REVIEW

Doctor–patient relations in dermatology: obligations and rights for a mutual satisfaction

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Abstract

The author examines different aspects of patient–doctor relationship in dermatological consultations. At first, a definition of patients satisfaction is given, based on available literature. It has been shown that satisfaction depends on diagnosis, but also on the doctor's ability to provide explanations on the probable cause of the illness, information on how long the symptom will probably last, and if she/he demonstrates empathy. Satisfaction also increases if the illness is serious, but decreases if quality of life linked to the symptom is underestimated by the doctor. After providing a philosophical definition of ethics, which emphasizes the importance of mutual satisfaction of patient and doctor, the concepts of empathy and compassion in patient-doctor relations are defined. Their importance in consultations is underlined, reporting, for example, that doctors with good communication skills experience fewer difficult consultations (8% vs. 23%). Afterwards, the dermatological consultation is analysed in its practical aspects, trying to define a good-quality consultation. First of all, the pitfalls that can affect good time management are analysed, suggesting to structure the consultation using the Soap method. Particular situations are analysed, such as announcing bad news and dealing with borderline patients. Finally, the concept of transference is defined, remembering that doctor–patient relationships can replay some difficult relationship coming from the past, and thus doctors need to be aware of this possibility and learn how to manage it.
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Conflicts of interest

None declared.

Introduction

The relationship between patient and provider is a relevant issue in clinical practice. In dermatology, it is particularly important since psychological problems are often associated to skin conditions, and thus they are relevant aspects of a comprehensive clinical assessment of the disease. However, research data suggest that the detection of psychiatric disorders by dermatologists is not completely satisfactory,[1,2] and also that quality of life aspects are differently evaluated by patients and dermatologists.[3] Discrepancies between patients' and dermatologists' opinions about severity and impact of disease may have important consequences, as it has been shown that they are associated with patients' lower satisfaction with care.[4]

At the basis of the reciprocal satisfaction of patients and dermatologists, there is a good-quality communication. To achieve a good communication between patients and dermatologists, a good-quality clinical consultation is necessary.

In this review, we aimed to define what a good dermatological consultation is, analysing it both from a theoretical and a practical point of view. The theoretical aspects include the concepts of ethics, empathy, and compassion, as important skills of a physician. From a practical point of view, we investigated the characteristics of a dermatological consultation, in terms of duration and structure. In fact, in daily practice, doctors' abilities have to deal with practical constraints, such as time limits, and at the same time to take into account patients' expectations, rights and tasks.

Patient satisfaction

Patient satisfaction and dissatisfaction are often used as an indicator of the quality of a medical consultation. However, satisfaction is an ambiguous outcome variable since patients tend to give positive answers, despite of the anonymous questionnaires. Anyway, studies may be useful to understand which aspects contribute to the overall satisfaction for care of patients, beyond

healing. A U.S. study of 500 difficult patients in general medicine[5] revealed that one patient out of two 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 were other variables that predicted immediate satisfaction following a consultation, such as receiving information about the probable cause of the illness and the duration of the symptoms. Between 2 weeks and 3 months afterwards, satisfaction increased if the symptom regressed, but decreased if additional consultations were needed for the same symptom.

An Italian study[4] carried out on dermatology patients showed that patient dissatisfaction and psychiatric morbidity were significantly and independently correlated with the patient's refusal to stick to the treatment. The study stressed the importance of the dermatologist's personal abilities and on the proper handling of psychiatric pathologies during dermatology consultations. It is thus of utmost importance that dermatologists can deal with psychiatric patients coming to them with problems like delusion of parasitosis, dysmorphic syndromes or self-mutilation. Those conditions are often associated to events of major psychological suffering (death of a child, abandonment, abuse, etc.), and it is important for a dermatologist to be aware of this suffering when treating such patients.

Taking patient expectations into account

In general, we can say that a powerful predictor of satisfaction is meeting patient expectations.

In 1994, Sanchez-Menegay[6] conducted a study to determine whether physicians took their patients' expectations into account. The most important patient expectations were 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 tended to fill out more prescriptions than patients expected, and they almost never talked 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[7] 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%) did not match the extent to which the doctor prescribed (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% received such medication, especially for minor diseases. What effect did this have? This study indicates that 98% of the patients were satisfied, regardless of their doctor's excessive prescription tendency.

When patients are dissatisfied, however, the effect is much more negative. In another study[8] of 750 patients it has been 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 had underlying mental problems. Patients whose expectations were met felt less anxious (54% vs. 27%) and more satisfied (59% vs. 19%). Patients who received information about their diagnosis and prognosis generally experienced improvements in their symptoms after 2 weeks.

What about patient satisfaction with their dermatologists? A study published in the British Journal of Dermatology[9] reported a 60% satisfaction level. Satisfaction depended either on the doctor's ability to provide explanations, show empathy or on the patient's age, the older being more satisfied. 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 lower when the quality of life was impaired more than evaluated by the dermatologist.

Doctor's and patient's views regarding the severity of the illness may diverge particularly in dysmorphic syndromes, which are experienced by 12% of dermatologic patients.[10] If we include subclinical cases in plastic surgery, the percentage rises to 18%.[11] This 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.[12] Not only will patient satisfaction be higher, chances are that adherence to treatment will be higher.[13]

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.[14] Comparing 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.[15] 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.

An ethical medical consultation

Comte-Sponville's philosophical dictionary[16] states that 'although ethics and morality are often synonymous notions, ethics sounds

better'. Ethics comes 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.

We could say that an act is ethic if it is good for others but also good for oneself. If doctors forget the second part of this proposition in their medical consultations, then they are headed straight for burn out (exhaustion syndrome). Recent surveys showed just how serious this risk is for doctors. This is why the word 'rights' in doctor–patient relations was included in the title of this article.

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

Empathy and compassion

The medicine of guidelines and techniques has lost sight of the importance of an art of healing that cannot always be measured and identified.[17] Treatment alone may not be enough to heal. A dose of empathy or even compassion is necessary in patient–doctor relationship.

The Dictionary of Human Sciences[18] defines empathy as 'intuitively sensing the feelings of others, emotionally participating in the subjective states of others.' Comte-Sponville wrote about 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 physicians can feel whenever a patient shares her/his suffering and feelings with them. With compassion, there is a deep communication between two human beings at the level of their very humanity, a real involvement by the physician. Of course, this feeling does not arise with all patients. However, when a physician does feel it, her/his patients can get better in a surprising way.

Nowadays, it has been discovered that empathy is linked to the activity of specific neurones called mirror neurones in some area of the brain, the prefrontal cortex and the insula.[19] Those neurones are developing during infancy and childhood and are lacking when there is relational problems like autism. There is a gender difference in recruiting those neurones, women seeming using this process more than males.[20]

Mirror neurones are used to discover the emotions beyond some non verbal manifestations and face expression.

It is not enough to simply discover these emotions. Physicians could help the patient to express their feelings by phrases like: It seems that you are very worried? What will give the opportunity for the patient to express his/her fear emotion. Physicians also need to express empathy, saying sentences like: 'I understand you're suffering', 'I can imagine what you are going through', 'I can see things from your perspective', 'this must be difficult for you.'. This gives the patient the feeling to be really understood.

If physicians listen to people asking them for help, they can guess or discover what is really bothering them. If they allow themselves to identify with patients' feelings, few patients will end up being 'difficult'. They will go out of the clinical consultation with a general feeling of satisfaction because they will feel that the physician has not only listened to them but also have understood them.

The dermatological consultation

How can dermatologists transfer all the above mentioned theoretical concepts into a clinical consultation? We are now examining different aspects.

1. 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[21] covering 19 192 consultations with 686 general practitioners revealed that the average duration of consultations was 16 min. It lasted longer for patients with psychosocial problems or with 4 or more diagnostics (71% increase), in day surgery (+34%), or for patient for whom hospitalization 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[22] of 1486 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 min or less with their doctor in 69% of 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 in a hurry 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. In another recent study, patients with psychosomatic or psychosocial problems where recognized to take more of the doctor's time, even they did not expect it.[23]

The average patient visiting a doctor in the United States gets 22 s for his initial statement, and then the doctor takes the lead.[24] If they simply allowed their patients to say whatever they have to say, the mean spontaneous talking time would be 92 s.[21] The point is, allowing the patient to talk without interruption will not be what uses up most of the consultation time.

What can get doctors side-tracked and behind schedule, causing patients to get upset and doctors to feel stressed? Leaving difficult patients aside for a moment, it seems that physicians can improve both their comfort and patient satisfaction if they follow a few rules.

a. Structure consultations It is important not to spend most of the time talking about trivial matters, leaving important information at the end of the visit. In some cases, the little last-minute item turns out to be very important, when the doctor was thinking that the consultation was over.

Twenty years ago, Dr Lawrence Weed developed a system of problem orientated medical record.[25] This is now worthwhile known with the acronym Soap[26] and helps physicians to structure the consultation.

S: Subjective symptoms, problems that patients bring with them. Some patients tell the doctors right away that there are other problems, otherwise the doctor should ask the patient a simple question: 'Is there anything else that you'd like to show me?'. The same question may be repeated again and again because there could be four or five more things to look at! Once all information is out, the doctor can rank the problems in order of importance. She/he can then tell the patient that there is only enough time to deal with the first two problems, and that a second consultation will be needed for the remaining problems. There is nothing wrong with scheduling their 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 the doctor is straightforward and nice about it.

O: Objective symptoms: This is when the doctor examines the specific lesions. Although there are times when she/he is able to see and diagnose the lesion as soon as the patient walks through the door, patients need to feel that their doctor has examined them. Moreover, by forcing themselves to examine each and every patient carefully, physicians may even find themselves correcting mistakes made in their initial diagnosis.

A: Assessment: Based on what doctors find in their clinical examination, and on what patients tell them, they make a diagnosis. Thinking aloud will help physicians to explain their diagnosis to patients. If they are uncertain or have no idea what that diagnosis could be, there is nothing wrong with telling the patients so. Will this have an impact on their satisfaction? Gordon's[27] study focused on physician expressions of uncertainty during patient encounters. 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: Plan, prognosis and prescription: This is when doctors explain to patients what tests need to be done to confirm their diagnosis, determine a prognosis (which is very important for them) and issue prescriptions (which are often excessive, as we saw before). This moment is an opportunity to find out what the patients would like to do and to be more in sync with their expectations.

b. The hand-on-the-door syndrome Patients sometimes tell the doctor the most important details at the very end of the consultation, right as they are reaching for the door. This can happen even when the consultation was properly structured. What can a doctor do in this case? On one hand, she/he realizes that it is very important, but can already feel the next patient's pressure level rising in the waiting room outside. After listening to the patient without interruption, the best thing is to simply tell her/him how important the matter is and schedule another appointment to handle it. Some patients are accustomed to this procedure.

It is very important to structure the consultation, especially in the case of particular patients, such as borderline types.

c. The never-ending patient The doctor opens the lines of communications and this kind of patient just keeps going on and on, saying the same things over and over again or asking the doctor to constantly repeat what she/he has already said. When the physician feels that the end of the consultation has been reached, but the patient does not show any signs of wanting to budge, some non-verbal means have to be used: standing up, walking towards the door and opening it. In some cases, the doctor can even refuse to reply or simply state that she/he does not

have any more time and that the patient 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 to deal with this, depending on available time or tolerance. The doctor can assess the problem and limit to giving just an opinion (even charging them for the advice). She/he 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. She/he can kindly explain that there is not enough time and then schedule another appointment. In such cases, it is necessary to insist on how important it is for patients to stick the schedule. If the doctor is late, she/he has to explain that she/he does not want to be even later. If doctors give in to their whims, they run the risk of being contacted again on other occasions. By being gentle but firm, they can generally wiggle their 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 have underlying problems, sometimes psychiatric (depression, paranoia, hypochondria, personality disorder). In such cases, the doctor needs to be even kinder and firmer. Otherwise, she/he may end up worsening the situation. At the very least, the doctor will never see the patient again but, in the worst-case scenario, they might even attack her/him. In most of the cases, if the doctor opens the dialogue, stays calm, empathises with the patient, she/he will feel understood and will accept the doctor's decision.

2. Difficult patients

Patients identified by dermatologists as difficult patients seem to be effectively the ones with psychiatric pathologies. A study[1] published in the *British Journal of Dermatology* shows a 25% prevalence of psychiatric morbidity. In other words, one out of every four of the patients who walk into the dermatologist's office will be difficult patient. Thirty per cent of the patients suffering from acne, pruritis, alopecia, herpes and dermatological non diseases have psychiatric disorders. In another study of 500 internal medicine patients,[28] 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 relation skills had more difficult consultations (23% vs. 8%).

3. Announcing bad news

There are several difficult situations dermatologists have to deal with, such as breaking the news to patients that they have a melanoma, are human immunodefiency virus (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, that is what doctors are for), doctors often cut loose, leaving patients and their families feeling very alone indeed. But what else can they do? Well, for one thing, they can prepare their patients for the bad news.[29] 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 cannot give this kind of news over the phone. A later consultation can be scheduled so that the laboratories can get back to the doctor with confirmation of the test results. Anticipating difficult diagnoses allows 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. The physician has to take her/his time, to chat with the patient or his/her family if they meet for the first time. The news has to be broken gently, giving the patient only as much as the doctor thinks they are able to bear, leaving communication lines open to the expression of unpleasant emotions, leaving room for hope, even if only slight, without misleading patients or their families. This is summarized in a mnemonic ABCDE: Advance preparation (clinical data, adequate time, adequate room, emotional preparation), Building a therapeutic relationship, Communicating (verify patient's understanding, place yourself at the patient's place), Dealing with the patients emotional reactions, Encouraging in offering realistic hope and support and do not forget to take care of your own needs.

How about patient needs after the diagnosis has been given? A study was carried out on psychotherapeutic interventions in melanoma.[30] 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 would not experience burnout or find themselves avoiding terminal patients. Ethics, which also takes into account doctors' needs, requires some sort of support structure enabling them to share difficult emotions, even if it is simply talking to a colleague about a case. If they are specifically assigned to melanoma patients, a multidisciplinary group would also give them the necessary support they require. It is in their own best interests as well as in the patient's not to try to go it alone.

4. Transference and counter-transference

An article published in the *Archives of Dermatology*[31] 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 doctors to better deal with their patients whenever they become aggressive, trying to understand that the patient is not reacting violently to them but rather to someone behind them, perhaps his/her mother or father in many cases.

At the same time, doctors should ask themselves why they feel irritated by a patient, by her/his attitude or even her/his physique. Who does this patient remind them of? What part of their past are they 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 doctors into a love affair if they are themselves in need. While there is nothing illegal about this, giving in to their 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 doctors spend too much time listening to a patient's problems or if they are unsatisfied with their 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. Some patients with highly psychosomatic pathologies were abused as children.[32] 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. Michael Balint, a well-known psychiatrist, developed a method where groups of physicians are helped at analysing this aspect of patient transference in all sorts of doctor–patient relationship scenarios.[33]

Conclusions

Physician and patient satisfaction are inexorably linked in a beautiful cycle. When doctors fulfil their patients' expectations, they are much likely to improve – even the difficult ones. Patients who improve under their care increase their satisfaction level. Satisfied physicians are much less likely to perceive their patients as difficult, and patients of satisfied physicians are more likely to be happy with the care they received.

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