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PRACTITIONER-PATIENT RELATIONSHIP: AN EVALUATION OF PERCEPTIONS IN GHANA

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ABSTRACT: *The relationship between health practitioners and their clients is central to the practice of healthcare as well as essential to the delivery of quality diagnosis and treatment of diseases. It forms one of the foundations of modern-day healthcare ethics; thus, a keystone of general healthcare. As expected of medical practitioners to maintain a serene and professional rapport with clients, support clients' dignity, and respect their position in the continuous development of health care, patients, on the other hand, are also anticipated not to annihilate this relationship. In Ghana, for instance, this relationship seems not to have obtained absolute appreciation, thereby hindering its helpful effects on healthcare delivery in general. As its purpose, the paper evaluates knowledge and perceptions concerning patient-practitioner relationship in Ghana to understand the context within which this relationship operates. This research -conducted in 2 districts in the Ashanti region of Ghana -involved a sample size of 300 respondents (78 healthcare professionals from 13 health institutions and 222 clients). A systematic search with questionnaires and interviews as research tools were used in gathering data. Respondents (over 85 per cent) exhibited a higher level of knowledge as regards health professional-patient relationship. Respondents were, however, divided as to whether or not this relationship was a positive one in their respective health centres. While some respondents (mostly health personnel) believed that the relationship was cordial, others (mostly patients) taught otherwise. This research is made relevant since there is considerable curative power in proper alliance between patients and health practitioners.*

KEYWORDS: Health Care Practitioner, Patient, Relationship, Evaluation, Perceptions

INTRODUCTION

The relationship between health practitioners and patients (clientele), over the years, has been a subject of ethical concern (Ludwig, 1998). The rapport has received philosophical, sociological, and literary attention from ethicists and scientists; Gordon and Rost (1995:248) have observed that it has been the subject matter of some 8,000 articles, monographs, and books in the modern medical literature. The reason is that a robust science of the doctor-patient encounter and relationship can guide decision making in healthcare plans (Levinson and Roter, 1993). The practitioner-patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation and support are provided (Lipkin and others, 1995). To manage healthcare organizations as well as the quality of care that patients may wish for, Tessler and Mechanic (1975) posit that it is important to ensure satisfactory relationship, which essentially is a significant factor in people's decisions to join and stay with a specific health facility.

Patient-Practitioner relation has been of utmost concern to many within and outside the healthcare sector. Modern healthcare practice can only function when healthcare providers

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and patients behave as partners. The enmity between health practitioners and patients in Ghana has become a teething phenomenon, which needs to be addressed to improve on the healthcare delivery system. According to the Ghana Health Service Patients' Rights Charter, all healthcare activities must hold as paramount patients' dignity and interest. In the charter is also the fact that patients must be entitled to information, consent, privacy and confidentiality by health professionals. These can be achieved when there is an existing cordial relationship between practitioners and patients (Ghana Health Service, 2015).

On several instances have been reports of sickening relationship exhibited especially to patients by practitioners and vice-versa. There are reported cases of ill-attitudes, arrogance, maltreatments, rude and disputes amidst this association. This, according to some stakeholders, has hindered the helpful effects of such an existing relationship (Boateng, 2013). According to Edwin (2011:86), "there are no commensurate measures in place to ensure the protection of the physician-patient relationship". The question which needs to be answered here is that 'Do patients and practitioners appreciate their relationship with each other?' and 'What has been the state of this relationship in Ghana?'

Medical practice in Ghana is still largely paternalistic with very little input, if any from most patients. By its staple approach, the research investigated views held in respect of the relationship between practitioners and patients, and its implications on healthcare delivery in Ghana. In this paper, the term 'evaluation' is used to refer to the appraisal or assessment of value or worth (Manser and Thomson, 1997). It offers a way to determine whether an initiative has been worthwhile in terms of delivering what was intended and expected. However, good evaluation can also answer other important questions. On the other hand, the word 'perception' signifies the intuitive recognition of a truth and the faculty of perceiving (Oxford Pocket American Dictionary, 2002). Referring to the faculty of discernment, awareness, conception and interpretation (Manser and Thomson, 1997) it is used to specifically connote the sum of what is known, in terms of practitioner-patient relationship in Ghana.

Understanding Patient-Health Practitioner Bond

The relationship between health practitioners and patients is one of ethical value. An ethical relationship, in most theories of ethics, is a basic and trustworthy relationship that one has to another human being. It cannot necessarily be characterized in terms of any abstraction other than trust, honesty and common protection of each other. The patient is an important stakeholder in all forms of healthcare and that his/her relationship with a medical practitioner should be considered as a fiduciary one (a legal or ethical relationship of trust between two or more parties; derived from the Latin *fides* -trust, confidence, reliance, belief, faith). The 'bond of trust' between the patient and all practitioners is vital to the diagnostic and therapeutic process (Ludwig and Burke, 2014). It forms the basis for the physician-patient relationship. Most relationships exist for the mutual benefit of all parties, but a fiduciary relationship is explicitly established for the benefit of one party (Finn, 1989:33). Likewise, a patient-practitioner relationship exists for the benefit of the patient, and the functions performed by medical practitioners are solely for the benefit of the patient, despite the fact that medical practitioners are being monetarily compensated for their services (Hui, 2005).

The historical model for the health practitioner-patient relationship involved patient dependence on the practitioner's professional authority (professionalism). Believing that the patient would benefit from the physician's actions, a patient's preferences were generally

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overridden or ignored. For centuries, the concept of physician beneficence allowed this paternalistic model to thrive (Ludwig, 1998). During the second half of the twentieth century, however, the practitioner-patient relationship has evolved towards shared decision-making. This model respects the patient as an autonomous agent with a right to hold views, to make choices and to take actions based on personal values and beliefs. Patients have increasingly been entitled to weigh the benefits and risks of alternative treatments, including the alternative of no treatment, and to select the alternative that best promotes their own values. In the twenty-first century, several researches have specified this relationship by presenting moral rules and principles (justice, beneficence, non-maleficence, autonomy, confidentiality, veracity, fidelity) as fundamental traits. As major aspects of the relationship, ethical principles are essential in the association between a practitioner and his clients. As viewpoints from which the relationship can be viewed in health care practice, each principle emphasizes different points such as predicting the outcome and following one's duties to others in order to reach an ethically correct decision. As a matter of fact, health care ethical principles are the common goals that all health practitioners try to achieve in order to relate well with their clients. Beauchamp and Childress (2001) have, therefore, explored the basis, meaning, limits and stringency of these principles in the context of practitioner and patient relationships.

Since time immemorial, health workers (physicians, nurses, mid-wives, pharmacists, anaesthetists) have recognized that the health and well-being of patients depend upon a collaborative effort between them and patient. Patients share with physicians the responsibility for their own healthcare. The relationship between the two is of utmost benefit especially to patients when they bring medical problems to the attention of their physicians while providing information about their medical condition to the best of their ability, and working with physicians (health personnel) in a mutually respectful alliance. Primarily, health workers contribute to this alliance by serving as patients' advocates and by fostering these rights:

- Patient's right to obtain information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action.
- Patient's right to make decisions regarding the healthcare recommended by his or her medical personnel. Accordingly, patients may accept or refuse any recommended medical treatment.
- Patient's right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.
- The patient has the right to confidentiality.
- Patient's right to continuity of healthcare. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated and available; he/she is to give the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
- Lastly, the patient has a basic right to have available adequate health care.

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Health personnel, along with the rest of society, should continue to work toward this goal. It is to be stated, however, that the realization of these rights is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. It is expected of all health personnel to continue their traditional assumption of responsibility for the medical care of those who cannot afford essential healthcare.

Significantly, it is to be mentioned and emphasized that the relationship between a health worker and a patient's family also holds considerable healing power. This potentially exists to pursue options that can improve the quality of life and health for the entire family (Ludwig, 1998). To explain why this is always the case, it is useful to consider the sources of medical power in the light of a framework suggested by the family practitioner and ethicist, Howard Brody. In his book: *The Healer's Power*, Brody (1993) outlines three sources of medical power: Aesculapian, Charismatic and Social. Aesculapian power is "the power that a physician possesses by virtue of his/her training in the discipline and the art or craft of medicine". Charismatic power is based on "the personality characteristics of the physician independent of the disciplinary knowledge and skill that give rise to Aesculapian power". Social power is that which "arises from the social status of the physician" (McMillan and Anderson, 1997: 267). It has also been suggested that another source of power -Hierarchical power, the power inherent by one's position in a medical hierarchy (e.g. specialist versus generalist) -can be added (Gabbard and Pope, 1989). This explains the fact that the relationship between patients and their medical personnel, in addition, influences ties with and health conditions of families.

There may be many barriers to effective practitioner-patient association. A number of such problems as identified by several researchers include; practitioner superiority (Ludwig, 1998), sexual relationships between health practitioners and patients (New Zealand Medical Council, 1994) and religious beliefs and affiliation. On many instances, Patients may feel that they are wasting the physician's valuable time; omit details of their history which they deem unimportant; be embarrassed to mention things they think will place them in an unfavourable light; not understand medical terminology; or believe the physician has not really listened and, therefore, does not have the information needed to make good treatment decisions. As a remedy to challenges of this nature, many countries through various codes of ethics -set up by medical professional bodies -prohibit the above-listed concerns in order to ensure good healthcare. Although these stances initially provoke a degree of controversy the harmful effects of such challenges upon patients and practitioner relationship have become increasingly recognized and condemned by the medical community (Cullen, 1996). However, some areas of debate do still remain. One such area is whether sexual relationships with patients destroy the morality of the relationship with health practitioners.

MATERIALS AND METHODS USED

The research approach was cross sectional (thus, among health practitioners in various medical fields and their clients/non-health care personnel). The case study designed used in the research was employed purposively to allow a detailed assessment of the perceptions of residence concerning practitioner-patient relationship (which is an existing contemporary issue). The study involved the use of both qualitative and quantitative methods of research. It made use of a specific procedure of data collection which involved views and opinions of

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health practitioners in hospitals and their clients in two districts in the Ashanti region of Ghana -Kumasi and Asokore Mampong districts.

The study relied on both primary and secondary sources of data collection. It became relevant to analyse views of respondents in order to ascertain the prominence of the relationship between health practitioners and patients (clients). This is because such a relationship is perceived to enhance healing. Both the general public (of greater number as compared to the health practitioners) -who regularly patronize health facilities -and health practitioners were engaged purposively to evaluate and justify findings obtained. We performed a systematic search with a structured questionnaire and an interview guide as research tools for evaluating the relationship between these two groups of people.

The research involved a sample size of 300 respondents which included 78 health care practitioners. The method of non-probability sampling was used in selecting health practitioners who were administered with structured questions. Among the health care practitioners were; medical doctors (physicians), mid-wives, nurses, physician assistants, health assistants, pharmacists, anaesthetists and biomedical scientists from thirteen (13) health care institutions. Also, a number of 222 individuals randomly selected from the general public were administered with questionnaires based on the sample that were given to health practitioners. This section of the general public was involved as a result of the daily usage of health facilities as well as their inevitable encounter with health professionals in their quest to promote their health. Among them were; teachers (19), bankers (16), traders (39), students (27), administrators (6), accountants (5), pastors (7), drivers (28), farmers (26), national service personnel (24), sales personnel (15), private and national security personnel (9), and a tailor.

In presenting data obtained from the field, the research made use of the descriptive method of analysis (descriptive analysis). It also applied the use of the Statistical Package for Social Science (SPSS) software (SPSS-PC for windows, version 16.0) for the presentation of tables that elucidate some key findings.

EMPIRICAL DATA

Analysis of Demography of Respondents

Respondents included males and females of diverse age groups, profession, marital status, educational and religious background. Among them were 170 males and 130 females. While respondents within the age range of 30-39 had a majority of 74, those within 60 years and above had a minority of 35. It was realized that many respondents (142) had obtained tertiary education, 78 had secondary education, 47 had received post-tertiary education and 33 with basic education (up to the Junior High School). Respondents consisted of Christians (161), Muslims (114) and others (6). The research revealed that no respondent associated with the African Traditional Religion. The table below presents the distribution of respondents' demography as obtained from the field.

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Table 1: Demography of respondents

Gender	**Non-Health Personnel (222)**			**Health Personnel (78)**	**Total (300)**
Male	125			45	170
Female	97			33	130
Age group	18-29	30-39	40-49	50-59	Above 60
	64	74	66	61	35
Marital status	Single	Married	Separated	Cohabitation	
	73	151	27	49	
Education	Basic	Secondary	Tertiary	Post-Tertiary	
	33	78	142	47	
Religion	Christian	Muslim	Traditionalist	Others	No idea
	161	114	-	19	6

Source: Author' Construction (2015)

DISCUSSIONS AND FINDINGS

Familiarity with Patient-Practitioner Relationship

Out of the total number of respondents, 293 indicated their knowledge about patient-practitioner relationship. They indicated that they have an idea about this form of relationship in health care delivery. However, 7 respondents shared a different opinion. They claimed to have no idea about patient-practitioner relationship. Some understood patient-practitioner relation as the free form of communication between the patient and the health professional. Other explained it to mean an essential form of cooperation between patients/hospital clients and health care providers. They considered this relationship as the basis and foundation for healing and treating all forms of diseases.

Respondents, according to their experience, graded the level of patient-practitioner relationship in their districts. Among the 222 respondents who were non-health care providers, 71 rated their relationship with their doctor (medical practitioner) to be average, 82 said it was good, 29 said very good, 7 mentioned excellent, while 27 said it was bad. Also, 6 respondents shared no idea in respect of the rate of this relationship. On the other hand, 7 health personnel rated patient-practitioner relationship in their districts to be of average standard, 31 said good, 21 mentioned very good, 18 stated excellent, while none perceived it to be of bad standard. This gives the indication that many respondents (health care providers) in the two districts considered their relationship with their clients to be good standard.

Many respondents believed that it is ethically good for this relationship to persist in Ghanaian health care. All 78 health personnel indicated that it was ethically and socially right to ensure good patient-practitioner relationship. On the other hand, 171 respondents from the general public also indicated that it was morally essential for both health practitioners and their clients to relate well. However, 32 of them believed that this relationship was not necessarily needed for disease treatment. Meanwhile, 19 stated that they have no idea about this question.

When asked whether or not patient-practitioner relationship was important for health care development, 289 mentioned that it was important, while 5 and 6 of them stated that it was

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not important and no idea respectively. Respondents (290) believed this relationship in medical care was influenced by several factors, while 7 thought otherwise. The remaining 3 respondents did not share any idea. They mentioned some of these factors as gender, time, physician workload, language, religion, literacy level, ethnicity and financial status. Though some factors do positively affect the relationships among patients and their care givers, others adversely affect it.

Respondents believed that patient-practitioner relationship had the tendency to benefit either the patient, health professional or both. 79 respondents out of the total number of respondents stated that patients benefit most from patient-practitioner relationship. 41 respondents mentioned that physicians (health workers) benefit extensively from this relationship. In addition, 180 respondents stated that both patients and health practitioners immensely benefit from the relationship in times of treatment.

Factors Facilitating Relationship

Among factors stated by respondents to facilitate patient-practitioner relationship were informed consent, justice, physician superiority, beneficence, religious affiliation, respect for patient autonomy, shared decision-making, the principles of non-maleficence and confidentiality. A number of 55, 47 and 52 respondents mentioned that the practice of informed consent, respect for patient autonomy and confidentiality, respectively. A minority of 12 respondents stated that among all these factors religious affiliation of both patient and health practitioner less impacted patient-practitioner relationship.

Table 2: Factors that facilitate patient-practitioner relationship

Factors	No. of Respondents	Percentage
Informed consent	55	18.3
Justice	23	7.7
Physician superiority	18	6
Beneficence	19	6.3
Religious affiliation	12	4
Respect for patient autonomy	47	15.7
Shared decision-making	26	8.7
Principle of non-maleficence	21	7
Confidentiality	52	17.3
Gender	27	9
Total	**300**	**100**

Source: Author' Construction (2015)

In similar vein, among the above listed factors, many respondents mentioned physician superiority and religious affiliation as factors that adversely affect patient-practitioner relationship. They included 189 and 72 respondents for physician superiority and religious affiliation, respectively. When respondents who were non-health care practitioners (222) were asked whether or not they appreciate their relationship with health officials, diverse views were obtained. Among respondents, 127 said yes, while 95 said no. Though all health practitioners attested to having good relationship with their clients, some complained of some ill-attitude exhibited by patients.

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However, 157 respondents attested to having been disrespected by a medical practitioner as against 55 who have not been abused by a practitioner. Meanwhile, 10 respondents shared no idea on this question. On the other hand, 7 health personnel mentioned of having been severely abused or disrespected by a patient, while 69 stated that they have not been abused by patients. This according to respondents is not overlooking petty confrontations with patients in their line of work –a condition considered to arise out of patients' ill-health. Also a remaining number of 2 shared no idea.

In relation to the above, 109 respondents out of the 222 non-health care practitioners mentioned of having had a change in their use of a health facility as a result of ill attitude exhibited to them by practitioners. Though a patient may have a change in their use of a health facility, the kind of change indicated by respondents were facilitated by the attitude of practitioners. However, 113 of them stated that they have not experience such a change before.

Level of Relationship in Health care and Its Effects

In identifying the group of health workers who mostly exhibit good relationship with patients, both hospital staff and respondents from the general public were of different opinions. While some respondents (81) mentioned medical doctors, others mentioned nurses (19), midwifes (32) and physician assistants (62) among others. The table below gives a fair distribution of respondents' view as obtained from the field.

Table 3: Health personnel with good relationship

Health Personnel	Number of Respondents	Percentage
Nurses	19	6.3
Midwifes	32	10.7
Medical Doctors	81	27
Pharmacists	77	25.7
Physician Assistants	62	20.7
Anesthetists	22	7.3
Other	7	2.3
Total	**300**	**100**

Source: Author' Construction (2015)

Among health personnel, though relationship with patients may vary, its importance in the treatment of diseases and in the healing process remains the same. 27 respondents asserted that relationship with patients must be different at specific levels of health care. This they believed is as a result of the fact that as patients' condition becomes critical, special form of care and attention is required. However, 51 respondents mentioned that this relationship remains the same at various levels of care.

296 respondents testified that the relationship between patients and practitioner has various effects. Out of this number 220 indicated that the effects were positive, as against 7 who believed that it was negative. Significantly, 291 believed that these effects were both positive and negative, while 4 respondents failed to comment on this.

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Again, several respondents, who are non-health care practitioners, attested to having shared a form of sexual relation with a health practitioner after receiving treatment from him/her. According to 17 respondents, such form of relationship has been experienced by them. Though they did not outline reasons for their relationship; respondents asserted to have been in this relationship out of their own free will. However, 205 respondents stated that they have had no sexual relationship with one practitioner or another. On the other hand, 1 health practitioner (respondent) mentioned of having had a sexual relationship with a client. Also, 72 of them talked of having had no sexual relationship with patients, while 5 shared no idea.

Irrespective of views shared by respondents, 241 of them stated that a good relationship between a patient and a medical staff had the tendency to ensure proper treatment in terms of the diagnosis and prognosis of diseases as well as instituting holistic healing. However, 34 people did not share the same idea, while 25 made no comment on the issue. Among other positive effects stated by respondents were patient satisfaction, good treatment outcome and adherence to treatment and medication. Others lamented that bad relationship may prolong illness and bad condition of patients; it may also lead to reduction in hospital attendants, dissatisfaction in service rendered by practitioners and the elimination of the principle of confidentiality.

In order to ensure that this relationship is beneficial, respondents recommended for the creation of an atmosphere of confidentiality, honesty, commitment, tolerance and humility; acknowledgement of good conduct in institutions; decent communications among patients and practitioners; improvement in the ethical and moral conduct of patients and practitioners through education; assessment of professionalism and competence of practitioners in medical institutions; good personal relationship; justice/equality and respect for all.

Implications of the Study

The relationship between healers and their clients is of ancient origin as well as inevitable in all medical practice. It has existed to ensure that absolute treatment and holistic care is achieved. It has in recent years become a subject of moral concern than of social worry. In view of this, the study highlights the moral obligations of both patients and health practitioners towards their relationship and the need to ensure its existence. It also identifies the impact of good patient-practitioner relationship in health care delivery. This will help the Ghana Medical Council (GMC) as well as Ghana Health Service (GHS) to outline policies in aid of good healthcare through good practitioner-patient relationship. It further encourages the need for an ultimate liaison between healers and patients as well as eliminates barriers that hinder proper association. Developing relationships is a way for physicians to become more accountable for the care of vulnerable patients in clinical practice.

CONCLUSION AND RECOMMENDATION

It is worth noting that there is considerable healing power in (good) physician-patient alliance. Working together, the alliance exists to pursue interventions that can significantly improve the patient's quality of life and health status as well as the practitioner's sense of duty and professionalism. The bond of trust between them is vital to the diagnostic and therapeutic process. In order for the physician to make accurate diagnoses and provide optimal treatment recommendations, the patient must be able to communicate all relevant

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information about an illness or injury (Bobyrov and others, 2012). Practitioners are obliged to refrain from divulging confidential information if their relationship is to be a cordial one. This duty is "based on accepted codes of professional ethics which recognize the special nature of these relationships" in health care (Besso, Lumb and Williams, 2009:34).

It is recommended that practitioners work to protect the interests and the preferences of clients. A relationship has a history of fidelity, reliability, support, informed consent and beneficence when trust is most realistic.

Again, it is suggested that practitioners in Ghana and elsewhere focus on continuity. In their fiduciary relationship with individual patients, practitioners must ensure that the bond does not collapse mid-way through treatment processes. Since, continuity encourages trust, provides an opportunity for patients and practitioners to know each other, as well as a foundation for making decisions with a particular patient, nothing must be done, whether or not medical, to impede the permanence of the relationship.

Since it is a matter of ethical concern and integrity, practitioners are highly anticipated to desist from defaming the moral content of their relationship with patients. Likewise, the same is expected of patients. On one side, physicians must talk to patients, find out why they are requesting certain services, and meet those needs in other ways. It allows physicians to be better advocates for their patients and allows patients some power by virtue of the personal relationship they have with physicians. On the other, patients must be educated about the limited nature of physicians' social attitudes in any treatment. For all these to be possible, it is strongly suggested that physicians learn to understand the patient's underlying concerns and socio-cultural background to improve and sustain their bond with patients.

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