

Patient-Physician Relationship; A keystone of Care in Emerging Health Care System

Anil Kumar Agarwal^{1*} and Avinash Sharma²

¹Associate Professor Community Medicine, India

²Associate professor Neurosurgery, India

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***Corresponding author:** Anil Kumar Agarwal, 4, Medical College Campus, G. R. Medical College, Gwalior, (M.P.) 474009, India, Tel: 8889289229; Email: anilanjindia@rediffmail.com

Abstract

The Global health system is in a period of tremendous flux, with changing rules, relationships, and expectations for all parties. Nowadays, the health status of population is generally related with progress in medical care intruding upon our experience of everyday life. Over a last 60-70 years, a wide range of phenomenon has been included in medical care, including normal life events (births, death), biological processes (aging, female reproduction, many human day-to-day physical problems), and type of social deviance appearance (obesity, unattractiveness), belief (racism), and conduct (drinking, gambling, sexual practices) come under patient-physician relationship. A robust science of the doctor-patient encounter and relationship can guide decision making in new health care plans and the administrative strategies used by managed care organizations and medical groups deserve more attention in emerging health & medical care system.

Editorial

From ancient Greek times, researchers had found] that the health and well-being of patients depends upon a joint effort between physician and patient. Patients share their illness with physicians and expect for their care by physician and this relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in well-timed and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights [1]. During the last two decades or so, there has been a struggle over the patient's role in medical decision of the patient and the physician for developing conflicting in both autonomy. Seeking to curtail physician dominance, many have advocated an ideal of greater patient control [2]. Still others are trying to delineate a more mutual relationship.

The doctor's job is to cure disease. Curing disease is not something a doctor can do alone. Patients are not just biological and chemical, anatomical and physiological person, but also intelligent, free, social, artistic, symbolic beings. You can't cure that without its cooperation. Physician acts as the patient's guardian, articulating and implementing what is best for the patient. The reciprocal relationship between doctors and

their patients has revived since Hippocrates, and is the matter of modern medical literature. The Hippocratic Oath speaks of healing as a source of wonder. These conflicts in between the expectations based on ethical and legal standards for the physician's duties, informed consent, and medical malpractice. This struggle forces us to back. What should be the ideal physician-patient relationship? [3].

Nowadays, the health status of population is generally related with progress in medical care intruding upon our experience of everyday life. Over a last 60-70 years, a wide range of phenomenon has been included in medical care, including normal life events (births, death), biological processes (aging, reproduction), human medical & health problems, deviance appearance (obesity, unattractiveness), belief (racism), and conduct (drinking, gambling, sexual practices) come under patient-physician relationship. Medical care occurs at three levels: the conceptual, the institutional and the interactional levels. At the conceptual levels a medical vocabulary is used to define the problem at hand. At the institutional level, organizations may adopt a medical approach to treat problem. Physicians function as gate keepers for benefits of an organization. At the interactional level, physicians are most directly involved.

Medical care occurs here as part of doctor-patient interaction, where a physician defines a problem as medical or treats a social problem with a medical treatment [3]. The doctor/patient relationship is a relationship where the medical needs of one person and the technical ability of another come together-should be understood as a humane partnership. The rapid penetration of managed care into the health care market raises concern for many patients, and physician about the effects that different financial and organizational features might have on the physician-patient relationship [4]. Some such concerns represent a blatant backlash on the part of physician whenever we talk to of health care practices with their patients' counterpart. But objective and theoretical bases for genuine concern remain. This article examines the foundations and features of the patient-physician relationship and how it may be affected by managed medical care/emerging medical care system.

Patient-Physician Relationship and Medical Ethics

Physicians and philosophers have contributed to the field of medical ethics several different paradigms for the physician-patient relationship. While the "older" medical ethics commonly proceeded by enumerating lists of rules and duties for physician (and sometimes for patients), the "newer" medical ethics of the last two decades has sought theoretical constructs which could ground or organize the rules and duties in a coherent way. Under New medical technologies physicians are increasingly aware of the importance of attending to their patients' psychological and social needs as a part of holistic practice and the faith patients have in them make it easier than ever to seek to avoid the natural unpleasantness surrounding illness. Virtually all patients hope, and some even hope against hope Biotechnology has given patients more reason to hope, even to hope against hope and this seems ever more rational. Broad-based astonishment at the extraordinary progress of medicine in the past few decades is a cultural phenomenon of which Physicians ought to be aware of the possible pitfalls inherent in the psychological aspects of physician-patient relationships with the expectations of patients. The physician can manage the expectations of patient demands sensitivity extend to their occasional delusions of control and the fragility of hope [5].

Respecting the fiduciary relationship and the trust of the patient is a cornerstone of the ethical physician's practice. The doctor-patient relationship is central to the practice of healthcare and is essential for the delivery of high-quality health care in the diagnosis and treatment of disease. The Patient-Physician relationship forms one of the foundations of contemporary medical ethics [6], where Physician knew all patients, their sufferings, dispositions, affections and he also knows his crafty illness, and all their secret problems; his false beliefs, and their true expectations There is considerable healing power in the physician-patient alliance. A patient who entrusts

into a physician's care creates ethical obligations that are definite and weighty. Working together, the potential exists to pursue interventions that can significantly improve the patient's quality of life and health status.

Patient-Physician Relationship and Trust

A trust phenomenon is a process in which every couple of patient is connected through a trust statement. This statement can devote full trust, partial trust, complete distrust... or ignorance (when two patients do not know each other at all). In other words, the trust relationship between every patient couple can be represented by a trust score. Remark that trust statements are not necessarily reciprocal; think e.g. of a trust network between oncologist and cancer patient: cancer patient may highly trust their oncologist for cancer problems, but this certainly does not imply that the oncologist will trust every single patient to the same degree. It is easy to see that a trust network can be modeled as a directed, fully connected graph. The patients in the trust network can then be represented by nodes in the graph, the relations between the patients and physician by directed edges, and the corresponding levels of trust (trust scores) as weights on the edges. Perhaps the strongest justification for framing physician-patient relationship in terms of a trust is that trusts seem to come down to on both-sided promises between someone with power, wealth, or both and someone less powerful or unhealthy [7].

The quality of the patient-physician relationship is important to each other. The better the association in terms of shared respect, shared values and perspectives about disease and life, and time available, the better will be the patient perception of care enhancing accuracy of diagnosis and increasing the patient's knowledge about the disease. Where such an association is not up to the mark the physician's ability to make a full assessment of patient is compromised and the patient is more likely to distrust the diagnosis and proposed treatment, causing decreased compliance to actually follow the medical advice. The bond of trust between the patient and the physician is vital to the diagnostic and therapeutic process for providing optimal treatment recommendations; the patient must be able to communicate all relevant information about their problem, and physicians' must keep divulging confidential information. The physician-patient relationship has evolved towards shared decision making. This trust model belief that the patient has his autonomy with a right to hold views, to make choices, and to take actions based on personal values and beliefs. Patients have been increasingly entitled to consider pros and cons of all treatments, including the alternative of no treatment, and to select the alternative that best promotes their own values and for that many patients admire a physician who brings a personal touch during prescribing the treatment and may feel more connected to a physician whose extracurricular activities and interests make him viable. Physicians may select in conversation to share

parts of their life stories according to patient level of comfort but it is essential that the patient, and the patient's concerns, be the focus of every visit.

Patient-Physician Relationship and Social Context

If, as evidence suggests, the patient-physician relationship does affect a patient's health care trajectory, how they are treated and encouraged for complying treatments suggested, otherwise patients can feel disempowered and may be unable to achieve their health goals. Bensing et al. [8] highlight that a patient's inclination to participate in medical decision making varies by different social characteristics such as age, gender, education, coping style, and severity of condition [8,9]. Street et al. [10] note the shared identity and its importance between patients and physicians facilitating more positive health care interactions. Furthermore, they found that the way a physician perceives a patient (intelligent, attitude etc) affects how they treat them during the consultation. Gender and age are also important influences on the doctor-patient relationship, with more smoking and alcohol-related advice being given to men and older patients. Doctors also communicate and treat their patients differently according to other social characteristics such as social position and ethnicity. Physicians themselves have contributed to a culture of medical practice in which objective test results are given more credence and are felt to be more reliable than the subjective history of the patient. In practically more than 80% of diagnoses are made by history alone [11]. Physicians need to control their own reliance on objective but noncontributing trial. By fostering a system of managed care in which cost concern is acceptable and necessary services are provided, physicians can be perceived as being socially responsible and perhaps restore some credibility in this area to the profession.

To managed health care organizations, its importance rests also on market savvy: satisfaction with the doctor-patient relationship is a critical factor in patient's decisions to join and stay with specific medical plans by ensuring that the benefits and importance of treatment are understood. Rapid penetration of managed care into the health care market raises concern for understanding of both parties' perspectives, by shifting from a perspective that is rigidly certain of one's belief to a more exploratory approach that strives to understand the situation from another perspective. Patients construct their own version of adherence according to their personal world views and social contexts, which can result in a divergent expectation of adherence practice. Good doctor-patient relationship is a mechanism used to gain an understanding of patients' social context, expectations, and experience, but is more critical for vulnerable patients as they experience a heightened reliance on the physician's competence, skills, and good will. The relationship need not involve a difference in power but usually does, especially to the degree of the patient is vulnerable or the physician is autocratic.

Sick people want help because illness threatens their connection to the vividness. They naturally invest hope in the physicians they find while patients as a group dislike thinking unpleasant thoughts. (No doubt physicians do, too, although probably less so in the health care setting. A study demonstrated that most patients who have not discussed preferences for end-of-life care do not want to do so. A culture heavily invested in "the power of positive thinking" produces patients who may resist thinking about the possibility that their physicians will disappoint them [5]. Managing the expectations of patients requires vigilance and demands sensitivity to their occasional delusions of control and the fragility of hope over what Aristotle identifies as a natural tendency to indulge emotionally those we care about.

Patient-Physician Relationship and Compliance

Compliance with physician advice is a key outcome of medical care consultations. The medical care physician is the key coordinator of prescribing medicine and Medication prescribing is a core component of medical care, and patient compliance with recommendations to take medications varies. Patients reporting high levels of concordance with the physician were one third more likely to be compliant in taking medications prescribed during that consultation. In contrast, continuity of care measures, trust in the physician, and enablement were not consistently or not independently related to compliance with medications [12]. One third to one half of patients will fail to follow a physician's treatment recommendations. Labeling of such patients as "noncompliant" implicitly supports an attitude of paternalism, in which the physician knows best. Patients filter physician instructions through their existing belief era; patients decide whether the recommended actions are possible or desirable in the context of their everyday lives, because so many patients are asking how they can change this in their lives, Physician started digging for solutions and could offer them, and found both surprised with the result.

Effective use of the structural elements of the medical advice also affects the therapeutic relationship and important outcomes such as biological and psychological quality of life, compliance and satisfaction. Effective use gives patients a sense that they have been heard and allowed to express their major concerns, as well as respect, caring, empathy, self-disclosure, positive regard, congruence and understanding, and allows patients to express and reflect their feelings and relate their stories in their own words.⁴ Compliance can be improved by using shared decision making or ensuring that the patient understands the physician, that there is agreement about the nature of the patient's problem, and that management is acceptable. For example, physicians can say, "I know it will be hard to stay in bed but we try to solve them together." Or, "I can give you a medication to help with your symptoms, but I also suspect the symptoms will go away if you wait a little longer. Would you prefer to try the medication, or to wait?" Most of the medical encounter is spent in discussion

between physician and patient and functions inextricably interact. For example, a patient who does not trust or like the practitioner will not disclose complete information efficiently. A patient who is anxious will not comprehend information clearly. The relationship therefore directly determines the quality and completeness of compliance the physician advice and treatment. It is the major influence on physician and patient satisfaction and thereby contributes to therapeutic maintenance and prevention of physician burnout and turnover, and is the major determinant of compliance [13,14].

Patient-Physician Relationship and Confidentiality

Confidentiality is based on the notion that a person shouldn't be worried about seeking medical treatment for fear that his or her condition will be disclosed to others and it comes under one of the core duties of medical practitioners. The obligation of confidentiality prohibits the health care provider from disclosing information about the patient's case to others without permission and encourages the providers and health care systems to take precautions to ensure that only authorized access occurs. Electronic medical records can pose challenges to confidentiality. Confidentiality provides the foundation for the physician-patient relationship with the objective of confidential relationship is to make patients feel comfortable enough providing any and all relevant information. This also helps the physician to make a correct diagnosis, and ultimately to provide the patient with the best possible medical care. This may require the discussion of sensitive information, which would be embarrassing or harmful if it were known to other persons. The expectation of confidentiality derives from the public oath which the physician has taken, and from the accepted code of professional ethics. The physician's plan and duty to maintain confidentiality for promoting patient privacy that also must extend for respect of the patient's autonomy [15].

Confidentiality is no longer solely in the physician's control but he should Plans to promote patient privacy and confidentiality influences the disposition to trust. The expectation of privacy is one of the most important aspects of the doctor-patient relationship and, but. Organizational personnel also have access to patient information and required to keep it private, they must thought how to keep it private and secured. Fulfillment of confidentiality comes from the sudden intimacies with total strangers and with those moments when the human barriers cracks open to reveal what is most secret and inarticulate. Another physician has strongly urged empathy in clinical encounters and has argued that passion is a part of that empathy [16]. Some patients expect their physicians to fill the role of a powerful paternal or maternal figure. By some taken, some physicians are comfortable only in relationships in which they are taking care of and controlling others. Even aside from relatively marginal cases, emotions can pervade physician-patient relationships.

Patient-Physician Relationship and Prudence

Norms regarding the role of patient preferences in decision-making have changed markedly over the past decades. Good Judgment or wisdom gained from experience and knowledge, expressed in a realistic and frugal attitude. Prudence, however, is not the same as grave caution or wariness concerned only with preserving the status quo. If there is no real cause for patient fear, prudence lies in avoiding excessive deliberations by physician in the readiness to sacrifice today's gain for tomorrow's greater gain. It is danger to the doctor-patient relationship in today's emerging practices is that individual patients with their individual needs and preferences may be considered secondary to following practice guidelines and patient adherence to which may form an integral part of an evaluation measure of physician's performance. According to medical practice guidelines and the "standard of care", if physician ignores the incredible variation in patient preferences and characteristics, patients suffer from which benefits are covered, so there is approach required to treat the disease without reference to the illness [4]. A penny of good prudence by physician in time may avert a pound of unnecessary or even harmful spending used to reassure an anxious patient or substitute for a sketchy history.

Physicians should focus on continuity in relationships with individual patients, as well as other specialists and nurses' staff, with the organization as a whole. Continuity encourages trust, provides an opportunity for patients and physician to know patients' as persons and provides a foundation for making treatment decisions with a particular patient. It allows physicians to be better advocates for their patients and allows patients some power by virtue of the personal relationship they have with this physician. Practitioners can practice prudence. Physicians should be prudent in their use of resources, and at minimum resources should provide services to patients with utmost benefits.

There are several pathways through which an affiliation may affect patient treatment. While respect for patient preferences is important, these preferences must be balanced with other considerations, including the medical indications, costs, and other contextual factors of the case. Only by carefully considering the entirety of the evidence in each of these domains can a physician act in a way that is in accordance with the patient's best interests and the physician's professional obligations. Time is another prerequisite for physician prudence. In the current practice environment, physicians face mounting demands on their time. Increasing administrative requirements for health care delivery (e.g., service and authorization requests, utilization review processes) encroach on time spent with patients. Physicians' time is one potentially constrainable resource. This can be accomplished by reducing access to physicians or by reducing time spent with physicians once the patient has gained access. However, it is also plausible that an increased use of physicians'

time could lead to equal or greater savings in other areas such as inpatient services [17].

The eminent bioethicist Robert Veatch and other defenders of a contract model reply that prudence is only a special form of promise that emphasizes moral relationships such as fidelity; they also mention that medical ethics is best understood in terms of a broader nexus of prudence between society, the professions, and patients. The question then is what is “acceptable and appropriate” to a “reasonably prudent” physician? Physicians seem to have a hard time with this simple standard. Where they have problems is that they do not want to accept that many reasonable and prudent courses of action can have bad outcomes. They assume that any course that could have been taken to avoid the bad outcome should have been taken. They assume that, being the smart and reasonable physician that they are, they would have foreseen the untoward outcome and taken the higher road to the right answer.

Patient-Physician Relationship and Doctor's Incentives

The doctor-patient relationship may be threatened by new financial and organizational arrangements that raise concerns about conflicts of interest and weaken patient trust. Conflicts of interest are present in any health care system and the trust is the cornerstone of the patient-physician relationship but under fee-for-service reimbursement, “self-referral” presents serious ethical problems. Conflicts of interest in managed care evoke strong concerns because beneficial interventions may be withheld. Traditionally, physicians have been regarded as fiduciaries that are trusted to act in the best interests of the patient, not in their own self-interest or the interests of third parties. Such trust may be called into question by new financial and organizational arrangements. Patients may fear that physicians are no longer independent professionals but rather are agents of managed care organizations or acting in their personal self-interest and in that cases physician-patient relationship may become adversarial rather than collaborative.

Physicians' role as business people has become more central to medical practice as we have moved into the 21st century. Critics have argued that the healthcare system has several incentives that drive costly behavior. Gawande argued: “Our fee-for-service system, doling out separate payments for everything and everyone involved in a patient's care, has all the wrong incentives and it discourages clinicians from working as businessmen together for the best possible results. Gawande also identified various revenue-enhancing approaches and profit-based practices that physicians were using have caused the over-utilization of healthcare. He contrasted this with lower-cost areas that used salaried doctors [18,19].

Patients and physicians who are disgruntled by managed care may yearn for a golden age of medicine. However, managed

care is here to stay because fee-for-service reimbursement led to intolerable increases in the cost of health care, with little evidence that the quality of care improved proportionately. However, patients in managed care may question whether the referral and tests truly are not indicated, or whether physicians are simply trying to save money for them, the physician group, or the health care plan. Furthermore, patients may question whether physicians are exercising independent clinical judgment or merely doing what the managed care organization directs them to do. Even a perception that physicians have conflicts of interest may lead patients to question physicians' recommendations to forgo referrals or tests, no matter how sound the recommendations. As a result, trust in physicians may be undermined [20]. One option involves an integrated series of healthcare providers charging a premium or flat fee from patients to treating into managed health care, rather than a fee for each individual service and this modifies the physician's incentive from ordering more services to solving the problem efficiently for catastrophic (extremely high cost) cases [19].

More dilemmas occur when the patient questions whether interventions are being withheld in order to save money. How should physicians respond to such concerns? Which responses by physicians are counterproductive, heightening rather than assuaging patient concerns? It is likely that the physician will need to acknowledge the patient's underlying emotions and not simply provide information about financial arrangements. In other cases, patient concerns about conflicts of interest and trust may be unspoken rather than explicit.

There are many actions that can be promoted to help patients avoid inappropriate care secondary to physician financial conflicts. First, physician should encourage patients to made more accessible, user-friendly, and interactive, Second, patients should be engaged to unapologetically quiz their physicians for other potential conflicts of interest —These financial conflicts include ownership of medical treatment provided However, if patients are encouraged to ask their doctors every question about their treatment other than those regarding financial conflicts, patients will continue to be hesitant about this issue, and it will remain largely hidden from patient sight. Furthermore, if a doctor reveals that they have a financial interest in the procedure or diagnostic test that they are recommending, this should raise a very serious red flag; the doctor has just admitted that they have motivations in their patients' care other than their health and well being. Finally, and perhaps most importantly, patients should vote with their feet; if patients' seek out physician who refuse financial conflicts, this will quickly change physician attitudes toward these financial arrangements [21]. This can only happen if we work to change our medical culture sufficiently so that patients feel free to speak with their physicians about this issue. Then both patients and doctors can enjoy relationships built on the mutual trust that

makes the practice of medicine so rewarding to professionals and comforting and safe for our patients. More cost-efficient care of patient needs a health care network rather than physician individual services. Physicians need to pay close attention to financial and nonfinancial incentives because conflict of interest makes strong deviate decisions for individual patients.

Physicians must look at how they are paid; realize how it might influence the care of their patients at the individual level with more or less appropriate use of medical services [22], because most patients trusted their physicians, but more fee-for-service (FFS) indemnity patients have higher levels of trust than salary, capitates, or FFS managed care patients and the impact of payment methods on patient trust may be mediated partly by physician behavior [23]. It's urgent need for making efforts to improve the quality of information available to patients through advertising and other media must be accompanied by concomitant efforts on the part of the medical profession to improve the ways in which physicians communicate with their patients, not only about the medical issues themselves but also about the conflicts of interest that are an inherent part of every physician-patient relationship.

Conclusion

Sick people want help. They naturally invest hope in the physicians they find. The trust models that had been proposed so far could not cope with such knowledge defects, since they do preserve vital trust provenance information. Seldom, very seldom, physician has just enough information to make a perfect assessment of patient's illness, sufferings or intentions. Instead, patients often have too little information or too much information for a good estimation. This is certainly the case in large patient networks where (partial) ignorance and conflicting opinions are the rule rather than the exception. The trust between physician and patient that had been proposed so far could not cope with such knowledge defects, since they do not preserve vital trust provenance information. Representing trust estimations as elements of a bilattice enables physician to accurately describe their own or computed (via propagation and aggregation) opinions, so that the requiring treatment can safely act upon patient. The ability to handle ignorance and inconsistency becomes extremely meaningful in an hospital network where the trustworthiness of some physician s are initially unknown to some patients , which does not imply that he distrusts all of them, but that he may eventually gather evidence to trust or distrust some physician and still ignore others. Try as we might to overcome our emotions, they some-times withstand even our best efforts. Particularly in medical care, fear and hope abound. Physicians and patients both would do well to consider how emotions can infiltrate our efforts to think clearly.

We have outlined briefly the fundamentals of the doctor-patient relationship, some features of the health care system particularly in managed care settings has been frustrating and confusing. We are angry and upset at a system in transition,

which we do not yet fully understand. Our current opportunity is to define in new way the doctor-patient relationship, and the modern health care context in which that relationship operates, and in particular, the influence of changes in the financing and organization of health care. The doctor-patient relationship deserves our serious attention and protection during these emerging new managed health care delivery times. The Global health system is in a period of tremendous flux, with changing rules, relationships, and outcomes for both patient and physician. Despite all dramatic changes, trust will remain a crucial element in the patient-physician relationship, with a profound impact on the therapeutic process. We need to understand more about patient behaviors as a client and practice patterns of physician that promote trust as well as how patients' expectations, attitudes, and knowledge affect their trust. The consequences of trust for medical professionalism and managed health care credibility are too important to allow uninformed perceptions to guide policy [24]. A robust science of the doctor-patient encounter and relationship can guide decision making in new health care plans and the administrative strategies used by managed care organizations and medical groups deserve more attention in emerging health & medical care system.

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