Doctor-patient relationship in dermatology

How can doctors be attentive, empathetic and ethical in 15-minute dermatological consultations with patients that are sometimes difficult?

What are our obligations but what are our rights as well?

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Summary

In this article, the author examines various relational aspects of consultations in dermatology. After providing a philosophical definition of ethics, which emphasizes the importance of mutual satisfaction (patient's and doctor's), the author goes over existing literature on patient satisfaction criteria. Generally speaking, 50% of patients are satisfied immediately after the consultation. This percentage rises to 63% after 3 months depending on whether the symptoms have disappeared. Patient satisfaction is likely to be higher if doctors provide information regarding the probable cause of the illness along with an estimate of how long the symptoms will last. Other important satisfaction predictors are the duration of the consultation and the quality of communication between doctors and patients. Patients expect consultations to last up to 20 minutes whereas consultations last 16 minutes on average. Patients who felt that their doctor spent more time with them than they had expected were significantly more satisfied but this degree of satisfaction was not influenced by the fact that doctors felt pressed for time. The degree of satisfaction in dermatology is 60%. Here, satisfaction depends on the doctor's ability to provide explanations and demonstrate empathy. Age is another important factor. Satisfaction also increases if the illness is serious but decreases if quality of life linked to the symptom is altered.

The author goes on to address the pitfalls that can affect good time management, which is a source of satisfaction for both patients and doctors. The major pitfalls include a lack of a structured consultation, the so-called "hand-on-the-door" syndrome (when the patient tells you the most important things at the very end of the consultation), the never-ending patient and unscheduled multiple consultations. In a nutshell, patients with psychiatric problems are generally the ones that doctors have most difficulty with. They make up 25% of consultations in dermatology and over 30% of the cases of acne, pruritus, urticaria, alopecia and dermatological non diseases. Doctors with good people skills experience fewer difficult consultations (8% vs 23%). Another delicate moment in medical consultations is when doctors have to convey bad news, which requires a great deal of tact.

Finally, doctor-patient relationships can be very similar to parent-child relationships. Patients can very easily put us in a position of authority but will also have a tendency to reproduce with doctors the same experiences that they had with their parents. Doctors therefore need to be aware of this psychological transference. At the same time, whenever we feel irritated by a patient, by his/her attitude or even his/her physique, we should ask ourselves why. Who does this patient remind me of? What part of my past am I bringing out and projecting on the patient? This is called counter-transference. It is important to realise that when doctors are satisfied with their work, patients will also feel more satisfied. One of the reasons why female doctors are more likely than their male colleagues to experience burnout is that they are not as well organised. To conclude, the author recommends compassion. Unfortunately, this philosophical virtue seems to be on its way out, leaving patients faced with technicians rather than human beings. It is in the patients' best interest that doctors bring compassion back into their consultations.

What is meant by ethical medical consultations?

Comte-Sponville's philosophical dictionary [1]states that "although ethics and morality are often synonymous notions, ethics sound better..." Ethics come from the Greek word – *ethos* – and morality comes from Latin – *mos* or *mores* – both terms meant basically the same thing (moral standards, character, way of life and behaviour)..." However, if we really want to draw a distinction between these two concepts, he says: "the best thing to do is to take literally what the history of philosophy clearly suggests: Among the Moderns, Kant is the great philosopher of morality and Spinoza is the philosopher of ethics...This amounts to opposing morality to ethics like the absolute (or supposedly absolute) and the relative...Put simply, morality commands and ethics recommends...It would be a mistake to try to choose between them because we need both. Morality answers the question "What should I do?" and ethics answer the question "How should I live?"

Ethics is much wider in scope. It includes morality but the contrary is not true (answering the question "How should I live?" includes a search for what one should or should not do; answering the question "What should I do?" does not give insight into how to live one's life.)

In other words, ethics is an effort, a process, a path that we follow: it is a carefully thought out approach leading up to a healthy lifestyle -as the Greeks used to say- or to the least damaging lifestyle possible. This is the only real wisdom, in fact.

One of my professors gave me a quick-and-easy rule that I refer to whenever in doubt. You could say that an act is moral (the word ethic was not used at the time) if it is good for others but also good for oneself. If we as doctors forget the second part of this proposition in our medical consultations, then we're headed straight for burnout (exhaustion syndrome). A recent survey showed just how serious this risk is for doctors. This is why I added the words "What are our rights?" in medical consultations to my title. As with the rights of the child - where people lost sight of the fact that children also have obligations to their parents - there has been a great deal of focus on the rights of patients and the legal consequences that we are all aware of. Perhaps people have forgotten that doctors also have rights. But let us not exaggerate our plight. Dermatology is a coveted profession (as attested by the large number of candidates). One reason for this could be that we have greater control over our own schedules than other professions. And as we will see, time management is an important factor of patient and doctor satisfaction.

We can therefore define a consultation as ethical if most of the doctor's and patient's expectations are met.

1. Patient satisfaction predictors

   A U.S. study of 500 patients in general medicine[2] revealed that 1 patient out of 2 was satisfied after leaving the doctor's office. The percentage increased to 63% when the same patients were asked about satisfaction 3 months later. The happiest patients were the ones over the age of 60 who experienced improvements in health. However, there are other variables that can be used to predict immediate satisfaction following a consultation. These include receiving information about the probable cause of the illness and the duration of the symptom. Between 2 weeks and 3 months afterwards, satisfaction increases if the symptom regresses but decreases if additional consultations are needed for the same symptom. Meeting patient expectations is a powerful predictor of satisfaction at all times. Immediately after the consultation, other predictors have to do with doctor-patient communication (i.e. receiving explanations regarding the cause of the symptom, probable duration, whether or not patient expectations were met). Later on, patient satisfaction improves when the symptom disappears.

Therefore, our patients have other expectations that go beyond their desire to be healed. What are those expectations exactly?

2. Duration of consultations

The duration of consultations is a very important variable. It has a significant impact on patient satisfaction. A study on the duration of ambulatory visits to physicians[3] covering 19,192 consultations with 686 general practitioners revealed that the average duration of consultations was 16 minutes. For what could be transposed to dermatology, consultations lasted longer for patients with psychosocial problems or when 4 or more diagnostics (71% increase), ambulatory surgery (+34%), or patient hospitalisation was required (+32%). Consultations were shorter when non-medical staff was present.

However, does the duration of consultations really have an impact on patient satisfaction?

A prospective study[4] of 1,486 consultations sought to determine whether patient's and doctor's perception of time was a determinant of patient and doctor satisfaction. Patients expected to spend 20 minutes or less with their doctor in 69% of the cases. After the consultation, those patients who felt that the consultation lasted longer than they had expected were significantly more satisfied. Patients who felt that the consultation should have lasted longer were significantly less satisfied. Patients who were anxious or feared that they were in poor health expected significantly longer consultations.

For their part, doctors felt pressed for time in 10% of the cases and associated this feeling with patient dissatisfaction, although this was not necessarily the case. Patients felt that their doctor was in a hurry in 3% of the cases and this did not have any impact on their satisfaction with the consultation.

What about patient satisfaction with their dermatologists? A study published in the British Journal of Dermatology [5] reports a 60% satisfaction level. Satisfaction depended either on the doctor's ability to provide explanations, show empathy or on the patient's age. Satisfaction was also higher among patients with severe illness but lower when the quality of life linked to the symptom was altered. The degree of satisfaction was lowest when the quality of life was altered more than the clinical severity observed by the dermatologist. Here, we see the entire problem of dysmorphic syndromes where doctor's and patient's views regarding the severity of the illness diverge. Remember that 12% of all of our patients experience these syndromes [6]. If we include subclinical cases in plastic surgery, the percentage rises to 18%[7]. This study seems to suggest that dermatologists have better dealings with patients who have severe illness. However, improving doctor-patient relationships in cases that are considered to be clinically average for doctors but psychologically dramatic for patients is still important [8]. Not only will patient satisfaction be higher, chances are that the patient will stick to the treatment rather than indulge in medical shopping with the corresponding extra costs that go with it.

Using time management to avoid the pitfalls

The average patient visiting a doctor in the United States gets 22 seconds for his initial statement, then the doctor takes the lead[9] . If they simply allowed their patients to say whatever they have to say, the mean spontaneous talking time is 92 second . The point is, allowing your patient to talk without interruption will not be what uses up most of the consultation time.
What can get us side-tracked and behind schedule, causing patients to get upset and doctors to feel stressed?

Leaving difficult patients aside for a moment, it seems to me that we can improve both our comfort and patient satisfaction if we follow a few rules.

a. Structure our consultations[10]. By doing this, you won't find yourself spending 15 minutes talking about trivial matters with your patient only to hear the dreaded words at the end of the consultation, "Doctor, I still have something to show you!" In some cases, that little last-minute item turns out to be much more important and here you were thinking that the consultation was over.

   Just keep the acronym SOAP in mind:

   S: Subjective symptoms, problems that patients bring with them. This is when you should ask your patients if there are any other symptoms. Some patients will tell you right away that there are other problems. Others will not do so. Every time we get ourselves in a bind, it's because we forgot to ask our patients that simple question: Is there anything else that you'd like to show me? And don't worry about repeating the same question again and again because you may have 4 or 5 more things to look at! Once all of the information is out, you can rank the problems in order of importance. You can then tell your patients that there is only enough time to deal with the first 2 problems and that a second consultation will be needed for the remaining problems. There is nothing wrong with scheduling your interventions in this manner instead of taking care of everything on the spot as the patient may have expected. However, it is important to take the time to explain that treating the problems will take longer than the time allotted and that there are other patients waiting who also need to be examined. Generally, this works fine if you are straightforward and nice about it.

   O: Objective symptoms: This is when we examine the lesions. Although there are times when we are able to see and diagnose the lesion the minute the patient walks through the door, patients need to feel that their doctor has examined them. Moreover, by forcing ourselves to examine each and every patient carefully and by using a good lamp, we may even find ourselves correcting mistakes made in our initial diagnosis.

   A: Assesment: Based on what our patients tell us and what we find in our clinical examination, we need to ask ourselves what can be done or what the diagnosis is. Besides, thinking aloud will help us to explain our diagnosis to patients. If we are uncertain or have no idea what that diagnosis could be, there is nothing wrong with telling your patients so. Will this have an impact on their satisfaction? A study focused on physician expressions of uncertainty during patient encounters[11]. An analysis of audio recordings of 216 internal medicine consultations showed that there were expressions of uncertainty in 71% of the consultations. Those doctors who stated that they did not feel comfortable sharing their uncertainty with their patients made less use of such expressions of uncertainty. However, those who used expressions of uncertainty on a more frequent basis also had a more positive outlook, created more partnership and provided their patients with more information. Patient satisfaction with these physicians was also higher. Therefore, patients prefer doctors who feel at ease and are not afraid of admitting that their diagnosis is uncertain and requires verification.

   P: Programme, prognosis and prescription: This is when we explain to patients what tests need to be done to confirm our diagnosis, determine a prognosis (which is very important for them) and issue prescriptions (which

are often excessive, as we shall see!) Why not take this opportunity to find out what the patients would like to do? We will be more in sync with their expectations.

b. The hand-on-the-door syndrome. Patients sometimes tell us the most important details at the very end of the consultation, right as they are reaching for the door. This can happen even when our consultation was properly structured. What do we do? On one hand, you realise that it is very important but you can already feel the next patient's pressure level rising in the waiting room outside. After listening to our patient without interruption, the best thing is to simply tell our patient how important the matter is and schedule another appointment to handle it. Some patients are accustomed to this procedure. You have every right to structure the consultation and this will also help these particular patients, who are often borderline types.

c. The never-ending patient. You open the lines of communications and they just keep going on and on, saying the same things over and over again or having you constantly repeat what you have already said. When you feel that you have reached the end of the consultation but the patient does not show any signs of wanting to budge, you can use all of the non-verbal means at your disposal: stand up, walk towards the door and open it for them. In some cases, you can even refuse to reply or simply state that you don't have any more time right now and that you will continue the discussion the next time.

d. Multiple consultations. Who hasn't had to deal with patients who ask for a second consultation or even a third? There are several ways that we can deal with this, depending on available time or tolerance. We can assess the problem and limit ourselves to giving just an opinion (we might even charge them for the advice). We can accept to meet with the patient for a second and more complete consultation (the first one can be a bit shorter than normal) and charge them. We can kindly explain that there isn't enough time right now and then schedule another appointment. In such cases, insist on how important it is for patients that you stick to your schedule. If you are late, explain that you do not want to be even later. If you give in to their whims, you run the risk of being contacted again on other occasions. By being gentle but firm, you can generally wiggle your way out of the situation and avoid the burnout that comes with having to deal with too many of these situations. If the patient nevertheless refuses to go away, it is probably because there are underlying psychiatric problems (paranoia, hypochondria, personality disorder). In such cases, you need to be even kinder and firmer. Otherwise, you may end up worsening the situation. At the very least, you will never see the patient again but, in the worst-case scenario, they might even attack you.

3. Taking patient expectations into account

In 1994, Sanchez-Menegay[12] conducted a study to determine whether physicians take their patients' expectations into account. The most important patient expectations are diagnosis (94%), prognosis (82%), prevention (76%) and follow-up care (80%). It is interesting to note that there was no correlation between what patients expected and what physicians gave them. In fact, physicians tend to fill out more prescriptions than patients expect them to and they almost never talk about prevention or prognosis. In random cases, physicians were informed of patient expectations but this did not significantly change their behaviour.

Doctors therefore tend to prescribe more than patients expect them to. A recent study[13] carried out on general practitioners in Germany found that the number one priority for patients was to receive information about their illness. The need for prescriptions (26%) and the desire to receive them (41%) do not match the extent to which the doctor prescribes (56%). Of the patients who did not express any desire to receive a prescription, 44% walked out of the doctor's office with one in their hand. 4% of the patients said they wanted medication even if it might not be effective. 21% receive such medication, especially for minor diseases.

What effect does this have?

Von Ferber's study indicates that 98% of the patients were satisfied, regardless of their doctor's excessive prescription itch.

When patients are dissatisfied, however, the effect is much more negative.

Another study [14] of 750 patients showed that practically all patients had logically at least one expectation. For 81% of them, it was to receive a diagnosis, for 63% it was for the doctor to tell them how long the symptom would last, for 60% it was a prescription, for 54% an additional examination and for 45% to be referred to a sub-specialist. After the consultation, the least satisfied expectations were the prognosis (51%) or information about the diagnosis (33%). The most frequent cases of patient dissatisfaction were when the doctor found the consultation difficult or when the patient in question had underlying mental problems. Patients whose expectations were met felt less anxious (54% versus 27%) and more satisfied (59% versus 19%). Patients who received information about their diagnosis and prognosis generally experienced improvements in their symptoms after 2 weeks.

4. Patient dissatisfaction

An Italian study [15] carried out on dermatology patients shows that patient dissatisfaction and psychiatric morbidity are significantly and independently correlated with the patient's refusal to stick to the treatment. The study stresses the importance of the dermatologist's people skills and on the proper handling of psychiatric pathologies during dermatology consultations. At this juncture, I would like to make a small recommendation to doctors facing manias of parasitosis.. Listen to your patients; accept their suffering without allowing yourself to get dragged into their mania. Do not make fun of them. If there are no other neurological signs, another thing you can do is prescribe a neuroleptic such as Orap or weekly injections of Imap. However, you will have to show tact when trying to convince your patient to accept the treatment. It is likely that they will refuse to go to a psychiatrist and will feel really hurt that you think they are insane. Of course, it's not that they are insane, it's simply that they are suffering from a monosymptomatic psychotic decompensation. Such patients tend to be less distrustful and more willing to accept

treatment than patients suffering from dysmorphic syndromes. In their immediate or distant past, we often find incidents of major psychological suffering (death of a child, abandonment, abuse).

5. Difficult patients

Patients identified by dermatologists as difficult patients seem to be the ones with psychiatric pathologies. A study [16] published in the British Journal of Dermatology shows a 25% prevalence of psychiatric morbidity. In other words, 1 out of every 4 of the patients who walk into the dermatologist's office will be difficult patient. 30% of the patients suffering from acne, pruritis, alopecia, herpes and dermatological non diseases have psychiatric disorders. In another study of 500 internal medicine patients (Jackson2001)[17], 15% of the consultations were said to be difficult. Doctors felt that the consultations had been difficult because patients had psychiatric problems, suffered from over 5 somatic symptoms, or had more severe symptoms. Patients felt that the consultations had been difficult because their expectations had not been met, because they felt dissatisfied with their consultation, or because they were excessive consumers. Doctors with less developed communication skills had more difficult consultations (23% vs 8%)

6. Announcing bad news

There are several difficult situations that our medical training has not prepared us for like breaking the news to patients that they have a melanoma, are HIV positive or are suffering from a severe pathology; having to inform family members; announcing a patient's death. How many times have doctors given this type of diagnosis in a hallway or over the phone? Feeling ill-at-ease and powerless to do anything about the disease (after all, curing the disease is what we're here for, isn't it?), doctors often cut loose, leaving patients and their families feeling very alone indeed. But what else can they do? They can prepare their patients for the bad news. If a nevus is suspected to be malignant, a subsequent consultation can be scheduled to give the results. This allows doctors to avoid giving the results at a less favourable time (like at the end of consultation, when time is lacking). The same thing holds true for HIV blood tests: you simply can't give this kind of news over the phone. A later consultation can be scheduled so that the laboratories can get back to you with confirmation of the test results. Anticipating difficult diagnoses allows you to side-step awkward announcements. If the diagnosis is a surprise, then the patient should be contacted (preferably by the secretary) so that an appointment can be scheduled for the very same day since the patient will be quite alarmed after receiving the call. Take your time. Chat with the patient or his/her family if you are meeting them for the first time. Break the news gently, giving the patient only as much as you think they are able to bear. Leave communication lines open to the expression of unpleasant emotions. Always leave room for hope, even if only slight, without misleading patients or their families. A six steps protocol has been established and can be thought and learned[18]

How about patient needs after the diagnosis has been given? A study was carried out on psychotherapeutic interventions in melanoma[19] In this study, a psychiatric unit was set up for a 7-year period at an Austrian university dermatology ward to assist patients suffering from melanoma. The most appropriate supportive methods were those where patients were permitted to express their emotions. However, the psychotherapists themselves also needed support from their colleagues so that they wouldn't experience burnout or find themselves avoiding terminal patients. Ethics (which also takes into account our needs) requires some sort of support structure enabling us to share difficult emotions, even if it is simply talking to a colleague about a case. If we are specifically assigned to a melanoma case, a multidisciplinary group would also give us the necessary support we require. It is in our own best interests as well as in the patient's not to try to go it alone.

7. Transference and counter-transference

An article published in the Archives of Dermatology [20]addresses the issue of medical ethics in modern dermatology. The article highlights the importance of the doctor-patient relationship, among other things, saying that the patient's interest must always come first. It goes on to say that the doctor-patient relationship is an unequal one. Patients are in a situation of dependence with respect to their doctors and this is why doctors must not take advantage of the situation. It is true that the doctor-patient relationship can have a lot of similarities with the parent-child relationship. Patients can very easily put doctors in a position of authority but will also have a tendency to reproduce with doctors the same experiences that they had with their parents. Doctors therefore need to be aware of this psychological transference. Attitudes of kindness, submission and aggressiveness are not necessarily targeted at us personally. Patients are simply reproducing something that they experienced in their past. This understanding can help us to better deal with our patients whenever they become aggressive. We need to tell ourselves that the patient is not reacting violently to us but rather to someone behind us, perhaps his/her mother or father in many cases.

At the same time, whenever we feel irritated by a patient, by his/her attitude or even his/her physique, we should ask ourselves why. Who does this patient remind me of? What part of my past am I bringing out and projecting on the patient? This is called counter-transference. These positions of transference are much easier to deal with when there are positive feelings being projected. However, this can also be tricky since too much proximity with a male or female patient could get us into a love affair if we ourselves are in need. While there is nothing illegal about this, giving in to our temptation would amount to taking advantage of the situation in a very broad sense. Even if the relationship lasts, it is based on a misunderstanding from the outset. It can happen more easily if we spend too much time listening to a patient's problems or if we are unsatisfied with our own partner. Feelings of attraction can come from either the doctor or the patient or be mutually felt. However, just like fathers must not give in to their daughters' seduction or mothers to their sons', it is important for doctors or psychotherapists not to give in to temptation. Many patients with highly psychosomatic pathologies were abused as children. Reproducing past suffering is a psychological mechanism. Paradoxically, these patients will be very seductive. If their seduction attempt is successful, you will be locking them into their scenario. However, if instead you stand firm and refuse, you will give them a chance to grow. Balint groups are good at analysing this aspect of patient transference in all sorts of doctor-patient relationship scenarios.

8. Correlation between patient and doctor satisfaction

A study shows patient satisfaction levels are higher when doctors are very satisfied with their work or work part-time [21] If we compare job satisfaction among male and female doctors, we find that female doctors have a higher risk of burnout. This is especially true if they do not structure their activity properly, which is often the case[22]. A Belgian study shows that 30% of female general practitioners discontinue their practise after 5 years (Journal du Médecin)[23]. Time management is one of the most important factors that go into job satisfaction for doctors, particularly female doctors. Considering the fact that there are more women in our branch of medicine, this statistic should to be taken into consideration. Since our satisfaction influences patient satisfaction, both sides will benefit.

9. Empathy and compassion: endangered species?

An article published in the Journal of the American Academy of Dermatology talks about these values [24]. What made us want to become doctors? When we were younger, we used to be so enthusiastic about taking care of people's suffering. What happened? Have we forgotten all about our enthusiasm and become so preoccupied with money? The medicine of guidelines and techniques has lost sight of the importance of an art of healing that cannot always be measured and identified. Medication alone may not be enough to heal. We might consider adding a dose of empathy or even compassion.

The Dictionary of Human Sciences[25] defines empathy as "intuitively sensing the feelings of others, emotionally participating in the subjective states of others." Coming back to Comte-Sponville, we find that he does not talk about empathy but rather compassion: "It means feeling other people's suffering. It is very close to pity but lacks the condescension that pity conveys or implies. Compassion is a feeling of pity between equals. It is very close to *misericordia*...which was badly translated by the Christians as "mercy or forgiveness": What it really means is love in the sense that a person feels happy when good things happen to others and sad when bad things happen to others."

There is a difference between empathy and compassion. Empathy is the least we can feel whenever a patient opens up ever so slightly to us. With compassion, there is a deep communication between two human beings at the level of their very humanity. It means allowing ourselves to be truly involved. Of course, this feeling is not felt with all patients. However, when we do feel it, our patients can get better in ways that will surprise us.

It is not enough to simply feel this emotion. We also need to express it, saying things like: "I understand your suffering", "I can imagine what you are going through", "I can see things from your perspective", "This must be difficult for you."

If we listen to the people who come to us for help, we can guess or discover what is really bothering them. If we allow ourselves to identify with what they feel and tell them so, few patients will end up being "difficult". They will walk out of our offices with a general feeling of satisfaction because they will feel that we have not only listened to them but also have understood them.

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