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VIEWPOINT OF SPECIALIST DOCTORS IN SPENDING TIME WITH THE PATIENTS FOR TREATMENT

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Abstract *Patients normally expect a fair treatment by the doctors. The doctors also need to be unbiased in treating the patients. Doctors strongly feel that the loyalty factor amongst the patients is declining due to more affordability, long waiting hours with the specific doctor, lack of patience in the younger generation, lack of trust, and also due to unavoidable circumstances like geographical barriers and time constraints. Doctors may have to spend different amount of time with different types of patients due to the type of the sickness, severity, and complications. Some patients may feel that doctors do not pay equal attention to all the patients. This is to say that the treatment by the doctors does not only comprise of administering the medicines but also involves satisfying the communication gap, interpersonal relationship, counselling and education regarding the disease. The communication gap that arises due to multiple factors also creates a situation of unequal exchange. There are certain intangibles such as culture and values and tangibles such as status and wealth of the patients which certainly impact doctor-patient relationship. Doctor-patient connection is one of the highest forms of human relationships. The human relationship that binds faith, trust, confidence, support, and respect becomes the core of the equal treatment to patients. The awareness of the human limitation is vital in encompassing any relationship in general and doctor-patient relationship in particular.*

Keywords: *Unequal Exchange, Communication Gap, Educational Qualification, Interpersonal Relationship*

INTRODUCTION

Patients normally expect a fair treatment by the doctors. The doctors also need to be unbiased in treating the patients. The treatment of the doctors does not comprise of just administering the medicines but also involves satisfying the communication gap, interpersonal relationship, counselling and education regarding the disease. The patients need to have trust in the ability of their doctor in order to share the essentials regarding the health which is necessary from the angle of diagnosis and treatment. Thus establishing the good rapport with the patients is all the more important for the doctors as well as the patients. The doctor-patient relationship is central to the practice of doctors be it physicians, surgeons, radiologists or dentists.This relationship is the centre of the delivery of high-quality health care, diagnosis and treatment of the disease. The patient should be able to receive the information from the doctors regarding their disease, prognosis, risk factors and the cost of the treatment without any hassle. Unfortunately due to various contextual factors there seems to be an unequal exchange between patients and the doctors, which is damaging to the health and well-being of our society. This paper gives the insights regarding giving equal treatment to patients from the perspective of the doctors.

A patient to a doctor is at once a dependent child, an eager student, a friend and a person needing advice, help, sympathy, understanding, and hope(Sharma, 2001).The doctor-patient relationship can be said to be one of the most unique and privileged relations next only to the mother-child bond. There may be differences in opinion between the doctor and patient in how formal or casual the doctor-patient relationship should be. For instance, according to a Scottish study (McKinstry, 1990),patients want to be addressed by their first name more often than is currently the case. In this study, most of the patients either liked or did not mind being called by their first names. Only minority disliked it, most of who were aged over 65. On the other hand, most patients didn't want to call the doctor by his or her first name.

Fochsen *et al.* (2006) gave an explanation to explore health care providers'experiences and perceptions of their encounters with male and female patients in a rural district in India with special reference to tuberculosis (TB) care. Findings reveal that doctors adopted an authoritarian as well as a consumerist approach in the medical encounter indicating that power imbalances in the doctor-patient relationship are negotiable and subject to change. Gender was identified as an influencing factor of the doctor's dominance. This seemed to be especially important for female patients, whose voices were not heard in the medical

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encounter. The doctor-patient relationship and the medical consultation are important resources for the health work of people living with chronic illness. West (1990) conducted a research on directive-response speech sequences to examine how physicians formulated their directives to patients and how patients responded to those directives. Author's analysis of encounters between patients and family physicians indicated that women and men physicians issued their directives in dramatically different ways, and that their alternative formulations had consequences for patients 'responses. Some directives were more likely than others to elicit compliant responses, and women physicians employed these more often than men did.

Liza McCoy, (2005) examined physician-based outpatient health care from the standpoint of women and men suffering fromHIV who live in poverty and social marginality. Using the approach of institutional ethnography, she offered a close reading of patients' descriptions of what they considered good doctoring.Areas of best practice that enhanced access to healthcare examined here included doctors' interactional styles, ways of providing treatment options and information, ways of addressing the specific needs, and life circumstances of patients living in poverty and social marginality.The introduction of information and communication technology(ICT) inthe patient-doctor relationship represents a significant change in modern health care. Moore *et al.* (2004) took a community sample of 1106 adults and examined to assess theimpact of the doctor–patient relationship on participants' avoidance of treatment for a recognized medical or psychological problem. Of five aspectsof participants' previous experience with their physicians, all but waiting time predicted participants' self-reported treatment avoidance. In two logistic regression models participants who felt their physicians listened more to their concerns were less likely to avoid treatment for both medical and psychological problems suggested that patients' perceptions of how they were treated by physicians.

Broom (2005) explained that in the context of health service delivery, de-professionalization denotes a trend towards a demystification of medical expertise and increasingly skepticism about health professionals, suggesting a decline in thepower and status of the medical profession. This process has been linked to increasing consumerism, the rise of complementary medicine and the emergence of the Internet. According to Andreassen *et al.* (2006), communication via computers, e-mediated communication was affecting the context of patient-doctor interaction, touching core elements of the relationship. Broom (2005) explored the complex effects and contradictory roles of the Internet as a source of empowerment and control, and as a site of 'risk management.' However, it was also clear that some medical specialists viewed Internet-informed patients as a challenge to their power within medical encounters and, as a result, employed disciplinary strategies that reinforced traditional patient roles and alienated patients who use the Internet. Nwosu and Cox (2000) presented the results of a study of 300 randomly selected obstetricians and gynecologists in the United Kingdom to assess their perception of the effect of Internet usage by patients on the doctor-patient relationship. Results showed that respondents accepted that the Internet might lead to patients being better informed than themselves, with 40 percent feeling that this might damage the doctor-patient relationship. Most respondents think all doctors should be Internet trained, but only a minority had training programmes in their hospitals. Kivits (2006) investigated how individuals' use of the Internet for finding health information may affect the relationship between health professionals and patients. According to policy makers, tele-medicine offers huge opportunitiesto improve the quality and accessibility of health services.This mediation was explored through Mort *et al.* (2003), ethnography of a U.K.tele-dermatology clinic. Diagnostic image transfer enabled medicine at a distance, as patients were removed from knowledge generation by concentrating their identities into images.

A high value doctor-patient relationship is based on a set of parameters which include the interpersonal relationship between the patient and the doctor. Kirshner (2003), based on the Primary Care Assessment Survey model, stated that measures of the interpersonal relationship were associated with communication, interpersonal care, contextual knowledge of the patient, and trust. Despite the proven value of the doctor-patient relationship, current trends indicate that the quality of these relationships is on the decline. The advent of communication and information technologies has greatly affected the way in which healthcare is delivered and the relationship between doctors and patients. Hart *et al.* (2003) assessed hospice patients 'attitudes regarding the discussion of spiritual issues with their physicians. They conducted in-depth interviews using open-ended questions on living with illness, spirituality and religion,and physician-patient relationships. The dominant themes identified were (1) treating the person,(2) treating with sensitivity, (3) favourable attitudes toward religious or spiritual discussions with doctors, and (4) nopreaching. Their findings suggested that patients did not expect physicians to be their primary spiritual advisors; however, physicians should be aware of and comfortable communicating with patients about religious or spiritual issues. Besides specific technical skills, successful encounters with patients require an understanding of the many ways in which patients may express themselves. This qualitative study by Hellstrom *et al.*(1998) reported on the clinical experiences of doctors when meeting patients with fibromyalgia (FM). Ten strategically chosen rheumatologists and ten general practitioners (GPs) in central Sweden were interviewed. The analyses indicated that doctors tried to comply with the wishes and demands of patients, and at the

same time avoided perceptions of personal frustration. As per Carlsen *et al*. (2008), general practitioners (GPs) who were positive toward shared decision making referred less to secondary care. Study concluded that congruence of attitudes toward shared decision making between GPs and patients influenced referral decisions, indicating that matching attitudes may enhance the effort to solve the medical problem through doctor-patient interaction. Fox *et al*. (2009) stated that work-related pressures and susceptibility to health problems mean that many general practitioners (GPs) will, at some stage, experience the role of patient. The findings highlight the relationship between empathy and empowerment and explore the role of self-disclosure of GP status by GPs in consultations. They made suggestions as to how empathy in doctor-patient relationships can be developed through consideration of power and status as well as through interaction with patients from similar backgrounds. Caccavo (2000) tried thirty audio taped and transcribed general practice consultations which were used to develop a classification scheme to code the content of doctor–patient communication in primary care. Open coding was used to identify subject matter discussed by general practitioners in consultations featuring commonly presented problems such as respiratory, psychological, and musculo skeletal complaints. Arborelius (1992) studied to describe and understand patients 'positive and negative experiences of general practitioners (GPs). Forty-six consultations were videotaped in four primary healthcare centres in Sweden. Afterwards the patients commented on the recorded consultations. The comments were categorized and analyzed using an exploratory qualitative approach. An image of the 'good' GP emerged that had two major characteristics: that of being a caring human; an individual who listens, understands, and is concerned, andat the same time, the good GP acts like anordinary person and treat the patient as an equal. The personal relationship with the GP also influenced the choice and course of medical interventions. A typical experience of a 'bad' GP was that the GP appeared unreachable as a person. An example is when the patient feels that the GP was not taking his orher symptoms seriously. Another characteristic of the bad GPis failure to communicate to the patient his or her standpoint on issues rose during consultations. Jones *et al.* (1990) selected randomly one hundred and six general practitioners and interviewed regarding their attitudes to health education in primary care. There was a high level of motivation amongst general practitioners towards health education of their patients andyet honesty about the difficulties they encountered in carrying this out.

Cocksedge and May (2005) conducted a study to understand family doctors' constructs of long-term therapeutic relationships with patients in primary care. Participants laid emphasis on personal and continuing relationships with patients who had diffuse needs connected with the experience of complex and chronic problems, and their accounts intimately connected life events with health status. Silber (1980) stated that doctors get in touch with their adolescent patients on many different levels and with varying degrees of intensity. The fact is that any interpersonal experience contains a moral element that acts as an ethical dimension to the physician-adolescent patient relationship. Shaw (2004) used information from research into the phenomenon of 'revolving-door'psychiatric patients, and explored general practitioners 'perceptions of difficult patients and the consequences for patient management. He presented the evidence of medical irritation with patients from interview data andexplored the rationalizations for the way in which patients were subsequently managed. In line with previous studies, the author argued that the construction of patients as difficult and the subsequent dynamics of exclusion lie in the breakdown of the normal doctor-patient relationship coupled with the doctor's need to get on with the day's workload. Perloff *et al.* (2006) presented an integrative perspective on the role that doctor-patient communication and cultural competency training in healthcare disparities. Communication between minority patients and physicians is characterized by doctors' biased expectations, patients' perceptions of discrimination, linguistic asymmetry, and self-fulfilling prophecy spirals. Cultural competency training, which had been put forth as a remedy, was itself a complex construct and methodological variations in cultural competency research made it difficult to reach simple conclusions about its effects. Werner and KirstiMalterud (2005), in their study, explored how doctors can help patients transform vulnerability into strength, instead of increasing a feelingof disempowerment. The authors analyzed their findings based on qualitative interviews with ten women with chronic pain, comparing the reported negative consultation experiences with the beneficial effects of good treatment experiences, in order to identify potentials for change. The blame was then put on the medical discipline instead of the individual patient who presented bodily symptoms or revealed help-seeking behavior that did not fit with biomedical expectations of what illness is and how it should be performed. The authors concluded by telling that although doctors might feel helpless or puzzled in the consultation, they must take the responsibility for turning the consultation into a space for empowerment of the patient.

Benedetti (2002) stated clinicians have long known that context was important in any medical treatment and that the words and attitudes of doctors and nurses could have great impact on the patient. There was experimental evidence indicating that the medical context influenced specific neural systems. Because the placebo effect was a context effect, its study had been useful in clarifying that complex issue.

Moreover, a placebo treatment was capable of affecting many brain regions in depressed patients. Author stated the factors that lead to a neurobiological under-standing of the events occurring in the brain during the interaction between the therapist and his or her patient.

Gao *et al.* (2009) expressed that the racial and ethnic disparities existed in both incidence and stagedetection of colorectal cancer (CRC). Authors found that interpersonal relationship themes such as power distance, trust, directness/ indirectness, and an ability to listen, as well as personal health beliefs,led to patient effective communication. Pandya (1995) stated that that it is unethical for a doctor to take over a patient already under the care of another doctor without a note of referral. Dissolution of the doctor- patient relationship also brings in its wake a major legal handicap. Since the patient is consulting more than one expert, each of whom is in ignorance of what the other is doing, no one will accept responsibility in the event of a mishap.Sharma (2001) describes the doctor's role as well as the patient's role meticulously. The doctor needs to pay full attention towards patient's symptoms, his story and above all his anguish and sufferings. Listening to the patient is very important even if the diagnosis is written on his face. This is one of the failings which a doctor should avoid as this would leave the patient dissatisfied. After his clinical examination and required investigations, the doctor should spend time in analyzing his problems and come to a tentative of definite diagnosis depending upon the situation.

The above research studies enrich us with lot of knowledge and practicalities with respect to doctors treating patients under various circumstances.

STATEMENT OF THE PROBLEM

Irrespective of the specialization and the educational qualification, establishing the good rapport with the patients is all the more important for doctors as well as the patients. Unfortunately due to various contextual factors there seems to be unequal exchange happening between the doctors and the patients. With the intention of filling this research gap, this micro study was taken up with the following objectives.

OBJECTIVES

The micro study, *Viewpoint of Specialist Doctors in spending time with the patients for treatment* has the following objectives to fulfill.

1. To understand the relationship between the qualification of the specialist doctors and spending time with the patients.
2. To identify the differences between doctors of ten specialties in giving equal treatment to their patients.
3. To identify the loyalty factor of the patients with respect to their doctors and treatment.
4. To find out the number of visits to the present doctor on the feeling of strength and confidence.

METHODOLOGY AND SAMPLE DESIGN

The study is a micro study and has been confined to Mangalore region of Dakshina Kannada District of Karnataka state, India. Mangalore has five medical college hospitals in private sector. As a result there is quite a large pool of specialist doctors residing in this region. Patient population is also quite alarming as they float from whole of Karnataka, Goa and northern Kerala, to avail of improved healthcare facility. To fulfill the objectives of this study, the patients often different disciplines, viz., medicine, surgery, radiology, dermatology, ENT, gynecology, orthopedics, psychiatry, ophthalmology, and cardiology were chosen for the administering the Likert's 5-point rated structured questionnaire and also for interaction. Stratified proportional sampling technique was adopted and 20 patients from each of the above category were selected from a tertiary teaching hospital leading to the sample size of 202. The survey was conducted for a period of three weeks. The tertiary teaching hospital on an average receives about 2000patients in three weeks' time (as per the data provided by the hospital administration office).Thus the sample size comprised of 10 percent of the population. The study was confined to the patients of tertiary teaching hospital. To identify the opinion of the doctors to effectuate the doctor-patient relationship, a structured questionnaire was administered to about 50 specialist doctors in the chosen disciplines of the study, who treated the selected respondent patients from the same hospital that comprised 10 percent of the patient sample chosen for the study. Thus the sample size of the patients is 202 and the sample size of the doctors is 50. A face to face discussion was held with them to understand their stance to enhance doctor-patient relationship. The data were subjected to percentages, t-test, ANOVA and chi square test.

FINDINGS AND OBSERVATIONAL PERSPECTIVES

Doctors' Perspective on Giving Equal Treatment to Patients

Even though patients have stressed that the personal relationship matters a lot with the treating doctor, doctors do not agree to this. The medical ethics says that there is no difference between the two human beings (patients) of different cadre, religion and status even with or without

Table 1: Doctors spend enough time to educate the patients according to experience

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	3.439	1	3.439	6.099	.017
Within Groups	27.061	48	.564		
Total	30.500	49			

Table 2: Doctors spending time to educate the patients regarding his/her disease based on experience (LSDMultiple Comparisons)

		Mean Difference (I-J)			95% Confidence Interval	
(I) Experience	**(J) Experience**		**Std. Error**	**Sig.**	**Lower Bound**	**Upper Bound**
5 Years	5-10 Years	-.28889	.37787	.448	-1.0491	.4713
	10 Years and above	-.44444	.23617	.046	-.9195	.0307
5-10 Years	5 Years	.28889	.37787	.448	-.4713	1.0491
	10 Years and above	-.15556	.39235	.694	-.9449	.6337
10 Years and above	5 Years	.44444	.23617	.046	-.0307	.9195
	5-10 Years	.15556	.39235	.694	-.6337	.9449

personal relationship where relationship matters very little though. Doctors strongly feel that the loyalty factor amongst the patients is declining due to more affordability, long waiting hours with the specific doctor, lack of patience amongst the younger generation, lack of trust, and also due to unavoidable circumstances like geographical barriers and time constraints. Both doctors and patients have agreed that the patient satisfaction is an important aspect in doctor patient relationship.

Observational perspective: Patients these days have a wide choice of doctors, treatment including alternative medicines which they consider to be harmless and less side effective. The doctor-patients' ratio is increasing with more doctors coming in to the market and the corresponding patients' ratio is declining as they have more awareness about the management of common sicknesses such as common cold, fever, headache, vomiting as well as diarrhea even when the diseases are increasing. Therefore the patient delight becomes essential to stick to the same doctor in the long run. The long waiting time with the particular doctor does not always become the factor to change the doctor. If patients are delighted with the treatment and the interpersonal relationship skill of the doctor the loyalty of the patients will be the maximum irrespective of the waiting time. The bonding and the trust the patients have with the doctors cannot be erased easily that too for the trivial issue of long waiting time with the doctors.Medical field has become so competitive these days as the doctors need to strategize their practice with efficiency, effectiveness, communication skill, listening skill, cost consciousness, and curability of the disease. Therefore doctors themselves have almost disagreed that the doctors' skill cannot be the dominant factor in doctor-patient relationship.

Difference between the Doctors with the Experience Spending time with the Patients

One way ANOVA was applied to understand the difference between the doctors with different experience groups spending time with their patients. The results of ANOVA are depicted in Table 1. The results show that there is significant difference between the experience level of the doctors and the amount of time they spend with the patients ($F= 6.099 df=1$ $P=0.017<0.05$). Since the study gives the viewpoints of the specialist doctors, more significance is laid on the statistical analysis from the perspective of doctors though the patients' perspective is not neglected.

Post-Hoc test interpretation in Table 2 states that there is no significant difference between the first categories of doctors, i.e. doctors with 5years experience and the second category doctors (the doctors with 5-10 years of experience) as $P=0.448>0.05$. But there is definitely a difference between the doctors with 5years experience and doctors with more than 10 years of experience as $P=0.046<0.05$ and is significant.

Observational perspective: The doctors with 5 years of experience might take more time with the patients as they are in the formative stages of their career. There is every chance that the junior doctors have all the time to spare for the limited patients. The multiple roles that an individual plays couples with more experience and age where the doctors with 5 years of experience may not yet be exposed. The doctors with 10 or more years of experience might be specialized in several medical modalities where they must be intelligent enough to divide the time accordingly.

Impact of Number of Visits to the Present Doctor on the Feeling of Strength and Confidence

Out of 202 patients 96 patients who have made 1-5 visits to the present doctor have strongly agreed that they felt strong and confident after the treatment. However the number of people feeling strong and confident after the treatment, does not proportionately increase with the number of visits to the same doctor as the same 96 patients have made 1-5 visits to other doctors as well. Kruskal Wallis Test value depicted in Table 6 is 1.457 with 3 degrees of freedom and the P value is 0.692 which is more than the alpha (α= 0.05) and is not significant. Table 3 depicts the crosstab of feeling of strength with number of visits to the present doctor; Table 4 and Table 5 are the part of descriptive statistics. Thus, the number of visits has nothing to do with patients feeling of strength and confidence.

Observational perspective: Some people are positive by nature and it is easier to fill in confidence and strength in them. For person belonging to negative category the number of visits to any number of doctors does not raise their level of confidence. Feeling of confidence and strength by the patients to some extent is reliant on the visit to the doctor on whom they feel confident with if not visit to the same doctor.

The Relationship Between the Qualification of the Doctors and Spending time with the Patients

The doctors are grouped in to three categories based on the qualification namely; post graduates (PGs), specialists and super specialists. ANOVA test reveals in Table 7 that (F= 2.903 P=0.045<0.05) there is a significant difference between the time spent by the doctors based on whether they are PGs or specialist categories. Table 8 depicts the descriptive statistics.

Results of Post-hoc test of multiple comparisons in Table 9 state that the time spent by PGs and specialists as well as super specialists is different as the P = 0.027<0.05 and P= 0.046<0.05 for specialists and super specialists in comparison with the PGs.

Observational perspective: PGs may be spending either more time or even lesser time with the patients depending upon the type of complications as well as lack of experience in dealing with the particular complications. Since PGs are in the formative stages of their career they naturally will be spending more time with new patients to build a rapport with them. However, they may be inexperienced to deal with the complications of the disease and they may not spend more time with the patients but might refer the patients to the specialists.

Table 3: Crosstab of feeling of strength with number of visits to the present doctor

			Visits to present Doctor				
Visit to all Drs			1-5 Visits	6-10 Visits	11-15 Visits	More than 15 Visits	Total
1-5	Feel strong and confident after treatment	Strongly agree [SA]	64				64
		Agree [A]	32				32
		Neutral [N]	4				4
	Total		100				100
6-10	Feel strong and confident after treatment	Strongly agree [SA]	37	10			47
		Agree [A]	20	8			28
		Neutral [N]	3	1			4
		Disagree [DA]	1	0			1
	Total		61	19			80
11-15	Feel strong and confident after treatment	Strongly agree [SA]	1	2	4		7
		Agree [A]	1	2	0		3
	Total		2	4	4		10
More than 15	Feel strong and confident after treatment	Strongly agree [SA]	1	0	0	3	4
		Agree [A]	1	1	3	2	7
		Neutral [N]	0	0	0	1	1
	Total		2	1	3	6	12

Table 4: Descriptive Statistics

		No.of visits to present Doctor/last one year	Feel strong and confident after treatment
N	Valid	202	202
	Missing	0	0
Mean		4.4703	1.4505
Median		3.0000	1.0000
Mode		2.00	1.00
Std. Deviation		5.76415	.60678
Minimum		1.00	1.00
Maximum		60.00	4.00

Table 5: Ranks

	Feel strong and confident after treatment	N	Mean Rank
No. of visits to present Doctor/last one year	Strongly agree[SA]	122	98.62
	Agree[A]	70	104.17
	Neutral[N]	9	115.44
	Disagree[DA]	1	140.00
	Total	202	

Table 6: Test Statistics [a, b] Impact of number of visits to the present doctor on the feeling of strength and confidence

	No.of visits to present Doctor/last one year
Chi-Square	1.457
df	3
Asymp. Sig.	.692

a. Kruskal Wallis Test
b. Grouping Variable: Feel strong and confident after treatment

Table 7: ANOVA of Doctors qualification and spending time with the patients

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.452	3	.484	2.903	.045
Within Groups	7.668	46	.167		
Total	9.120	49			

Table 8: Descriptive Statistics

		Qualification	I spend enough time to educate my patient regarding his/her disease
N	Valid	50	50
	Missing	0	0
Mean		1.7600	4.3000
Median		2.0000	4.0000
Std. Deviation		.43142	.78895
Minimum		1.00	2.00
Maximum		2.00	5.00

Table 9:qualification and spending time with the patients- Multiple Comparisons LSD

(I) Qualification	(J) Qualification	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
PG	Specialist	-.58602*	.25735	.027	-1.1037	-.0683
	Superspecialist	-.73810*	.36000	.046	-1.4623	-.0139
Specialist	PG	.58602*	.25735	.027	.0683	1.1037
	Superspecialist	-.15207	.31676	.633	-.7893	.4852
Superspecialist	PG	.73810*	.36000	.046	.0139	1.4623
	Specialist	.15207	.31676	.633	-.4852	.7893
The mean difference is significant at the 0.05 level.						

Table 10: Descriptive statistics on doctors of Ten specialties giving equal treatment to all the patients irrespective of their background

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
medicine	5	4.0000	1.73205	.77460	1.8494	6.1506	1.00	5.00
surgery	5	4.6000	.54772	.24495	3.9199	5.2801	4.00	5.00
ophthalmology	5	4.6000	.54772	.24495	3.9199	5.2801	4.00	5.00
ENT	5	4.8000	.44721	.20000	4.2447	5.3553	4.00	5.00
orthopedics	5	4.2000	.83666	.37417	3.1611	5.2389	3.00	5.00
dermatology	5	4.2000	.83666	.37417	3.1611	5.2389	3.00	5.00
gynecology	5	4.6000	.54772	.24495	3.9199	5.2801	4.00	5.00
radiology	5	4.0000	.00000	.00000	4.0000	4.0000	4.00	4.00
cardiology	5	3.6000	1.51658	.67823	1.7169	5.4831	1.00	5.00
psychiatry	5	4.6000	.89443	.40000	3.4894	5.7106	3.00	5.00
Total	50	4.3200	.91339	.12917	4.0604	4.5796	1.00	5.00

Table 11: ANOVA of doctors of Ten specialties giving equal treatment to all the patients irrespective of their background

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	6.480	9	.720	.837	.587
Within Groups	34.400	40	.860		
Total	40.880	49			

Differences Between Doctors of ten Specialties in Giving Equal Treatment yo Their Patients

ANOVA test was used to find out if there is any difference between the doctors of ten different specialties viz., medicine, surgery, ophthalmology, ENT, orthopedics, dermatology, gynecology, radiology, cardiology, and psychiatry. The results are depicted in Table 11, preceded by the descriptive statistics in Table 10. F= .837, P = 0.587>0.05 which shows that there is no significant difference between the specialists giving equal treatment to the patients.

Observational perspective: Doctors may have to spend different amounts of time with different types of patients due to the type of the sickness and severity and complications in it. It may be the feeling of some patients that doctors are not paying equal attention to the patients irrespective of their background as the mean value of patients responding to doctors giving equal treatment to the patients is less than the mean value of the doctors responding to the same (4.242<4.320).

Evident Findings Regarding the Responses of the Doctors in Brief

For most of the questions to doctors ideally the response should have been 'Agree' except in few cases. Hence 'Neutral' is considered as 'Disagree' and the frequencies are calculated. Around 36 percent of the doctors disagree to 'they feel comfortable with the patients belonging to the same gender'. With respect to, 'Personal relationship with patient counts a lot in giving treatment' is concerned, 70 percent of the doctors agree to the same point. Around 52 percent of the doctors have agreed that the influence of power and status can very much manipulate doctor patient relationship. 36 percent of the doctors have disagreed that their patients have confidence and trust in them. 44 percent of the doctors have disagreed that the long waiting time is the reason for changing the doctors by the patients and 76 percent of the doctors have expressed that frequent change of doctors by patients adversely affects doctor-patient relationship. 46 percent of the doctors have disagreed that technical brilliance of the doctors matter a lot in sustaining the doctor-patient relationship. 86 percent of the doctors have agreed that the patient satisfaction and delight becomes the core factor in maintaining the strong and perennial doctor-patient relationship.24 percent of the doctors stated that they cannot give the treatment to the patients irrespective of their affordability.46 percent of the doctors do not encourage the patients communicating with them beyond regular visits.80 percent of the doctors do not encourage the patients to learn about the disease from the Internet. 16 percent of the doctors do not like patients taking the second opinion. 34 percent of the doctors have disagreed that they instill psychological strength amongst their patients.

Observational perspective: The medical profession also has become a big business like any other profession. The doctors also will look in to the affordability and status of the patients to administer the treatment due to the several facts such as expensive nature of the treatment, perennial nature of the treatment and follow up of the medicines. Doctors have become busy to entertain the patients beyond their regular visits unless called for. Therefore, most of the time the doctor patient relationship is restricted to pure medical treatment, rather than to instilling the psychological strength in to the patients.

Unequal Exchange in giving Equal Treatment to Patients

The authors have observed certain aspects which significantly influence the doctor-patient relationship, after conducting a semi-structured interview with the patients who take treatment under different specialists randomly. The morale of the sick patients and their family members will be usually low and there will be a strong feeling of lack of confidence and helplessness in them. The state of helplessness is more prominent among the less affluent people. The state of powerlessness makes the patient feel that the doctor's treatment is not fair and equal. Patients many times feel that doctors should know the conditions, needs and demands of the patients even without direct interaction from them. Since doctors are not super natural human beings who could diagnose the disease even without proper consultation with them, the patient party feels alienated and unsupported. The communication gap that arises due to multiple factors also creates a situation of unequal exchange. There are certain intangibles such as culture and values and tangibles such as status and wealth of the patients which certainly impact doctor patient relationship. Patients always feel that they should approach the familiar doctor at least in the beginning of the commencement of the treatment than the doctor who is a specialist in treating the specific disease. Many patients move from one specialist to another for second, third and several rounds of opinion which is nothing else but indicates the lack of trust in the specialist doctors.

Recommendations with Respect to the Roles of Doctors

Following recommendations are suggested based on the observation and the findings.

1. **Active listening:** The doctor needs to pay full attention towards patient's symptoms, his story, and above all his anguish and sufferings. Listening to the patient is very important even if the diagnosis is written on his face. This is one of the failings which a doctor should avoid as this would leave the patient dissatisfied. After his clinical examination and required investigations, the doctor should spend time in analyzing his problems and come to a tentative of definite diagnosis depending upon the situation.
2. **Maintenance of patient's confidentiality and records:** Maintenance of patient's confidentiality is absolutely essential and should never be breached except in a court of law. Maintaining a good record is very good both for the doctor and the patient perhaps even more for the doctor. This often is the saving grace for a doctor under some kind of blame.
3. **Participative decision making**: Patient should be offered choice and alternative not in a superficial manner but in a very formal manner so that the patient has the feeling of participation in the decision making. This will to some extent depend upon the patient's intellectual capacity and social background.The consent taken for any procedure should not be a mere formality but should be explained to the patient fully in his own language and his own level.

4. **Timely reference**: Referring the patient to a colleague in time is most important to avoid complications. Doctor should never sit on prestige or hold on the patient longer than required.
5. **Rapport with the patients and patient's family:** Even if something has gone wrong, taking the patient into confidence would help in most of the circumstances unless there is an ulterior motive. The patient or the family needs to be informed about the nature of the disease which is not always optimistic or hopeful, but it need not be traumatic. Somebody has said, 'The truth may be brutal but the telling of it need not be'. Doctor should not be judgmental about patient's personal habits or attitudes.

Recommendations with Respect to the Roles of Patients

1. **Patient awareness:** Patient should choose his doctor or the hospital carefully and with awareness. Having done this, full trust and faith should be reposed in the doctor.
2. **Rapport with the doctors:** Building the rapport not only lies with the doctors but also with the patients. Patients should provide complete information about the illness and all the relevant social and family background. They should not hesitate to ask as much information as he wants and clarify the instructions without any hesitation. Reporting in case of any drug reaction or other adverse happening by the patient is necessary.
3. **Understanding the realities:** Patients should understand the risk involved in a procedure or operation. They should ask the doctor for any alternative or choice available. Patients should know that medical science is a biological science and lots of decisions are made on the basis of experience and personal judgment. Many things cannot be fully explained or predicted. They must carefully read the consent for any procedure, try to understand its implications and ask for clarifications, it required
4. **Multiple Doctors:** Patients must avoid shopping around with multiple doctors and alternative systems. They must also avoid believing in hearsay, rumors and not readily believe the facts printed in non-professional publications.
5. **Blame Game:**Patients should have the wisdom to differentiate between a complication or mishap and negligence and not blame the doctor for everything that goes wrong.

CONCLUSION

Doctor-patient bond is one of the highest forms human relationships. The human relationship that binds faith, trust, confidence, support, and respect, becomes the core of the equal treatment to patients. The equal treatment to patients is not only the obligation of the doctors but depends very much upon loyalty, trust and faith of the patients towards the doctors. Keeping in mind the roles and responsibilities of both doctors and the patients and trying to act upon it create a healthy and exemplary healthcare system at various levels. The patients who trust their doctors to the core create a win-win situation as they will be cooperating with the doctors in connection with the examination, diagnosis and treatment. The awareness of the human limitation is vital in encompassing any relationship in general and doctor-patient relationship in particular.

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