the junior doctor and patient.

**Outcome:**

Junior doctor and the patient’s relatives subsequently complained to the hospital regulatory authority (Medical Superintendent) and Department of security (police). Similarly doctors on duty also complained to police and hospital regulatory authority. Resident went on strike under the protest of incident hence hospital services were compromised for three days. Media coverage12 and defamation of institution were the some of the important outcomes. Two people were arrested under Maharashtra Medical Practioners Act 196114 in the month of July 2014.

**Discussion**

Very old patient left medical college and hospital due to doctor patient conflict. Media coverage12 and defamation of institution were the some of the important outcomes.  
The clinics of primary care training programs face the annual problem of residents leaving their patients. The responses of the resident physician and the patient can be understood in terms of the grieving process. Feelings of anger, guilt, anxiety, and fear may complicate this phase of the resident-patient relationship and threaten continuity of care.15

Hospital healthcare is essentially teamwork. Frequently, however, one comes across incidents where inter-departmental cooperation is compromised. It can create an awkward situation for residents and other staff members involved in the healthcare system.16We can recall many such incidents during their training at this institution. Studies have indicated that failure in "tightly coupled" organisational relationships between hospital departments imposes a threat to patient safety.17,18

Clear guidelines on how to manage certain situations should be in place, leaving no ambiguity as far as issues concerning patient management are concerned. A lot more needs to be done by administrators to avoid such incidents and to promote inter-departmental co-operation. In addition, more caution and effort by administrators, residents and faculty can help avoid such incidents. A good example is the shift in what Thomas Kuhn describes as “the ethical paradigm”. 19of the paternalistic relationship between doctors and patients to a new standard of respect for the principle of autonomy.

It has been the traditional responsibility of the health care provider to integrate all the sources of medical information and convey to the patient at the time of the consultation. Traditionally, the relationship between the physician and the patient was asymmetrical; that is to say, doctors had significantly more information about medical conditions than their patients. Increasingly however this traditional sole professional filter is being bypassed by the patients who now have access to both external means of procuring health information as also to their health records. The locus of power in health care is shifting: instead of the doctor acting as sole manager of patient care (i.e., “the captain of the ship”), a consumerist model has emerged in which patients and their doctors are partners in managing the patient's care.20These changes are already finding resistance from the provider community.

Doctor and healthcare worker (HCW) strikes are a global phenomenon with the potential to negatively impact on the quality of healthcare services and the doctor-patient relationship. Striking doctors usually have a moral dilemma between adherence to the Hippocratic tenets of the medical profession and fiduciary obligation to patients. In such circumstances the ethical principles of respect for autonomy, justice and beneficence all come into conflict, whereby doctors struggle with their role as ordinary employees who are rightfully entitled to a just wage for just work versus their moral obligations to patients and society.10

This case need to be discussed because strike has become recurrent phenomenon which adversely affecting the health care system at tertiary health care facility. Focus group discussion with relative of young patient reveals“ I came from all the way to take treatment for health ailment and necessary charges have been paid. Patient is admitted but further surgical treatment is halted”. “ I am frighten due to unexpected strike of junior doctors”.14This indicates patient care was compromised.

Focus group discussion with office bearer of Maharashtra association of resident doctors revels following themes and subthemes. “Lack of Security personnel’s while working was the major concerns felt by resident”. Some of the resident expressed that “existing CCTV monitoring is inadequate”. Unanimously they have demanded more security personnel’s in the emergency department and also emphasized strengthening of surveillance system.1,13

At this juncture it was warranted to find out exact causes of conflict which in turn terminated the patient care in total. In this case conflict was predominantly with junior resident surgeon and relatives of old patient who had medical emergency

Historically, surgeons have had little formal training in conflict resolution; however, there has been an increasing body of evidence that poorconflict resolution skills may have an adverse impact on patient outcomes and career advancement. Furthermore, the Accreditation Council for Graduate Medical Education has recognized the importance of conflict resolution skills in resident training by mandating the training of communication skills and professionalism. These skills have often been taught in other professions, and surgeons may need to acquaint themselves with the literature from those fields.21We propose a model for conflict resolution by using the basic tools of the history and physical exam, a process well known to all physicians.

Despite best intentions, junior doctors cannot meet all patient expectations. Junior doctors encounter difficult behaviour and conflict with some patients or patients' families. Such behaviours can include patients not complying with recommended investigations and treatments, repeatedly doubting the doctor's approach to their care, reacting with anger to their doctor's suggestions, or avoiding a therapeutic alliance with their doctor.

Although some patients may have expectations, or even demands, that are medically inappropriate and may complain to the hospital, other local authority and media. Junior doctors are not required to accede to patient demands that are medically unnecessary or inappropriate. Should the patient lodge a complaint, the hospital will generally expect the Junior doctor to have provided sound medical advice, to have presented it in a professional way, and to have documented the discussion in the medical record.

**Understanding conflict:**

Root cause of conflict: Patient and relatives of the patient may have minimum expectations. Immediate attention, investigations, early initiation of treatment and sympathetic approach from treating physician and paramedics are the minimum expectations. Moreover, patients attending emergency department are serious, high expectations of family members of a patient, ignorance of patient charter, patients agony, and stressed family members. We deal with patient health issues in a casual way rather strong involvement and sincere efforts to fulfil minimum expectations. Focus group discussion with junior doctor reveals that “they are overburden- they have to attend large number of patients”. Most of the junior doctors stated that “majority of the patients are very serious needs urgent investigations like X-ray and ultrasonography but these investigations are not easily accessible”. All speciality junior doctors shares a common room where all variety of patients directly enters which one is just at the entrance of the emergency unit. It has also been observed junior doctors are very easily accessible to patient and their relatives. In spite of easy accessibility patients’ needs are not fulfilled. Sometimes; those junior doctors may not be related to speciality that the patient is in need. Patient is in agony and tense relatives are not able differentiate which one junior doctor is related to their patient. Patient and relatives are directly interacting with the available junior doctor who is not related to speciality which is required for the patient. So, extensive verbal altercation leading to unwarranted communication leading to conflict.

Every hospital has unique needs, and every conflict management process must be tailored to individual circumstances.9,22Therefore; restricted Consultation, easily accessible laboratory facility, good working environment – emergency triage system, maintenance of confidentiality, separate counselling facilities, and conservation of highest level of health care are utmost important.

To avoid misunderstandings that can lead to conflict, clear communication is essential. Junior doctors should always let the patient know their intentions, whether asking personal questions, performing a physical examination or procedures, or responding to patient requests.Conflict is normal, understandable, and inevitable. Conflict cannot be avoided at all times and when it does occur, care should be taken to understand the situation properly without taking it personally. Conflict that is addressed before it becomes unmanageable may present an opportunity to better understand patients and their needs. Conflict that is allowed to escalate, however, may become destructive.

Difficult patient behaviours may evoke negative reactions in junior doctors. Junior doctors need to be acutely aware of maladaptive responses to which they may fall prey. Rather, junior doctors must strive to remain calm and focus on understanding the patient's behaviour and considering how to best respond.[2](https://oplfrpd5.cmpa-acpm.ca/-/dealing-with-conflict-in-the-doctor-patient-relationship#ref)

Junior doctors should try to understand patients' behaviours in the context of their medical conditions. Conflict arises when expectations are not met. Conflict resolution requires junior doctors to focus first on patients' needs, and later on solutions. Initially, junior doctors should listen to patients to determine their needs. It helps if the junior doctor confirms awareness of a patient's concerns and viewpoints by verbalizing and stating their understanding of the issue back to the patient. This approach demonstrates empathy and is reassuring to patients.

Arbitrary actions such as termination of striking doctors or threats of unjustifiable disciplinary action by regulatory authorities, will not encourage speedy resolution of junior doctor, and may lead to undesirable consequences such as brain drain.

**Managing conflict**5, 16, 23, 24 :Managing conflict is particularly challenging when the other individual is angry, aggressive, intimidating, or threatening. Anger is always a secondary emotion. By understanding what is underlying a patient's anger, junior doctors can learn to confidently negotiate many of these situations.

Communication and manner are paramount. Throughout negotiation of a solution, junior doctors should use non-confrontational vocabulary. It can be helpful to use "I-statements," as illustrated in the examples below, to verbalize observations, thoughts, feelings, and needs.5 Such verbalizations help clarify the perspectives of the individuals in conflict.When a patient or relatives are agitated and confrontational, remaining calm and speaking politely in a soft voice often helps to diffuse emotions. Excellent communication skills are needed to de-escalate conflict. The environment must be safe and the discussion non-judgmental.

Five useful steps junior doctors can take in de-escalating the conflict include:

1. **Active listening23.** Junior doctors should give patients their full attention and use verbal prompts and nonverbal behaviour (e.g. body language) to encourage patients to share information. They should listen to patients and informants. Junior doctors should confirm what patients have said through reflection or summarizing.
2. **Agreeing24.** Patients need to feel they are being heard. Junior doctors should try to find a fact that they can agree with. "You are right. I did not refer you to the specialist when you requested that."
3. **Acknowledging the patient's feelings23.** "I can see this has made you quite upset." Reflecting the emotion back to the patient helps demonstrate empathy. When Junior doctors show they understand why patients are experiencing a particular emotion, the situation usually improves. **Apologizing may be helpful.** "I am sorry that you may have felt that way. That was not my intent. A referral was not necessary at the time since your symptoms had resolved."
4. **Acting as a team and working together without blame or judgment.** "Even though I'm not referring you immediately, I am going to continue to monitor your condition very closely and we will work through this together." Statements that demonstrate a partnership are surprisingly important in establishing collaboration in the doctor-patient relationship.16
5. Demonstrating genuine respect for the patient should weave through all aspects of the doctor-patient relationship and may need to be communicated more explicitly: "I know this is difficult for you. I'm taking all possible measures to improve your health” Let's work through this together step by step.24

"Moral consensus theory24: Bioethical reflection does not automatically result in change to conflict in daily doctor patient relationship. However, these reflections are important because they promote the search for moral consensus that establishes new ethical rules for day to day medical practice.25We suggest that these areas interact to establish new standard of behaviour among physician. Public health ethics has been receiving increasing attention to recent years. Frequently, public health Practioners have to confront complex decisions, with numerous and often conflicting ethical implications.26Present case study imply need of teaching public health ethics in tertiary health care facility.

Summary: Despite best intentions, junior doctors cannot meet all patient expectations. Junior doctors encounter difficult behaviour and conflict with some patients or patients' families. Junior doctors should try to understand patients' behaviours in the context of their medical conditions. Communication and manner are paramount. Throughout negotiation of a solution, junior doctors should use non-confrontational vocabulary. Therefore; restricted Consultation, easily accessible laboratory facility, good working environment – emergency triage system, maintenance of confidentiality, separate counselling facilities, and conservation of highest level of health care are utmost important. Agreeing, acknowledging the patient’s and family feeling, active listening, **Acting as a team and working together without blame or judgment and**demonstrating genuine respect for the patient should weave through all aspects of the doctor-patient relationship and may need to be communicated more explicitly: Let's work through this together step by step.

"

References:

1. Lemieux-Charles L, Leatt P. Hospital-Junior doctor integration: case studies of community hospitals. Health Serv Manage Res. 1992;5(2):82–98.
2. Hinchey S A, Jackson J L., "A cohort study assessing difficult patient encounters in a walk-in primary care clinic, predictors and outcomes. Journal of General Internal Medicine 2011; 26(6):588-94.
3. Stokesa T, Dixon W M, McKinleya K R. Ending the doctor patient relationship in general practice: A proposed model. Oxford journals Medicine and Health general practice 21 (5):507-14.
4. Weston WW, Brown JB. Overview of the patient-centered method. In Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR (eds). Patient-centered Medicine Transforming the Clinical Method. Thousand Oaks (CA): Sage; 1995: 21–30.
5. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. SocSci Med 2000; 51**:** 1087–1110.
6. Nicholls W, Jaye C. Opting out: why patients change doctors. NZ Fam Physician 2002; 29: 402–407.
7. For more information, see: Gautam, M., The Tarzan Rule: Tips for a healthy life in medicine, Book Coach Press, Ottawa 2011 ISBN 0978470176
8. Farnan, P.A. Conflict Management, in: The CanMEDS Junior doctor Health Guide, The Royal College of Junior doctors and Surgeons of Canada, 2009 p.60-61, ISBN 978-1-926588-03-2
9. Chima S C. Global medicine: Is it ethical or morally justifiable for doctors and other healthcare workers to go on strike? BMC Medical Ethics 2013; (Suppl 1):S5

Available on: <http://www.biomedcentral.com/1472-6939/14/S1/S5>

# Last accessed on: 15th Aug 2015

1. Rietveld J. Strike action by senior medical staff in Timaru-how did this come about? N Z Med J. 2003;14:1170:U352.
2. Stovall JG, Hobart M, Geller JL. The impact of an employees' strike on a community mental health center. Psychiatr Serv. 2004;14:188–191.

# Times of India 2014. Available on: <http://timesofindia.indiatimes.com/city/nagpur/MARD-strike-enters-2nd-day-govt-accepts-demands-partially/articleshow/36792090.cms>

# Discussion with relatives of patients admitted. Available on: <https://www.youtube.com/watch?v=3HR4WIy_lk0>

1. Maharashtra Medical Practioners Act 1961. Available on:<http://bombayhighcourt.nic.in/libweb/acts/1961.28.pdf>.
2. Lichstein PR. Resident leaves the patient :another look at the doctor patient relationship Ann of internal Medicine 1982:96(6):762-5.
3. Agrawal S, et al. Seeking better inter-departmental cooperation in healthcare settings. IJME 2010;7(3):180
4. Pandya S. Conflict resolution in the health care environment. Indian Journal of Medical Ethics 2010;7(3):181.
5. Roy N. conflict resolution in the health care environment. Indian Journal of Medical Ethics 2010;7(3):182.
6. Kuhn TS. The structure of scientific revolutions. Chicago: The University of Chicago Press; 1970.

|  |
| --- |
| 1. Reents S. Impacts of the Internet on the doctor-patient relationship: the rise of the Internet health consumer. New York: Cyber Dialogue; 1999.[http://www.cyber](http://www.cyber/) dialogue.com/ [Back to cited text no. 6](http://www.jpgmonline.com/article.asp?issn=0022-3859;year=2004;volume=50;issue=2;spage=120;epage=122;aulast=Akerkar#ft6) 2. [Lee L](http://www.ncbi.nlm.nih.gov/pubmed?term=Lee%20L%5BAuthor%5D&cauthor=true&cauthor_uid=18787896), [Berger DH](http://www.ncbi.nlm.nih.gov/pubmed?term=Berger%20DH%5BAuthor%5D&cauthor=true&cauthor_uid=18787896), [Awad SS](http://www.ncbi.nlm.nih.gov/pubmed?term=Awad%20SS%5BAuthor%5D&cauthor=true&cauthor_uid=18787896), [Brandt ML](http://www.ncbi.nlm.nih.gov/pubmed?term=Brandt%20ML%5BAuthor%5D&cauthor=true&cauthor_uid=18787896), [Martinez G](http://www.ncbi.nlm.nih.gov/pubmed?term=Martinez%20G%5BAuthor%5D&cauthor=true&cauthor_uid=18787896), [Brunicardi FC](http://www.ncbi.nlm.nih.gov/pubmed?term=Brunicardi%20FC%5BAuthor%5D&cauthor=true&cauthor_uid=18787896).   Conflict resolution practical principles for surgeons. World journal of surgery2008; 32(11):2331-5 |
|  |

# Akherkar S M, Bichile L S. Doctor patient relationship: changing dynamics in the information age. Journal of Post Graduate Medicine 2004; 50 (2):120;22.

# Richmond VJ, Berlin JS, Fishkind AB, et al. Verbal De-escalation of the agitated Patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA de-escalation workgroup. Western Journal of Medical Emergencies 2012;13(1):17-25

# Smith MJ. When I Say No, I Feel Guilty: How To Cope – Using the Skills of Systematic Assertive Therapy. New York, NY: Dial Press/Bantum Books;; 1975.

# Mizirara ID, Mizirara CS. Moral consensus theory: paradigm cases of abortion and orthothanasia in Brazil. Indian Journal of Medical Ethics 2013;10(1):58-61.

# Pati S, Sharma A, Zodpey S. Teaching public health ethics in India. Indian Journal of Medical Ethics 2014;11(3):185-90.

# Acknowledgement:

# We would like to take this opportunity to express our sincere gratitude to all those who have in some way contributed to bring this study in the final shape. In particular, we would like to thank Dr.JagadishHedau, Medical Superintendent, and resident doctors who participated in this study with all enthusiasm. Special gratitude goes to patients and relatives of patient for their support and participation. We hope this study will serve the purpose of informing the strategies and actions for any concerned stakeholders in improving the doctor patient relationship and in turn minimizing the conflicts in doctor patient relationship.