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Graduates' preparedness for the changing doctor-patient relationship: a qualitative study

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Abstract (300 words)

Background

A positive doctor-patient relationship is a crucial part of high-quality patient care. There is a general perception that it has been changing in recent years however there is a lack of evidence for this. Adapting to the changing doctor-patient relationship has been identified as an important skill doctors of the future must possess. This study explores 1). multiple stakeholder perspectives on how the doctor-patient relationship is changing and 2). in what ways medical graduates are prepared for working in this changing doctor-patient relationship.

Methods

We conducted a national qualitative study involving semi-structured interviews with multiple stakeholders across the UK. Interviews lasting 45-60 minutes were conducted with 67 stakeholders including doctors in the first two years of practice (ECD's), patient representatives, supervisors, Deans, medical educators and other healthcare professionals. The interviews were audio recorded, transcribed, analysed, coded in NVivo and analysed thematically using a Thematic Framework Analysis approach.

Results

The main ways the doctor-patient relationship was perceived to be changing related to increased shared decision-making and patients having increasing access to information. Communication, patient-centred care and fostering empowerment, were the skills identified as being crucial for preparedness to work in the changing doctor-patient relationship. Graduates were reported to be typically well prepared for the pre-conditions (communication and delivering patient-centred care) of patient empowerment but that more work is needed to achieve true patient empowerment.

Conclusion

This study offers a conceptual advance by identifying how the doctor-patient relationship is changing particularly around the 'patient-as-knowledge-source' dimension. On the whole ECD's are well-prepared for working in the changing doctor-patient relationship with the exception of patient empowerment skills. Further research is now needed to provide an in depth understanding of patient empowerment that is shared amongst key stakeholders (particularly the patient perspective) and to underpin the design of educational interventions appropriate to career stage.

Graduates' preparedness for the changing doctor-patient relationship: a qualitative study

1. Background

A positive doctor-patient relationship is a crucial part of high-quality patient care. It has been shown to improve patient satisfaction and a variety of other biological, psychological and social outcomes.¹ There is a general perception that the doctor-patient relationship has been changing in recent years however there is a lack of evidence for these perceptions. Adapting to the changing doctor-patient relationship has been identified as an important skill doctors of the future must possess.² The Future Doctor report sets out how education and training of doctors in England should evolve so that future doctors are equipped with the right skills to respond to population needs in an ever-changing healthcare landscape.²

As part of a multi-methods study on the preparedness of medical graduates for future anticipated healthcare needs, we conducted a rapid review of the literature on medical graduates' preparedness for the changing doctor-patient relationship.³ The review found very little literature addressing this topic specifically. The extent of in-depth qualitative research was also limited with previous studies being centred on survey research,^{4,5} which have quantified graduate's preparedness for practice in patient-centred care. If being prepared to adapt to the changing doctor-patient relationship is such an important skill for future doctors then an understanding of how the doctor-patient relationship is changing and to what extent current graduates are prepared for this is vital. Understanding these two problem areas will make a significant contribution to knowledge in this area, which will have implications for educational practice.

Through the ages the doctor-patient relationship has changed continuously in response to external, societal drivers. Up until the 1980s, the paternalistic model prevailed and the relationship typically involved a patient requiring help and a doctor whose decisions were complied with by the patient unquestioningly.⁶ First proposed by Parsons in 1951, this paternalistic model involved the doctor having a high degree of control over the patient.⁷

This asymmetrical or imbalanced interaction between doctor and patient has changed in many situations for many patients over the years and a more active, autonomous and thus patient-centred role for the patient has been advocated for.⁶ Patient-centred care involves a shift from more traditional, paternalistic, provider-driven, disease-focused approaches to healthcare systems that integrate patient's preferences, needs, desires and experiences into every phase of the medical consultation, treatment and follow-up.^{8,9} Patient-centred care involves empowering patients, focusing on the doctor-patient relationship and facilitating providers to work with patients to meet patient goals.¹⁰

Mead and Bower's seminal work on patient-centred care has been influential in conceptualising patient-centred care.⁹ Based on a literature review, they conceptualise patient-centred care as having five key dimensions and identified a variety of factors influencing patient-centredness (Figure 1). We will use Mead and Bower's model as our starting point to explore how the doctor-patient relationship is changing and to elucidate key factors on the changing doctor patient relationship identified by doctors in their first two years of practice. The research proposed here seeks to produce an in-depth exploration of the changing doctor patient relationship as well as of medical

graduates’ preparedness for this. Thus the study had two aims: 1). To explore multiple stakeholders perspectives on how the doctor-patient relationship has been changing and 2). To explore in what ways medical graduates are prepared for working in the changing doctor-patient relationship.

Table 1: Mead and Bower’s⁹ 5 key dimensions of patient-centred care

1. Biopsychosocial perspective – patient-centred care requires a doctor to treat the full range of problems that patients have, not just their biomedical problems.
2. The ‘patient-as-person’ – this involves understanding the individual’s experience of illness in order to develop a complete understanding of the patient’s presentation. Patients cannot be fully characterised by a diagnostic label and doctors should strive to understand the patient as an individual personality within his or her unique context.
3. Shared power and responsibility – a doctor-patient relationship that is democratic and where power and responsibility is equal.
4. The therapeutic alliance – patient-centred care prioritises the personal relationship between the doctor and patient, building on psychotherapeutic developments around the concept of the therapeutic alliance. Empathy, congruence, and unconditional positive regard are essential attitudes for effecting therapeutic change in patients, including adherence to treatment.¹¹
5. The ‘doctor-as-person’ – the biomedical model can be described as “one-person medicine” in that an acceptable clinical description does not require consideration of the doctor. By contrast, patient-centred medicine is “two-person medicine” with the doctor being a fundamental aspect of any description. The doctor and patient cannot be considered separately as they are influencing each other all of the time.¹²

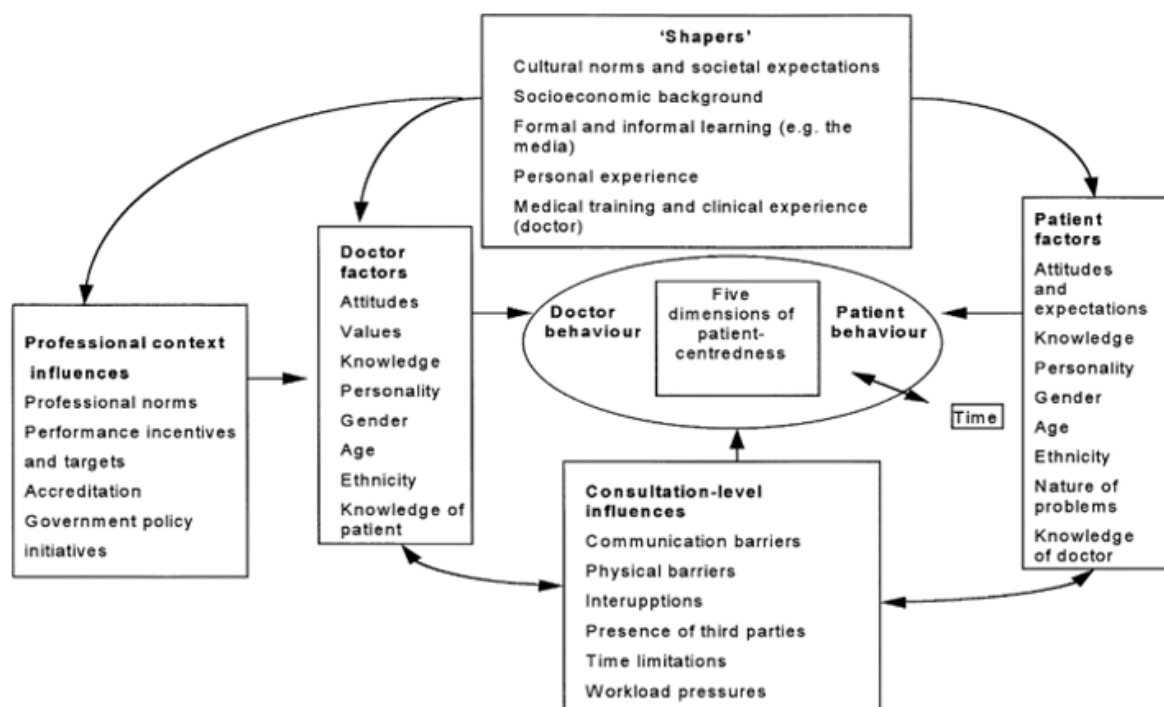


Figure 1: Mead and Bowers’ Model of Factors Influencing Patient-Centredness

2. Methods

2.1 Design

In 2021 our research team conducted a large multi-methods study that aimed to explore the preparedness of new medical graduates for anticipated healthcare needs including the changing doctor-patient relationship, multidisciplinary teamworking and complex clinical decision-making.³ As part of this study we used qualitative interviews to gain an in-depth multi-perspective understanding of key stakeholders' experiences of medical graduates' preparedness for the changing doctor-patient relationship. We report the findings from this part of the study in this paper. We adhered to the COREQ standards for reporting qualitative research.¹³ The theoretical orientation of this study is interpretivist in that we believe that reality is subjective and changing and that there is no ultimate truth, only people's differing experiences of it.¹⁴

2.2 Reflexivity

The research team consisted of 6 members (1 male and 5 females) with different backgrounds (clinical, clinical education and social science).

The interviews were conducted by NL, NB and NK. There were no pre-existing relationship between the study participants and the interviewers. The analysis process was led by NB, NL and NK, with wider team input into the development of the thematic framework. The analysis and interpretation of the results were discussed regularly in team meetings, providing the different perspectives of the full team to shape the process and the findings.

This study was funded by the GMC whose primary function is to regulate doctors in the UK. Interview participants were informed that the study was funded by the GMC, which may have influenced (positively or negatively) stakeholders' participation. While the research was carried out independently, the GMC met regularly with TG and NB to discuss progress, and the GMC contributed to the development of the interview schedules.

2.3 Sampling and recruitment

A purposive sampling strategy was utilised to recruit a variety of participants including early career doctors (ECDs, doctors in their first two years of practice post-graduation), patient representatives, clinical/educational supervisors, education programme leads, postgraduate deans, medical educators and healthcare professionals. We recruited across all four nations of the UK (England, Scotland, Wales and Northern Ireland) to maximise variability in demographics e.g. social, economic and political. ECDs, educational/clinical supervisors and education programme leads were recruited via the UK Foundation Programme Office (UKFPO). Additionally, the research team made use of their networks with ECDs to have invitation e-mails distributed to ECDs. Postgraduate Deans, other healthcare professionals and patient representatives were recruited via contacts within the research team and the General Medical Council. TG, NB and KM were involved in a concurrent study funded by the GMC which involved doctors in their first year of practice and we also recruited some participants that signed up to this study.¹⁵ All stakeholders were sent an invitation e-mail containing a Participant Information Sheet (PIS). The PIS described the study, data management procedures and a link to the online consent form hosted by JISC online surveys. Some ECDs were selected in the latter stages of recruitment to address underrepresented aspects of the sample e.g. training stage and geography.

2.4 Data collection

The interviews used a semi-structured format. A topic guide was developed by the research team to address the research questions; however it was flexible enough to allow the conversation to develop depending on the individual participant's particular perspective and expertise. The interview schedules were tailored for three categories of stakeholders; 1. ECDs, 2. educational/clinical supervisors, medical educators, education programme leads, postgraduate deans and 3. patient representatives.

The interviews were carried out by video call using MS Teams/Zoom between November 2020 and May 2021, to accommodate the geographical spread of participants and the restrictions associated with the Covid-19 pandemic. The interviews were audio-recorded using a dictaphone or the recording facility on the video call. The interviews were transcribed verbatim by two professional transcribers bound by a confidentiality agreement. Interview participant names were anonymised before transcription and identified by a signifier (a unique reference number and stakeholder type). 67 interviews were completed in total (Table 1). The interviews took place when ECDs in their first year of training were 4-10 months into their training programme and when ECDs in their second year of training were 16-22 months into their training programme.

2.5 Data analysis

The interview transcripts were uploaded into NVivo 12. An inductive content analysis approach to thematic analysis using the Thematic Framework Analysis method was used to analyse the data.¹⁶ This approach offers researchers a systematic structure to manage, analyse and identify themes consisting of 5 inter-connected stages. The five stages involve familiarisation, constructing a thematic framework, indexing and sorting, data summary and display, and mapping and interpretation. NB, NL and NK developed an initial coding framework. The first step in this process was for each to code three transcripts independently. Each developed their own coding framework and then met as a full research team to discuss and agree the overall coding framework. After this meeting had taken place NL consolidated the agreed framework. The same three researchers coded all of the interviews using this framework. The interviews were not double-coded but in order to maintain consistency of approach, regular meetings were held to discuss coding, additions to the framework and emerging findings. The coding framework in the NVivo files were merged on a regular basis by NB and shared such that each coder was using the agreed framework. The codes and themes were data driven.

2.6 Ethical approval

Ethical approval was received from the University of Plymouth Faculty of Health Research Ethics and Integrity Committee on the 1st of October 2020 (ref no: 2306).

3. Results

3.1 Participant demographics

Eight stakeholder groups comprising of 67 individuals participated in the interviews (Table 2). The largest group comprised of ECDs in their first year of training post-graduation (n=24) and ECDs in their second year (n=18). The majority of participants were female (n=39) and most were based in England (n=46) (Table 3).

Table 2: Characteristics of Stakeholders Interviewed

Stakeholder Type	Completed Interviews	Male	Female
ECDs Year 1 post-graduation	24	11	13
ECDs Year 2 post-graduation	18	8	10
Educational/Clinical Supervisors	9	4	5
Education Programme Lead	3	2	1
Postgraduate Deans	2	1	1
Other healthcare professionals	5	1	4
Medical Educators	3	1	2
Patient Representatives	3	0	3
Total	67	28	39

Table 3 Geographical Spread of Stakeholder Participants

	No. of stakeholders
England	46
Scotland	14
Wales	2
Northern Ireland	5
Total	67

3.1 How has the doctor-patient relationship changed?

3.1.1 Increased shared decision-making

The most important change identified was a perceived increase in shared decision-making. This was perceived by participants to be a positive change, that enabled the patient to have more responsibility over their health, and for them to be involved in the dialogue with healthcare providers about their needs.

"...the role of the doctor isn't to make all the decisions, it's to make them together, which I think is what's changed between patients and doctors" (Interview 13, F1 Doctor, Female, England)

"Cos I think in the past it was very much the doctor knows best and you don't challenge the doctor, whereas now [...] there is the relationship between the two, so there's more of a discussion rather than the doctor breezing in, well I'm so and so, you don't ask me any questions" (Interview 65, Patient representative, Female, England)

However some negative implications of shared decision making were also identified. A more balanced dynamic and onus on patients to take part in decision-making sometimes led to increased

patient expectations. This resulted in a sense of patients being consumers, and doctors feeling pressurised into satisfying patient demands rather than providing their professional medical opinion. There was also less respect for the doctor and at times this went to the extreme and resulted in rudeness.

"I suppose if a patient came to me as a consumer then I probably wouldn't enjoy it if they demanded,sometimes you do get people demanding investigations and things, and one patient I had demanded like quick treatment for their psychiatric condition, which we just couldn't offer and that can be quite frustrating like trying to communicate that you can't necessarily fix things straightaway" (Interview 4, F1 Doctor, Male, England)

A remarkable aspect of the shift towards shared decision-making was the generational differences in the expectations of the doctor-patient relationship. Some participants noticed that older patients preferred a paternalistic dynamic and would often defer decision-making to the doctor and were keen to do what the doctor decided was best for their care. On the other hand, participants reported that younger patients were much more likely to be informed and participatory in their healthcare decisions.

"from speaking to patients there is definitely a difference across generations, ...the older generation they have a very paternalistic attitude in the doctor / patient relationship, when you offer them the opportunity to get involved in their care and nine times out of 10 the answer is always well do what you think is best, or what would you like me to do..., Whereas the younger generation ... they're a lot more well versed ... and so you are able to practice your more shared decision-making" (Interview 31, F2 Doctor, Male, England)

"if this was my mother-in-law she'd just sit there and accept that she didn't know who the doctor was, it wouldn't bother her, she would just ... take whatever's said" (Interview 66, Patient representative, Female, England)

3.1.2 Patients having greater access to information

Another aspect of the changing doctor-patient relationship identified by participants was patients' greater access to information. To some extent this could be beneficial, enabling shared decision-making as patients were more informed about their health, especially those with chronic health conditions. However, it was also reported to be a challenging aspect of the doctor-patient relationship as it sometimes meant patients were misinformed by poor sources of evidence, or confirmation bias. Therefore managing patient beliefs and expectations can present a challenge for doctors, particularly if a patient is convinced of the need for a particular medical investigation or treatment. This difficulty can be further compounded for doctors by time or workload factors.

"When I first started I knew everything and the patient knew nothing and my role was to transmit information, now because of what's out there patients sometimes potentially can even know more than the doctor knows, particularly if you're in general practice where you won't know everything about everything but if you're a patient, IT savvy and reasonably intelligent,you can come in more as a disease expert than the doctor you're seeing" (Interview 61, Dean, Male, England)

"Lots of people [patients] won't say that they've looked stuff up but I find it quite useful to ask them have you looked it up, cos I think if you ask them in a non-judgemental way they'll then just admit to it or say what they find, so I find it better to just engage with the fact that they've probably done that (Interview 26, F2 Doctor, Female, Scotland)

Despite these difficulties, patients having greater access to information can help them to understand their condition, treatment options and when to seek help. It can also play a key role in starting discussions and allowing patients to become more involved in shared decisions around their health and wellbeing.

"I think there is a lot of people come in saying I've read this or I've seen that or I've heard this,I think patients are bringing their own stuff to the table and wanting to talk about what they know compared to what you know, and have that kind of open discussion"
(Interview 2, F1 Doctor, Female, Scotland)

3.2 In what ways are medical graduates prepared for the changing doctor-patient relationship?

3.2.1 Communication skills

Good communication skills were perceived to be crucial in order to explain a diagnosis, treatment options, risk or uncertainty, and to empower patients.

"So I think communication is probably the key thing, mainly because often empowering patients actually requires being able to explain to them what's going on to them and what the treatment options are ...And I think having that ability to be able to communicate that effectively kind of outweighs the other aspects because you can always look up or add in extra bits of knowledge over time" (Interview 28, F2 Doctor, Male, Scotland)

All the stakeholder groups interviewed felt that ECDs in the UK were well prepared for communicating and building rapport with patients. This preparedness was due in part to a strong emphasis on communication skills within contemporary medical training, despite the participants representing a variety of different medical schools and training environments. Many of the ECDs described refining their communication skills through simulation exercises with actors, sessions on breaking bad news, or by gaining experience by communicating directly with patients during clinical placements and time on the ward.

"The rationale around building a rapport with the patient stems back to having good and effective communication skills, and it's creating an environment where they feel that they can tell you everything they want to tell you, and feel comfortable saying whatever they want to say, and knowing that the doctor would be listening to them and not just saying yeah that's all fine. So I feel quite prepared and med school helped me quite a lot with that in terms of the communication skills and things we did throughout the year, and from placements" (Interview 13, F1 Doctor, Female, England)

Some participants felt they were less prepared for more complicated aspects of communication i.e. a patient refusing an intervention, or communication through third-parties. This was primarily due to less clinical exposure and experience in those unique situations.

3.2.2 Patient-centred care

Patient-centred care was identified as a core capability for the doctor-patient relationship, which included recognising, listening to, and demonstrating an understanding of patient ideas, concerns and expectations, and encouraging the patient to participate in the consultation and care decisions. Ensuring there is mutual understanding between the doctor and patient was key to delivering patient-centred care.

“we’ve taken this idea of ideas and concerns and expectations on board, where part of every consultation should include us asking the patients what they think the problem is? Asking the patient what they’re worried it could be? Asking them what they want from the consultation? So a lot, a lot of patients, I think in the past, may have come in, worried that they have cancer, but not be confident enough to say, “I’m worried that they have cancer”, which means that the doctor can’t reassure them...” (Interview 43, F2 Doctor, Male, England)

The ECDs interviewed reported feeling well prepared for delivering patient-centred care. Many of the ECDs interviewed felt that this was a central element of their medical training from day one which has carried through to their clinical practice.

“My medical school training always put patients at the forefront of medicine, we were taught in a sort of case-based way that always centred around patient care, evidence-based practice and shared decision-making was emphasised a lot, and I think that’s something I’ve seen and hopefully carried through into my practice” (Interview 16, F1 Doctor, Male, England)

While it may not be feasible to be fully prepared for the future of patient-centred care, as it depends in part on how the doctor-patient relationship evolves, the following interviewee felt that their communication skills training allowed them to prepare for delivering this style of medical care.

“I do feel well prepared to involve patients in my care, and to create that more balanced patient / doctor relationship. It’s quite daunting to think how far that will go and what the patient / doctor relationship will look like in the future, I can’t be prepared entirely without knowing what that’s going to look like in another 10 years’ time. But I do think the amount of communication training I’ve had has been adequate in order to kind of prepare for this style of medicine that we’re delivering” (Interview 1, F1 Doctor, Female, England)

Again, time and resource constraints could sometimes prevent ECDs from delivering good patient-centred care. The competing priorities of the job often resulted in the doctors not being able to spend as much time on an individual basis with patients as either parties would like. Other participants felt that they were not prepared enough for the ways in which to deliver the best patient-centred care, and integrating that skill into daily practise.

“we don’t always get the opportunity to deliver good patient-centred care, and there’s always priorities beyond the one patient that you’ve got in front of you, that you need to think about. I think some patients would love it, if we could spend forty-five minutes to an hour, just talking to them about their life, and that would be good patient-centred care, but we can’t always provide that, because we haven’t got the time or the resources, you see” (Interview 43, F2 Doctor, Male, England)

3.2.3 Fostering empowerment

Fostering empowerment was identified as being an important skill. While some stakeholder groups indicated this was something they felt prepared for, others felt that it was not something that ECDs had been given the opportunity to gain experience in. As illustrated below, some of the respondents felt able to try to empower patients, and were able to describe how they would go about this i.e. by gauging the level of patient understanding, how much the patient wanted to know and be part of decision-making, by educating or signposting patients to information, presenting an unbiased explanation of the different options and their risks and benefits, and consenting patients. One of the

This is a post-print author's draft of an article accepted for publication in the journal Medical Education 2023
healthcare professionals interviewed felt that the best way to empower patients was to get them involved in their own healthcare and prevention.

“providing education whether it be yourself or signposting them to the right places and not forgetting that actually, the best way that you can help a patient and empower them... is getting them on-board with their own treatment and prevention” (Interview 59, Healthcare Professional, Female, England)

Some of the interviewees felt that their preparedness for empowering patients depended on the specific context, and that as ECDs they were still developing these skills. Other barriers to empowering patients included not always having the time to demonstrate this skill due to the volume of work. This highlighted the difference between textbook training and the practise of empowering patients in the real-world. The early career status of the doctors means they have not always gained the knowledge and experience to be able to empower patients. However, some of the other stakeholders observed that this was a grade-specific skill expected from more senior clinicians and not expected from ECDs stage of career.

“I think that takes a bit longer, I think when you are a foundation doctor you are still very much learning the nuts and bolts of acute medicine or surgery, and empowering patients to take decisions is something which is probably the next grade up at least, and I think they will have the skills to get there at the appropriate time in their training but it's not something I would expect them to be taking on or be competent at in the first two years of being a doctor” (Interview 50, Educational/Clinical Supervisor, Male, England)

4. Discussion

4.1 Summary of main findings

The aim of our study was two-fold. Firstly, to explore multiple stakeholders' perspectives on how the doctor-patient relationship has been changing. Secondly to identify the key skills required for working in the changing doctor-patient relationship and whether medical graduates are prepared for these. The main ways the doctor-patient relationship was perceived to be changing related to increased shared decision-making and patients having increasing access to information. A negative aspect of this change is that the more balanced dynamic sometimes resulted in increased patient expectations and doctors feeling that patients were more like consumers. Communication and patient-centred care skills as well as being able to foster empowerment in patients were the skills/capabilities identified as being crucial for being prepared to work in the changing doctor-patient relationship. All the stakeholder groups interviewed felt that ECDs were well prepared for communicating and building rapport with patients. Participants felt that ECDs were generally well prepared for delivering patient-centred care but that time and resource constraints can act as a barrier for ECDs to be able to deliver good patient-centred care. Fostering empowerment was a key skill with mixed reports on preparedness. Our research furthers the debate by providing a deeper understanding of the changing doctor-patient relationship, shared decision-making and patient empowerment in relation to ECDs.

4.2 Comparison with existing literature

Patient-centred care

Of the five key dimensions of patient-centred care conceptualised by Mead and Bower, 'shared power and responsibility' was most strongly evident in the stakeholders' descriptions of patient-centred care with some evidence that the balance of power sometimes tipped too much in favour of the patient and the consequences of this (more below). Based on the changes we identified in the doctor-patient relationship we propose the addition of a sixth dimension to Mead and Bowers conceptualisation of patient-centred care which is 'patient-as-knowledge-source'. This dimension involves recognising that patients can have an in-depth understanding of their health, particularly for chronic health conditions, due to having greater access to information on the internet. Patients having access to more health information can enhance patients' own health monitoring and management and also puts an increased emphasis on shared decision-making and consent in relation to their care. However difficulties may arise in consultations due to the quality, variability and interpretation of information accessed by patients to inform shared decision-making.^{17, 18}

Mead and Bower⁹ also identified a variety of factors influencing patient-centredness (Figure 1). Our research provides qualitative data to support some of these factors. Looking first at the consultation-level factors identified by Mead and Bower, which were purported to have the most immediate impact on the propensity of doctors to be patient-centred. Our study found that effective communication skills were a crucial part of working within the changing doctor-patient relationship and implementing patient-centred care. Our study also identified that time limitations and workload pressures often got in the way of the ECDs being able to deliver patient-centred care as effectively as they would have liked to. In terms of the patient factors that influence patient behaviours our study also found that age had an impact on patients' behaviour, in that patients from older generations were more likely to still seek a paternalistic approach and expected doctors to make decisions on their behalf. Increased shared decision-making was having a negative impact on the attitudes and expectations of some patients in that a more balanced dynamic and onus on patients to take part in decision-making sometimes led to increased patient expectations. This resulted in a sense of patients being consumers, and doctors feeling pressurised into satisfying patient demands, rather than providing their professional medical opinion. Our study contributes to theory on this topic by elucidating the key factors influencing patient-centredness for doctors in the first two years of practice.

Patient as consumer

Doctors feeling that patients were more like consumers was seen as a negative impact of the changing doctor-patient relationship. Various socio-political forces, including the commodification of healthcare and the gradual shift from the paternalistic to the patient-centred model of healthcare, have prompted debate about the use of alternative labels to describe 'patients'.¹⁹ A study by Goldstein and Bowers²⁰ highlights how studies around patient engagement and empowerment often use the term consumer and patient interchangeably. "Patients are not consumers who pick and choose among physicians and treatments on the basis of price and quality. Patients are sick and vulnerable people who are truly not themselves and are incapable of shopping around for the best deal."²¹ Treating patients as consumers could have a detrimental effect on the doctor-patient relationship. It may result in a more business-like attitude towards the interaction by the doctor. People need to be able to completely trust the person helping them make life and death decisions and likening that relationship to a mere purchase transaction could be disastrous for healthcare.²⁰ It could also eliminate the most crucial element in the effective delivery of care: compassion.

Temporal aspect of doctor-patient relationship

An interesting finding from the study was the perception that older patients might prefer a paternalistic dynamic and would often defer decision-making to the doctor and were keen to do what the doctor decided was best for their care, whereas younger patients were much more likely to be informed and participatory in their healthcare decisions. Previous research had suggested that there is a positive correlation between younger age and preferences for health information and participation in decision making. However subsequently a review article found that existing evidence is 'inconclusive' due to inconsistent findings from studies using different measurements.²²

Our findings highlight the fact that shared decision-making is not always wanted by patients. A systematic review of patient preferences for shared decision-making found that the majority of patients preferred sharing decisions with physicians in 63% of the studies. It also identified a trend over time in that the majority of respondents preferred sharing decision roles in 71% of the studies from 2000 and later, compared to 50% of studies before 2000.²³ It may be that shared decision-making is the preferred approach however doctors and patients may need to tailor their approach to changing circumstances at different stages in the care of a patient.

We suspect that culture and/or ethnicity is also an important factor affecting the doctor-patient relationship as outlined in the Mead and Bower model. Ethnicity differences may create barriers to effective communication and particularly when there are language and cultural differences. Although there were limited insights provided by the data in the current study, we suggest it will be an important topic for future research.

Fostering empowerment

Fostering empowerment was first included in the GMC's Generic Professional Capabilities Framework for practising doctors in 2017 which reflects a societal change in the increased expectation of the importance of this skill, in the UK at least. The Future Doctors report²⁴ highlights the need to empower patients to manage their own health and wellbeing according to individual preferences and capabilities which again emphasises the importance of this skill in future clinical practice.

Patient empowerment is often conflated with patient-centredness. However a concept analysis by Castro²⁵ based on a review of the international literature found that patient empowerment is a much broader concept than patient-centeredness and is a relational concept with different levels. Patient empowerment is a paradigm that approaches problems in a fundamentally different way to patient-centredness. Crucially, patient-centeredness can be seen as a precondition for patient empowerment. Castro²⁵ (pg 1927) propose the following definition for individual patient empowerment which is a practice that supports patients "to exert more influence over their individual health by increasing their capacities to gain more control over issues they themselves define as important".

ECDs in our study were typically well prepared for the pre-conditions (communication and delivering patient-centred care skills) of patient empowerment²⁵ but more work is still needed to achieve true patient empowerment. While some of the ECDs felt that empowering patients was something they were prepared for, others felt that it was not something that they had had the opportunity to gain experience in. Some educational supervisors reported it is a grade-specific skill not required of ECDs. These differing perspectives highlight the complexity of this skill in practice. This is also echoed in the literature with there being a lack of clarity of what is meant by the concept and how it overlaps with patient-centredness.²⁵

Global Implications

It is important to consider how the changes to the doctor-patient relationship identified in this study might play out differently outside of the UK and in countries that are less well resourced. Our study participants felt that ECDs were generally well prepared for delivering patient-centred care but that time and resource constraints can act as a barrier for ECDs to be able to deliver good patient-centred care. In the UK the average consultation time is just under 10 minutes.²⁶ This time ranges from 48 seconds in Bangladesh to 22.5 min in Sweden.²⁶ The consultation time would have a big impact on the development of the doctor patient relationship with less time resulting in a less patient-centred care approach²⁷. Time or workload pressures may limit possibilities for full negotiation and resolution of conflict between doctor and patient 'agendas'.⁶ However the Irvine et al²⁶ study also found that the association between average consultation length and per capita healthcare spending supports the claims that shorter consultation length is a good measure of poverty, even in the industrialised world thus reminding us that there can be variation even within first-world countries.

In sub-Saharan Africa patient-centred care has not been widely adopted mainly because providers are not trained to deliver it but there is much variation across the continent in terms of training.²⁸ Furthermore, in low-income countries where patients have limited access to the internet the 'patient as source of knowledge' dimension of patient centred care would have less relevance.

4.3 Implications for educational practice

In terms of educational practice, undergraduate education needs to continue to focus on patient-centred care skills and clinical training needs to allow students or new graduates the opportunity to put these skills into practice on clinical placements, to deliver good patient-centred care and empower patients. There also needs to be a particular focus on the challenge of being patient-centred within the context of time limitations and workload pressures. Current training may be leading to frustration due to false expectations of an ideal situation of enough time, rather than training within more realistic scenarios of limited time and resources.

A lack of shared understanding of what patient empowerment actually is and at what training level it is expected, could lead to misunderstandings and misplaced expectations about graduates' workplace performance. Therefore, the development of shared understanding (and thus expectations) of patient empowerment between graduates and other stakeholders is key. It is also important that there is a clear understanding of how this skill can be cultivated in medical training. Support and feedback from supervisors and the multidisciplinary team will play a key role in this.

Specific strategies that could help develop patient centredness among students include spending sufficient time with patients to build a relationship and hear their stories, and involving patients in patient advocate roles. Practical steps to inquire about patients' ideas, concerns, and expectations (ICE) during consultations have been established in models of clinical reasoning taught at undergraduate and postgraduate levels in medical education. To include ICE effectively as a communication skill, techniques need to go beyond the use of additional questions when taking a patient history and promote clinician curiosity throughout the whole doctor-patient consultation to understand patient perspectives.²⁹ Our study found that Foundation doctors were well prepared for investigating patient perspectives but less so for fostering empowerment in patients due to lack of opportunity and prior experience. Educating trainees to use clinical reasoning models which introduce choice, options and preferences to patients, would be beneficial as would increase

opportunities for graduates to put these skills into practice, with support and feedback from supervisors and members of the multidisciplinary team.

4.4 Strengths and limitations of the research

Our study has a number of methodological strengths including a large sample size incorporating a variety of different stakeholder perspectives across the four nations of the UK to maximise variability in demographics. We also took a reflexive team-based approach to data collection and analysis.

A limitation of the study was that some of the ECDs (who were a significant proportion of the study participants) were not able to comment first hand on the changing doctor-patient relationship. They felt that as they had only recently started working as a trainee doctor they had not experienced any significant shift in the doctor-patient relationship, instead they were accustomed to the current relationship dynamic that they had trained and worked within. However, from working with more experienced colleagues they were able to comment on a perceived change in dynamics retrospectively.

Other limitations were that it was a UK only study and thus the changes identified in the doctor-patient relationship cannot be transferred to the rest of the world particularly lower income countries. However we think that they would be transferable to high-income countries. Despite the study being about the changing doctor-patient relationship, there were a limited number of patients in the sample (n=3) and therefore it was difficult to tease out generational differences between doctors and patients. Finally, our study focussed on the doctor-patient relationship but we did not explore the implications for the wider multidisciplinary healthcare team.

5. Conclusion

This study offers a conceptual advance by identifying how the doctor-patient relationship is changing particularly around the 'patient-as-knowledge-source' dimension. On the whole ECDs are well-prepared for working in the changing doctor-patient relationship with the exception of patient empowerment skills. Further research is now needed to provide an in depth understanding of patient empowerment that is shared amongst key stakeholders (particularly the patient perspective) and to underpin the design of educational interventions appropriate to career stage.

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Authors Contributions

NB designed the study, conducted interviews, developed the coding framework, coded interviews, wrote the first draft of the paper and led the editing of all subsequent iterations.

NL conducted interviews, developed the coding framework, coded interviews, thematically analysed the data and reported the analysis and approved the final manuscript for publication.

NK conducted interviews, developed the coding framework, coded interviews and approved the final manuscript for publication.

KM designed the study, developed the coding framework, commented on the analysis and critically revised the manuscript

TG was chief investigator for the study. TG designed the study, developed the coding framework, commented on the analysis and critically revised the final manuscript.

Appendix A

Interview Schedule

Section 2: The changing doctor-patient relationship

1. Do you feel the relationship dynamic between patients and doctors is changing? And if so, in what ways? Prompts: patients as 'consumers', 'Dr Google', e-health information, use of technology e.g. remote consultations, empowering patients, shared decision-making, dealing with multiple conditions in an ageing population.
 - a. Can you provide an example of this from your clinical work?
2. Do you feel this is having a positive or negative effect on your interactions with patients? And can you explain why?
3. What are the core skills, capabilities and attributes doctors will require to in order to empower patients and foster an effective doctor-patient relationship?
4. Now thinking about your training to date as a whole, how prepared do you feel for delivering patient-centred care?
 - a. How prepared did you feel for empowering a patient to make a decision? Can you give an example of doing this from your clinical work?
 - b. How prepared did you feel for promoting shared decision-making? Can you give an example of doing this from your clinical work?
 - c. How prepared did you feel for building rapport with patients? Can you give an example of doing this from your clinical work?
 - d. How prepared did you feel for communicating through third-parties e.g. carers or people with powers of attorney for a patient, to understand the patient's wishes and make decisions?
5. If feeling unprepared – what else could be done to prepare/support doctors in gaining the necessary skills/capabilities?
6. To what extent has COVID-19 affected or will affect the doctor-patient relationship?
7. Do you have any further thoughts around the future doctor-patient relationship?

Appendix B

Table 2: National stakeholder interviews – ECDs demographics

Interview #*	F1 or F2	Gender	Interim Foundation (FiY1)	Country
Interview 1	F1	Female	Yes	England
Interview 2	F1	Female	Yes	Scotland
Interview 3	F1	Female	No	England
Interview 4	F1	Male	Yes	England
Interview 5	F1	Female	Yes	England
Interview 6	F1	Male	Yes	England
Interview 7	F1	Female	Yes	England
Interview 8	F1	Male	Yes	England
Interview 9	F1	Female	No	England
Interview 10	F1	Male	Yes	Scotland
Interview 11	F1	Male	Yes	Wales
Interview 12	F1	Female	Yes	England
Interview 13	F1	Female	Yes	England
Interview 14	F1	Female	Yes	England
Interview 15	F1	Male	Yes	England
Interview 16	F1	Male	Yes	England
Interview 17	F1	Female	No	England
Interview 18	F1	Male	Yes	Scotland
Interview 19	F1	Female	Yes	England
Interview 20	F1	Female	Yes	Scotland
Interview 21	F1	Female	Unclear	Scotland

Interview 22	F1	Male	No	Scotland
Interview 23	F1	Male	Yes	N. Ireland
Interview 24	F1	Male	Yes	N. Ireland
Interview 25	F2	Male	n/a	Scotland
Interview 26	F2	Female	n/a	Scotland
Interview 27	F2	Female	n/a	Scotland
Interview 28	F2	Male	n/a	Scotland
Interview 29	F2	Female	n/a	England
Interview 30	F2	Female	n/a	England
Interview 31	F2	Male	n/a	England
Interview 32	F2	Male	n/a	England
Interview 33	F2	Female	n/a	England
Interview 35	F2	Female	n/a	England
Interview 36	F2	Male	n/a	Scotland
Interview 37	F2	Female	n/a	Wales
Interview 38	F2	Female	n/a	England
Interview 39	F2	Female	n/a	England
Interview 40	F2	Male	n/a	N. Ireland
Interview 41	F2	Female	n/a	Scotland
Interview 42	F2	Male	n/a	England
Interview 43	F2	Male	n/a	England
Totals	24 F1s 18 F2s	23 Females 19 Males	19/24 did FiY1	25 England, 2 Wales, 12 Scotland 3 N. Ireland

*The characteristics of the participants were grouped according to participant type thus the table does not reflect the order in which they were interviewed.

Table 3: National stakeholder interviews - Other stakeholders' demographics

Interview #*	Stakeholder type	Gender	Country
Interview 44	Educational/Clinical Supervisor	Female	England
Interview 45	Educational/Clinical Supervisor	Male	England
Interview 46	Educational/Clinical Supervisor	Female	England
Interview 47	Educational/Clinical Supervisor	Male	England
Interview 48	Educational/Clinical Supervisor	Male	England
Interview 49	Educational/Clinical Supervisor	Female	England
Interview 50	Educational/Clinical Supervisor	Male	England
Interview 51	Educational/Clinical Supervisor	Female	N. Ireland
Interview 52	Educational/Clinical Supervisor	Female	England
Interview 53	Education Programme Lead	Female	England
Interview 54	Education Programme Lead	Male	England
Interview 55	Education Programme Lead	Male	England
Interview 56	Nurse	Male	England
Interview 57	Nurse	Female	TBC
Interview 58	Pharmacist	Female	England
Interview 59	Physician Associate	Female	England
Interview 60	Physician Associate	Female	England

Interview 61	Dean	Male	England
Interview 68	Dean	Female	Scotland
Interview 62	Medical Educator	Female	England
Interview 63	Medical Educator	Female	England
Interview 64	Medical Educator	Male	N. Ireland
Interview 65	Patient Representative	Female	England
Interview 66	Patient Representative	Female	England
Interview 67	Patient Representative	Female	England
Totals	25 other stakeholders 9 educational/clinical supervisors 3 education programme leads 5 healthcare professionals 3 medical educators 2 deans 3 patient representatives	16 Female 9 Male	21 England 2 N. Ireland 2 Scotland

*The characteristics of the participants were grouped according to participant type thus the table does not reflect the order in which they were interviewed.