Doctor- Patient relation

Scheduling a patience while he is having a matter of life and death is not child's play. But there are doctors who believe that their time is more important than a patient are appreciated and encourages because they are more practical and professional in their jobs. While those doctors who pay more attention to their patience than that of schedule are not encouraged as they spoil schedule and others have to wait for them beyond limits. Dealing with these two important factors, best will be diagnosed.

Dr. A is very punctual and professional. He gives proper time but less attention to his patients. Here a patient feels bad because it is his right to get full care and attention of his doctor. Until a doctor is unable to pay regard to his patient in order to diagnose problem and provide guidance to his patient. This not only satisfy a patient but also has a healing effect.

Contact between a doctor and a patient has received philosophical, sociological, and literary attention since Hippocrates and is a matter of great concern. A robust science of the doctor–patient encounter and relationship can guide decision making in health care plans. An average doctor is often unfamiliar in this area. It is pertinent to describe problems that exist and are said to exist, we promulgate principles for safeguarding what is good and improving that which requires remediation.

The medical interview is the major medium of health care of a patient. Most of the medical encounter is spent in discussion between doctor and patient. In this process a doctor has to gather information, develop and maintain a therapeutic relationship, and communicate information. These three functions inextricably interact. For example, a patient who does not trust or like the doctor 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 information elicited and understood. It is the major influence on doctor and patient satisfaction and thereby contributes to practice maintenance and prevention of practitioner burnout and turnover, and is the major determinant of compliance. Increasing data suggest that patients activated in the medical encounter to ask questions and to participate in their care do better biologically, in quality of life, and have higher satisfaction and perfection.

The competition to enroll patients is often characterized by a combination of exaggerated promises and efforts to deliver less and inefficiently. Patients may arrive at the doctor's office

expecting all their needs to be met in the way they themselves define. They discover instead that the employer's negotiator defines their needs and the managed care company has communicated them in very fine or incomprehensible print. Primary care doctors thus become the bearers of the bad news, and are seen as closing gates to the patient's needs. When this happens, an immediate and enduring barrier to a trust-based patient-doctor relationship is created.

Doctors should manage to promote patient privacy and confidentiality. The expectation of privacy is one of the most important aspects of the doctor–patient relationship and influences the disposition to trust, but confidentiality is no longer solely in the doctor's control. Organizational personnel have access to patient information and must be required to keep it private. They should taught how to keep it private, and monitored to be sure they do.

Time is another prerequisite for trust and requirements. Organization should determine a reasonable minimum average time for doctor visits so that they should pay attention when doctors or patients complain they do not have enough time together. Because the time of visit varies by type of visit, type of doctor, and complexity of the patient, patient complaints about visit time may be a useful patient-centered indicator of potential trouble in doctor–patient relationships.

Doctors can encourage consideration of psychosocial issues in all forms of patient care. An organization can use continuing education, promotional materials, patient-directed education, and quality improvement efforts to promote this aspect of patient care. In doing so, discussions about these areas between doctors and patients will be enabled, patient satisfaction will increase, and unnecessary visits, such as to the emergency department for panic attacks, may even go down. Organizational changes may be a more efficient way to promote caring than changing either medical education or the process by which medical students are selected. After all affection is always greater than perfection.

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