Achieving a Balanced Patient-Physician Relationship: A Multi-Perspective Analysis

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Abstract

Despite the many advancements in the field of medicine, the delivery of quality, personalized care for patients is seldom consistently achieved. In a field where excellence of patient care is a focal point, patient dissatisfaction continues to be a paramount symptom of a poor, fragmented patient-physician relationship. What can physicians do to achieve a stronger, balanced relationship with their patients and improve the quality of care they provide? Through a critical examination of the perspectives of physician authors of several texts, including Dr. Paul Kalanithi's *When Breath Becomes Air*, Dr. Danielle Ofri's *What Patients Say, What Doctors Hear,* Dr. Oliver Sacks' *The Man Who Mistook His Wife for a Hate and Other Clinical Tales*, Dr. Damon Tweedy's *Black Man in a White Coat*, and Dr. Ian Williams et al.'s *Graphic Medicine Manifesto*, this paper discusses, synthesizes, and evaluates such current published insight in order to achieve a balanced, patient-physician relationship. By exploring and critiquing these viewpoints, an overall plan for patient care is proposed; the resulting need for communication and restrained empathy serves as a takeaway in patient care for both current and aspiring healthcare professionals.

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Introduction

The science and art of medicine have been practiced since the dawn of human civilization. However, medical practitioners, specifically physicians, cannot seem to consistently deliver quality, personalized care. Patients, en masse, continue to complain that they feel ignored and undervalued. As Dr. Danielle Ofri, author of *What Patients Say, What Doctors Hear* reveals,

> "The doctor gets the home-field advantage, at ease with the intricacies of the medical setting that, for most people, is only a few shades more alluring than an IRS audit. And of course it's the patient, not the doctor, who is doubled over in pain during the conversation, or who is nervously awaiting the CT scan report that will reveal whether the cancer has returned. All handicaps to the visiting team…" (Ofri 2017, 16).

To overcome this innate imbalance, the field of Health Humanities advocates for a patient-centered approach, in which the physician is decentralized as the source of sole authority in the relationship so that the patient, too, wields power in the interaction. Yet, a decentralization of either party may be unnecessary. Balance within the relationship can allow *both* parties to feel empowered and play an active role in medical discussion and treatment. So, what can a physician do to achieve a balanced patient-physician relationship? Is it more time, connection, communication? All of these or something else? Can it be applied to every patient? What happens (if anything at all) when a physician goes too far? The diversity of perspectives of physicians, particularly physician-authors, illuminate the factors physicians may be able to incorporate into their care to foster this relationship. As Dr. Paul Kalanithi wrote in his memoir *When Breath Becomes Air*, "Human knowledge is never contained in one person" (Kalanithi 2016, 172). Thus, each physician's reflections offer individual insights, which when analyzed together, can build a framework for how medical providers can deliver balanced, quality care.

Extended Appointment Times

In his piece "The Twins," Dr. Oliver Sacks discovers that *time* is necessary to develop a relationship in which the physician understands the *person* behind the case they are treating. Sacks recounts the failures of detached, conventionally-minded physicians when examining two twin brothers with Autism. Sacks writes that the physicians claimed that "there was 'nothing much to them'–except… for their use of an unconscious, calendrial algorithm (Sacks 2015, 95). These physicians saw nothing in the twins other than their strange mathematical skills, a misapprehension which Sacks believes results from "the stereotyped approach, the fixed format of questions, the concentration on one 'task' or another' with which the original investigators approached the twins" (Sacks 2015, 95). The rapid nature and standardization of medical assessment strips the humanity behind the twins' care, rendering them to be defined by their disability and not their individuality. Outraged, Sacks is inspired to understand the twins on a deeper level than the physician's prognostic checklist can offer. After interacting with them for hours on end, he realizes that in order for physicians to truly understand their patients, they must closely observe them through a lens that goes further than a mere patient, but rather a human being. He asserts that for the twins to be properly understood, one must "observe them… as they live and think and interact quietly" (Sacks 2015, 95). This mentality of not only determining the ails of a patient but also the characteristics (personality, habits, etc)

overthrows a key concept medical students are taught: time is of the essence. Identifying and analyzing the "full patient"- and not solely their sickness- takes time, a great deal of time. Sacks goes on to notice that "all the numbers, the six-figure numbers, which the twins had exchanged were primes– i.e. numbers that could be evenly divided by no other whole number than itself or one" (Sacks 2015, 99). A potential reason why the twins find eternal joy in prime numbers is because these numbers cannot be divided, cannot be separated, by anyone else but themselves. After living lives of ostracization, the twins find value in an idea that cannot be separated and split into fragmented pieces unlike they were, being that they were considered different from the mass majority of neurotypical individuals. It is because he invests the time, far greater than a few minutes, to become acquainted with his patients that he is able to understand this and better assess the twins' condition.

However, as Ofri mentions in her work, the average medical appointment lasts fifteen minutes (Ofri 2017, 52). While Sacks' recognition of the importance of more time to observe the patient has its benefits, being able to interact with a patient for multiple hours is oftentimes infeasible. Perhaps establishing a sense of similarity can foster a balanced patient-physician relationship in the limited amount of time provided for an appointment. In this way, both the physician and the patient can understand each other, not to the extent Sacks was able to but to a smaller, yet still critical, degree.

Establishing Common Ground

Dr. Damon Tweedy offers insight into this thought in his work *Black Man in a White Coat*. Tweedy recounts meeting Keith, a Caucasian patient whose "main passions were guns, motorcycles, pickup trucks, and race cars, which suggested that [they] had no common ground" (Tweedy 2016, 240). He describes the stark contrasts in their clothing and the short, staccato responses Keith provides to him. The lack of common ground (race, passions, clothing, etc) establishes a sense of separation between the two. However, Tweedy has resolve and when Keith states "that his girlfriend told him he sometimes still trashed about in his sleep, [Tweedy] used that as an opening to ask more about her" and understand Keith's life (Tweedy 2016, 242). In learning about his girlfriend and their similar interests in billiards, Tweedy is able to build a longitudinal relationship with Keith that encourages Keith to return for more visits. Tweedy's care indicates how crucial communication and similarity is in fostering patient trust and comfortability. By establishing common ground with Keith in mere minutes, Tweedy is able to form a bond that surmounts the tension that their differences had initially created. As Tweedy writes, "the five minutes we spent on pool had nothing to do with Zoloft or anything else ostensibly medical, yet it was important. It helped me see him as more of a person than a stereotype; maybe it did the same for him too" (Tweedy 2016, 243).

However, Tweedy's encounters with another patient named Robert suggest that similarity may not be enough to foster a positive connection between a doctor and his/her patients. During his appointment Robert, of African American ethnicity, claimed that he did not want to be treated by Dr. Tweedy because, in Robert's eyes, black physicians are incompetent (Tweedy 2016, 123). Having the same race as his physician did not instill a sense of comfort or familiarity for him; instead, it only put strain on their relationship due to the illegitimate preconceived notions Robert had about African American physicians. Yet, why do studies show that race-concordant care (i.e. African American physician and African American patient) leads to greater satisfaction amongst patients? Researchers Thomas Laviest and Amani Nuru-Jeter argue that it may be because patients feel greater trust with a physician who identifies as the same race as them (Laviest and Nuru-Jeter 2003, 246). Dr. Daniel Ofri, corroborates this idea, claiming, "This may be from the comfort of familiarity. Perhaps patients– and doctors– are more relaxed in a

situation, leading to a more easy going conversation" (Ofri 2017, 182). So, what makes Robert different? Frankly, Robert, just like any other human being, is shaped by his environment. While his prejudiced opinions should not be condoned, he is a prime example of how every patient is unique. Perhaps superficial similarity does not provide a concrete way to develop a balanced patient-physician relationship if *each patient handles similarity differently*. Maybe the similarity must be rooted deeper and a physician must have the same condition as their patient for the physician to truly understand the patient and for the patient to find true comfort with his/her physician. The experiences of Dr. Paul Kalanithi shed a potent light on this seemingly radical idea.

True Similarity and Empathetic Care

For Kalanithi, it was the journey of becoming a patient himself which completed the outlook he needed to be able to deliver balanced, personalized care. Cancer redefined Kalanithi's emphasis on empirical data in patient care as he claims, "it occurred to me that my relationship with statistics changed as soon as I became one" (Kalanithi 2016, 134). He then shifts gears and realizes that even by studying the humanities– what he believed would make data and science come to life– during his education, he was still missing a piece to the delivery of quality care. After questioning the future of his life post-recovery, he notes:

> "I had learned something, something not found in Hippocrates, Maimonides, or Osler: the physician's duty is not to stave off death or return patients to their old lives, but to take into our arms a patient and family whose lives have disintegrated and work until they can stand back up and face, and make sense of, their own existence" (Kalanithi 2016, 166).

Living the "patient experience" made him realize that a physician's role is not to merely support the patient by treating the disease but also support the patient in their illness- the *experience* of their disease. Becoming a patient allows him to gain even deeper empathy for those he has treated because "as a doctor, you have a sense of what it's like to be sick, but until you've gone through it yourself, you don't really know" (Kalanithi 2016, 140). He even reflects, "when you get an IV placed, for example, you can actually taste the salt when they start infusing it. They tell me that this happens to everybody, but even after eleven years in medicine, I had never known" (Kalanithi 2016, 140). While it is extreme to conclude that every physician must endure the same life-changing disease their patients experience, empathy for patients through patient interaction is a way physicians can revitalize the way they see their patients and provide personalized care for them.

What exactly is the purpose of providing empathetic care? Most obviously, patients leave the office feeling satisfied, heard, and understood. Additionally, as Ofri details, empathetic care on behalf of the physician can actually improve patient health outcomes. One study which split doctors into 2 groups– one group that delivered usual care and one that delivered empathetic care (in which the physicians verbally acknowledged the patients' troubles and were optimistic about a positive outcome)– found that patients taken care of by empathetic doctors faced a 17% decrease in the severity of their colds. Additionally, their colds dissipated a day earlier than for patients who were treated by physicians who did not actively empathize with patients (Ofri 2017, 87). Thus, by providing empathetic care, physicians can deliver personalized and quite literally better and more effective care for their patients. However, it may not be as simple as it seems.

According to Ofri, there exists a significant qualification. In her novel, Ofri discusses how an overbearing amount of empathy can actually fracture the relationship between the doctor and the patient. By no means, however, is a doctor's desire to connect with a patient ill-intentioned or outright wrong. In doing so, doctors try to show that they, too, are human, real people who have gone through the same, or similar, painful or troubling experience. As Ofri claims,

> "The attempt to empathize is genuine: 'My father had lung cancer. I know how difficult it can be' or 'I also had knee surgery; I know how hard the recovery is.' But patients sometimes interpret these as disruptive, as the focus is shifted off them onto the doctors. In primary-care visits these self-disclosures are associated with lower patient satisfaction" (Ofri 2017, 84-85).

These surprising findings demonstrate the need for balance in the way physicians empathize with their patients. Given the fact that a physician may dominate the conversation for up to 70-80% of the appointment, given an already short appointment time, the patient may indeed feel that they are no longer the focus of the appointment or as though the physician's personal experience is minimizing the urgency or pain of his/her condition. Ofri goes on to note that "patients of doctors who disclosed personal details gave lower ratings of both friendliness and reassurance" (Ofri 2017, 85). In an attempt to be more supportive, by "over-empathizing," they were perceived as being *less* supportive; it had the exact opposite effect as what was intended!

The Nuances of Empathetic Care

This notion of over-empathization impeding the development of a balanced patient-physician relationship is one that strongly conflicts with my own experiences as a patient. A few years ago, I tore a tendon in my wrist, bringing about agonizing pain. I was left unable to perform simple tasks such as rotating my wrist or even carrying a heavy load of laundry up the stairs. I felt alone in my condition until my first appointment with an orthopedic physician who told me that the injury would be a lifetime one yet he shared the same tendon tear as me. Like Kalanithi, he *knew* his patient's pain, and this shared injury provided me reassurance that if an orthopedic surgeon, who used his wrists every day, could live with the injury, I would be able to as well. While in the studies Ofri cites, over-empathizing may have fractured the patient-physician relationship, it only catalyzed my relationship with my physician, and I left the office feeling a sense of community. All of this is to say that each situation, each patient, is different. There is no such thing as the universal patient, affected by the same disease or extension of similarity the exact same way another person is. As human beings, the extension of empathy is natural, but as providers of care, physicians must do so "reflexively and ask themselves if these particular details will offer assistance or if they will instead detract from the singularity of the patient's experience" (Ofri 2017, 85).

Thus, there is great nuance within the delivery of empathetic care. On behalf of the physician, there is a need for balance between self-preservation and professionalism. An unnecessary disclosure of personal details and experiences by the physician can harm both the physician and the patient. Dr. Ofri recounts an interaction with a patient who questioned why Ofri did not replace the photos of her children with new ones. When Ofri showed the patient a recent photo of her family, Ofri claimed that the patient became subdued due to her lack of the happy family Ofri had (Ofri 2017, 84). Leaving the office, the

patient might have felt even more hopeless because she was reminded of two– not one– harsh realities: her illness and her lack of a support system.

Negative Externalities

While empathy is crucial for the formation of trust, over-identifying with patients has negative externalities associated with it. Over-identifying with patients can blur professional boundaries, causing physicians to be too emotionally invested in all of their patients. While emotion is undoubtedly necessary in healthcare, too much emotion can lead to physician burnout and a failure to deliver objective care. Dr. Ian Williams, co-author of *Graphic Medicine Manifesto*, reflects on a comic he drew of himself on a long on-call shift at the hospital:

(Williams 2021, 127)

As physicians, the conditions of long hours, low sleep, and death have a heavy emotional toll on their own. Over-identifying with patients can make physicians feel even more attached to their patients, and when minor or major complications arise in a patients' illness, physicians' mental energy may be spent on grief as opposed to providing clear-minded care for the same patient or other patients.

Conclusion and Future Directives

So, where does all of this leave us? The factor of time that Sacks discovered to build a balanced relationship was overthrown by Ofri's short appointment time statistic. The notion of connection via similarity, while it worked for one of Tweedy's patients, was overthrown by another, encouraging me to believe that perhaps a doctor needed to have the exact condition their patient had (in the case of Kalanithi) in order to truly understand them. Finally, Ofri's experiences, along with those of Williams, extended upon Kalanithi's focus on empathy but helped qualify the argument with the nuances of the degree to which empathetic care can be delivered. Thus, there is no straightforward, step by step way, to achieve a balanced patient-physician relationship… and that is perfectly fine. As previously mentioned, each patient, and each physician is different and therefore, they will react to each other differently than the next patient that a physician sees. Like a game of chess, "'each person is responding to each other's moves'" (Ofri 2017,

90). This applies, yes, to the patient-physician relationship, but it also applies to the process of learning and the basis of both science and the humanities as a whole. Learning from each other and building off of pre-existing knowledge is how future physicians can find the strategies they can employ in their practice of medicine to deliver care in the best way possible. While the perspectives of each author contradicted and qualified one another, they led to a final consensus: through communication and restrained empathy, physicians can learn to understand their patients in a manner that is personable and efficient in a rigid hospital or clinic schedule. While discontent is bound to arise, hopefully these discoveries can pave the way for the next generation of healthcare providers who can satisfy a greater portion of their patients through balanced medical care, and in turn, satisfy themselves.

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