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Different Behavioral Patterns in Doctor Patient Relationship

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ABSTRACT

Background:"A good physician treats the disease and a great physician treats the patient who has the disease"

In a doctor patient relationship not only the clinical skills of doctor matter,but the behavior of doctor toward his patient how he deals with the problem, the communication skills of doctor and trust of patient on his doctor.

Methods: This study was conducted at Swami Rama Himalayan university after due ethical clearance and thirty willing patients were asked to reflect on their experience during interaction with the treating doctor, using "Gibb's reflective cycle".The Gibb's cycle was explained to the patient. The observed behavior was charted out on a 5 point Likert scale (1 to 5) by the patient for the analysis of event. After a broad categorization of the behavior as disagreeable/agreeable, the probable cause of the behavior was analyzed qualitatively and further categorized as due to 'direct factors' and 'indirect factors.

Results –Themes emerging from narratives were qualitatively analyzed. Agreeable behavior was reported by the patients in 90% of doctor-patient interactions. "Mutual respect, trust and faith" were perceived as agreeable behaviors by most. A disagreeable behavior where the patient expressed annoyance after he developed rashes due to a medication was reported. He argued that the doctor should have warned him before about the possibility of adverse effect.

Conclusion-Though most of the times the interaction between doctor and patient is perceived as agreeable as doctors have maintained a good eye contact and doctors were very responsive to queries and did not get irritated or frown during the interaction which must be appreciated and acknowledged .However, it is the rare case of patient dissatisfaction that needs to be addressed objectively so that it is converted into an agreeable behaviour

Key words- Trust, Faith, Compliance, Communication skills**.**.

I. INTRODUCTION:

"A good physician treats the disease and a great physician treats the patient who has the disease"

- Sir William Osler

Besides the 'clinical skills', it was the behavior' inherent in the interaction between patient and doctor that plays an important role in the practice of medicine[1,2]. Incidentswere reported and with the help of narratives of patient encounters that evoke strong emotional responses had been used to identify good and bad behaviors since a long time.

The nature of clinical encounters has undergone transformation with time and it was evident that the patient's expectations from doctors had played a major role in this transformation. The 'paternalistic' trend in the doctor-patient relationship, where the patient simply complied with a nod to the doctor's advice, is now changing. The doctor of today is expected to give expert advice and convince the patient who have access to huge amount of information through various internet resources and media. The decisions have to be shared and hence communicated well for better patient satisfaction. Researchers have focused on different aspects of doctor- patient relationship and have found that good behavior, trust and communication can immensely improve patient satisfaction and the subsequent response to treatment.

For the same treatment offered, the patient's response and satisfaction may differ. This difference may be

attributed to differences that go beyond clinical competence. Certain behaviors may influence our communication skills, cultural sensitivities, cultural competence, societal expectations and interpersonal equations. The good behaviors can be reinforced and appreciated while bad behaviors can be timely amended.[4, 5,6]

But unfortunately, the good behaviors often go unnoticed and bad behaviors result in patient dissatisfaction or poor patient compliance

and sometimes may escalate to abusive and violent behaviors.

Narratives of clinical encounters have helped to identify and highlight the points where doctors, patients and health care givers digress from the conventional expected good behavior. Critical incident reporting, interviews, narratives have all been used to provide very useful information about the interplay of various influences.[3,9,10] When properly documented and qualitatively analyzed, they have been able to pinpoint problems with greater accuracy for enabling effective and timely corrective measures.[7,8]

The book of a doctor's life is replete with anecdotes and hence a habit of reflecting on behaviors can be a good guide to ponder upon an incident at leisure and to learn from mistakes.[7]

Since we have no formal chapters in the medical curricular on behaviors, patients are our best books. If students are in a habit of reflecting from the very beginning,they may learn from their own mistakes and also from the mistakes of others even before they make one themselves. Reflective narratives on doctor-patient encounters can thus help inculcate and reinforce good behaviors and discourage the undesired[3].

AIM-
To identify good and bad behavior in clinicalencounters using reflective narratives.

Objectives:
1. To write reflective narratives on clinical encounters that evoked strongemotional response.
2. To analyze the apparent cause of the observed behavior.
3. To suggest improvement for bad behavior.

Methodology:
The study was conducted during scheduled clinical posting after taking ethical clearance from the Institutional Ethics Committee. The application for ethical clearance has been submitted to the research committee. The names of people involved in the clinical encounter will be kept anonymous and only behaviors, will be narrated and analyzed.

1. The narrative will structured and written as a reflection using **"Gibb's reflective cycle"**

The reflections are recorded under three major heads-
1.What happened?
2. So what?
3. What Next?
The structuring of the reflection will help record the information in a rather uniform and systematic manner for qualitative analysis. It shall provide some basic guidelines along with advantage of free expression. (Annexure 1)
Annexure 1- Reflection format

What happened-
- Describe the details of the event without revealing identities
- Actions taken
- Feeling evoked
- Perceived lapses / good gestures
- So what

Lessons learnt
- Was it an exemplary good behavior or the one that needs amends?
- Emotional reactions and their consequences
- What could have the incident led to?
- Did it carry the potential to be escalated / cause further harm?

What Next–
- The corrective measures or alternatives to a bad or disagreeable behavior.
- What improvements are needed
- If a similar episode is encountered again, how should it be dealt with

1. The behavior will be identified as disagreeable/agreeable behavior .The factors which could have lead to the identified behavior will be categorized as: 'direct factors'and 'indirect factors' and recorded in a tabular format. The individual factor shall then be ranked-1 to 5, based on a 5 point likert scale **(Annexure-2)**

Annexure -2
Behavior observed and ranking of factors (1 to 5) that may have contributed to the behavior based on Likert scale

5 point likert scale: 5=Very good, 4=Good 3=can't say 2=poor 1=Very poor
Type of behavior-Disagreeable/agreeable -……………………

Common factors affecting Doctor-Patient interactions	Ranking of the responsible factor as per the LIKERT SCALE (1-5)	What was the most striking feature of the behavior (as described in detail in reflection)
Direct factors		
Communication skills		
Trust		
Cultural competence		
Mannerisms/ Gestures/Body language		
Any other		
Indirect factors		
Societal expectations		
Relatives and family expectations		
Finances/Insurance		
Healthcare facilities		
Any other		

3. The themes emerging from Qualitative analysis of the reflective narrative will be analyzed with help of peers and use of scientific literature in order to find out the finer nuances, solutions and future course of action

Annexure -3 Format for identifying themes from reflections and suggested corrective measures

Most striking factor influencing behavior	Themes emerging from reflection	Future Course of action	Suggestions from faculty/experts

Study design: Descriptive study
Sample size: A minimum of 30 narrations will be recorded as reflective narrative and analyzed.
Subject area: Medicine
Selection of subjects: Since the study does not directly involve patients, only the incidents will be recorded as reflections without disclosing identities.

Study tools:
1. Reflective writing format based on "Gibb's cycle" of reflections writing.

(Annexure -I)
2. Analysis of event based on 5 point likert scale and its description

(Annexure II)
3. Themes emerging from reflection for finding areas needing interventions

(Annexure III)

Statistical Analysis: Qualitative and Quantitative analysis using SPSS version 22

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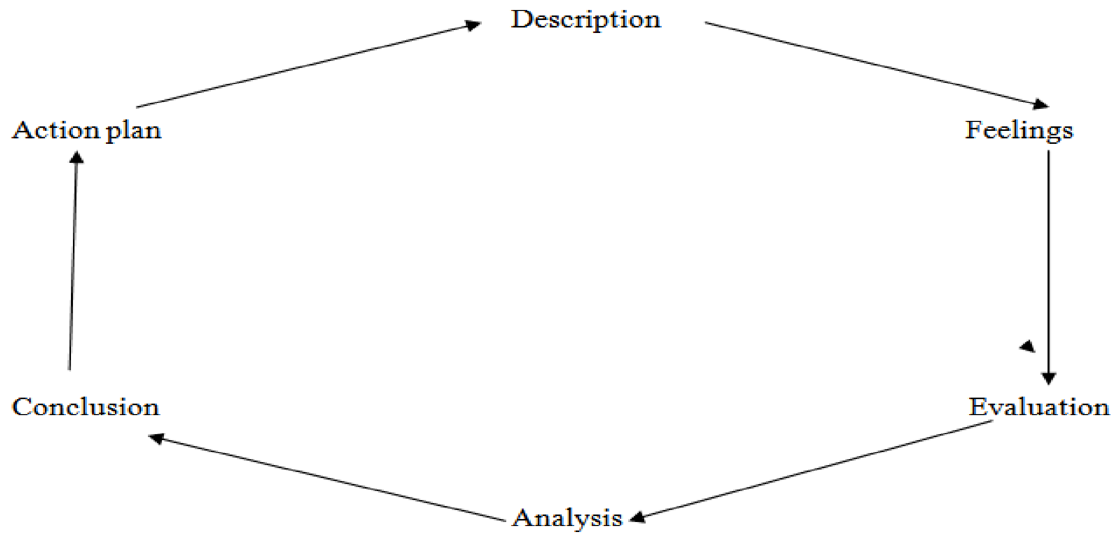
Implication /Outcome: The study shall help us to:

1. Understand and document the good and bad behaviors during doctor patient interactions
2. Help us analyze the cause of emotional reactions inherent in the interaction itself
3. Think of an action plan to reinforce good behaviors and modify the bad behaviors



II. RESULTS-

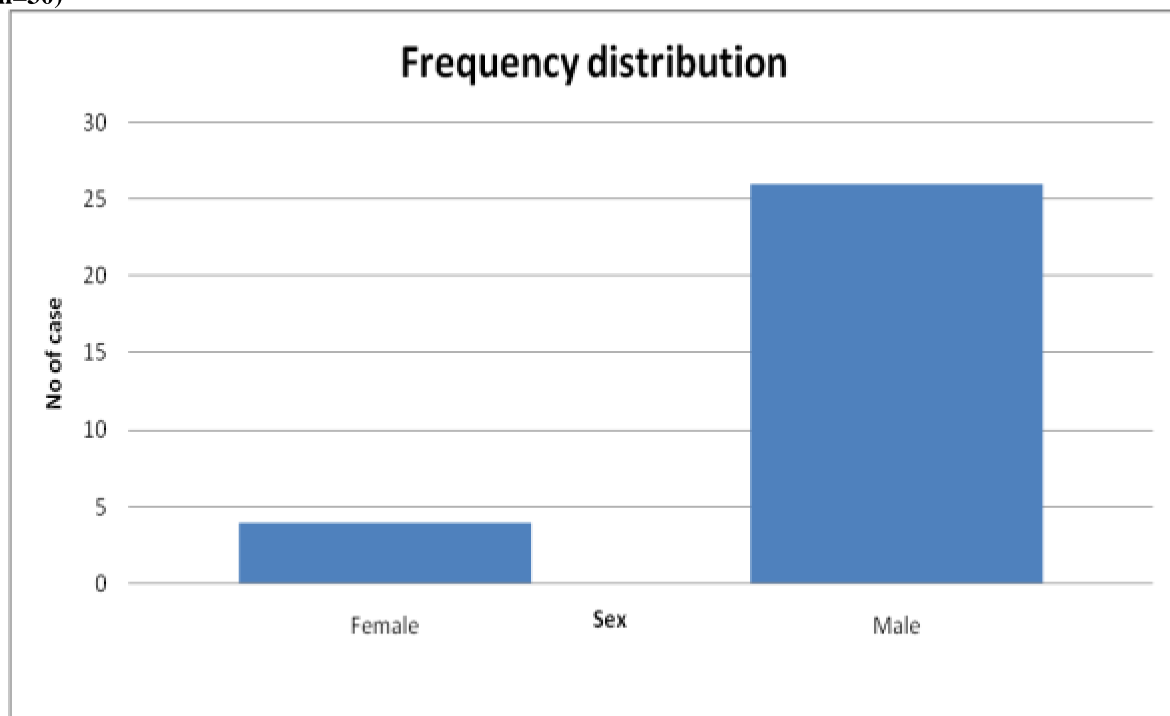
Table numberI: (n=30)

Themes emerging from reflection	Number of times the theme emerged in reflections	Most striking influencing behavior
‘ Trust’ and ‘faith’	10	Patient mentioned “doctor it was you, because of whom I am felling alright. I consulted a doctor, previously, but he couldn’t cure my illness, I am very thankful to you” doctor.
‘Unconditional faith’	2	Patient told “ doctor you are like God to me on this earth “but doctor said “ it’s not me who saved you, it’s God who blessed you, not me”
A ‘caring’ and ‘trustworthy’ doctor	3	Patient mentioned the caring nature of doctor and hospital staff as he mentioned that doctor always asks “is there any problem with you in the hospital”?
Trust builds up and perpetuates	8	Patient told “doctor you have taken out our child from the mouth of death when all other had lost hope .The doctors of Himalayan have saved the life of our child” Extreme trust in doctor’s capability which was extrapolated to entire doctor community working at our institute.
‘Considerate’ and ‘empathetic’ behaviour of thee doctor was appreciated	1	Patient mentioned “doctor I am a poor person I can’t afford the treatment but if you have not told us about the schemes rum by government for the benefit of poor people I won’t be able to get that benefit

		and receive the treatment"
Respect for patients	1	The consultant/physician mentioned during ward rounds: "Patient are your real guru respect them." Patients are real life books
concern about patient welfare	1	Doctor told to patient's attendant "You must take medication in appropriate dose and on a regular basis"
Poor communication	3	"You did not mention that this medicine will cause me these rashes and I am not feeling well" Improper communication which led to patient blaming the doctor. Adverse effects and consequences must be communicated.
Cultural competence	1	"The doctor talked to me in my language" The doctor was aware of societal norms language that patent can understand that doctor was culturally competent

Graph I: Gender wise distribution of patients

(n=30)



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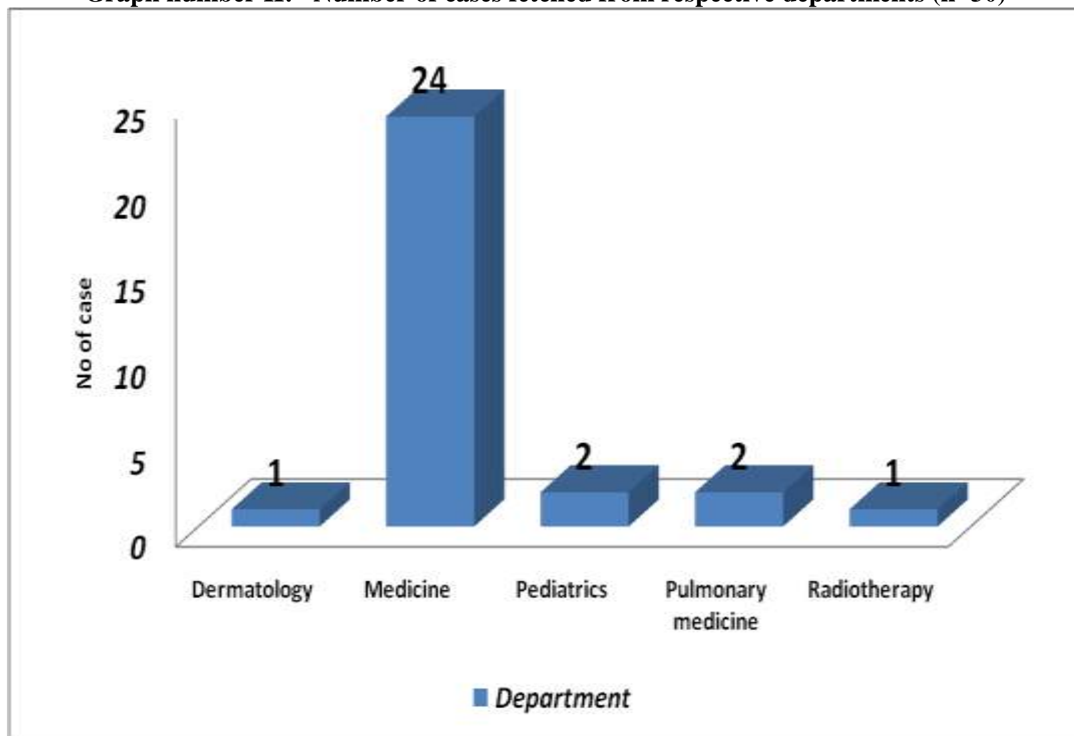
Graph number II: Number of cases fetched from respective departments (n=30)



Graph number III: Broad category of behavior perceived by patients during doctor patient interactions (n=30)

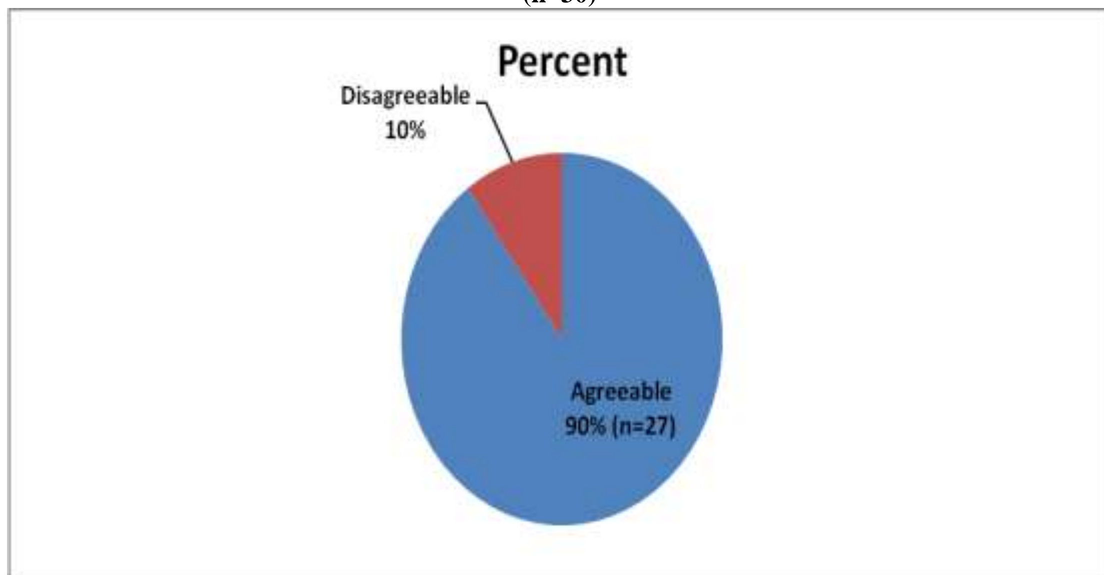


Table number II:Common factors influencing 'behaviors' in Doctor –patient interactions (n=30)

DIRECT FACTORS	INDIRECT FACTORS
Communication skills	Societal and family expectation
Trust	Relative and family expectation
Cultural competence	Finances/insurances
Mannerism/gesture/body language	Health care facilities

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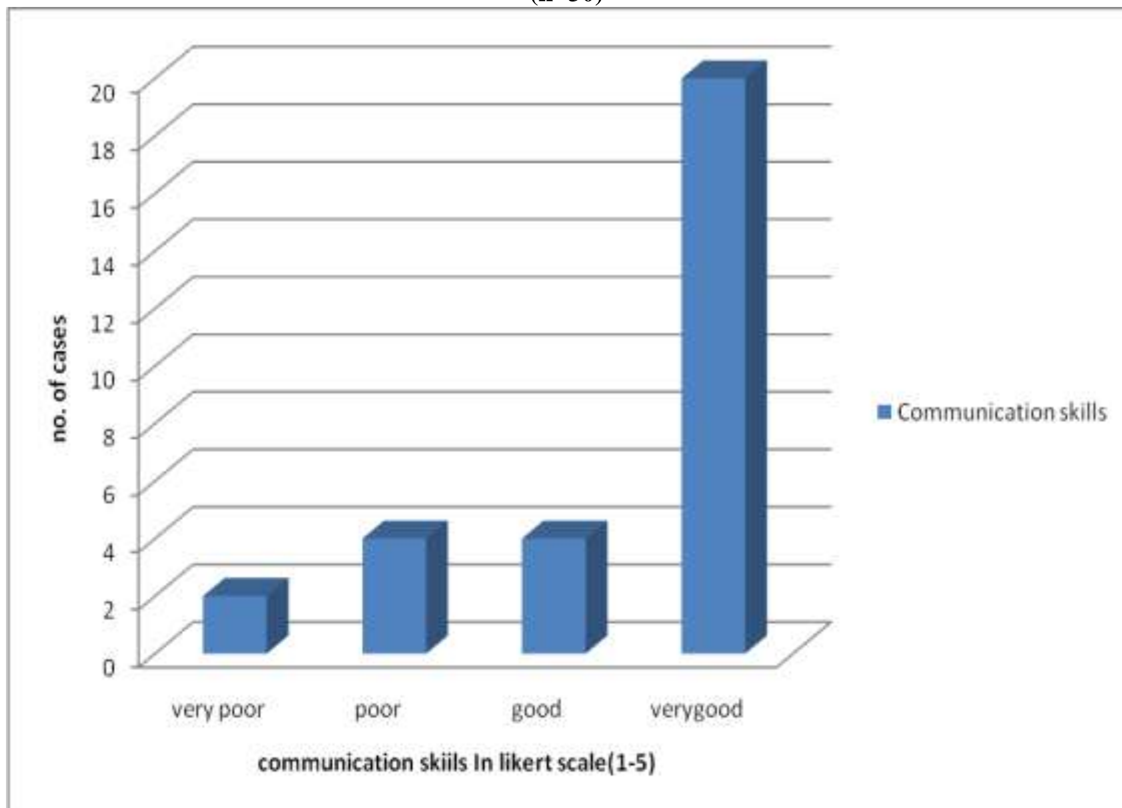
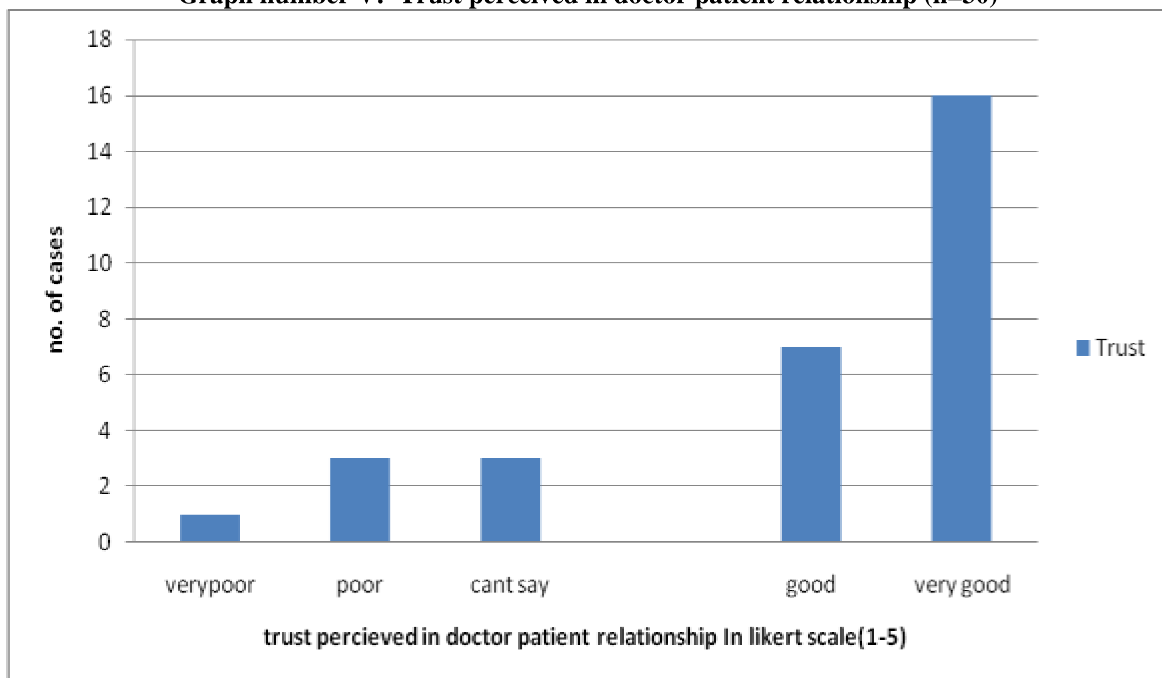
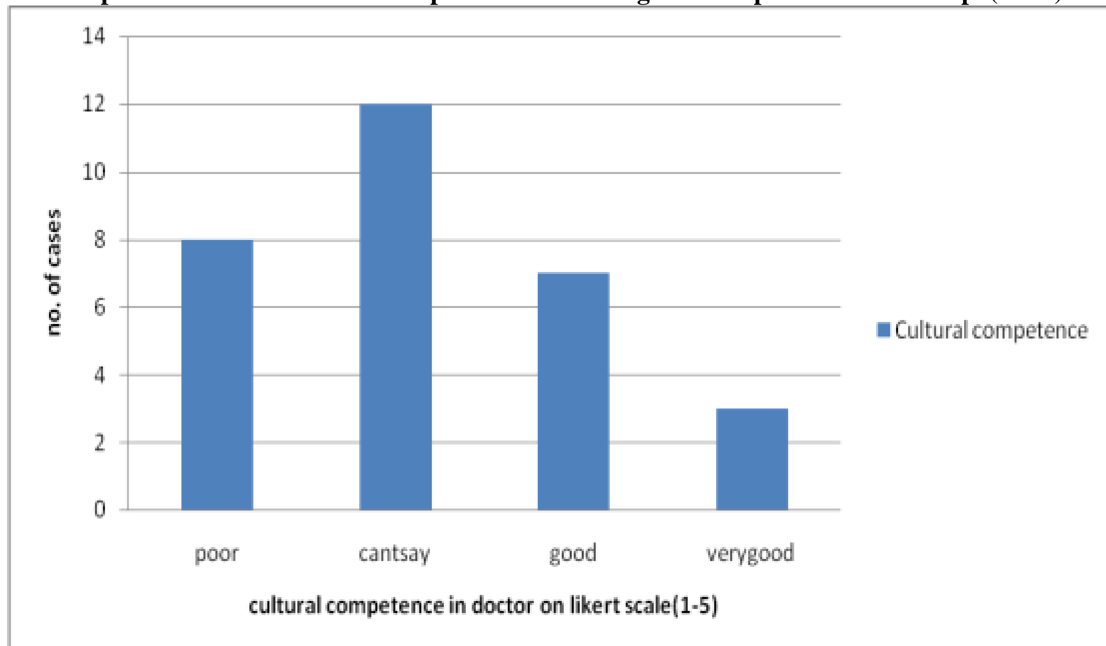
Graph number IV: Communication skills rating (Likert scale1-5)influencing doctor patient interactions. (n=30)



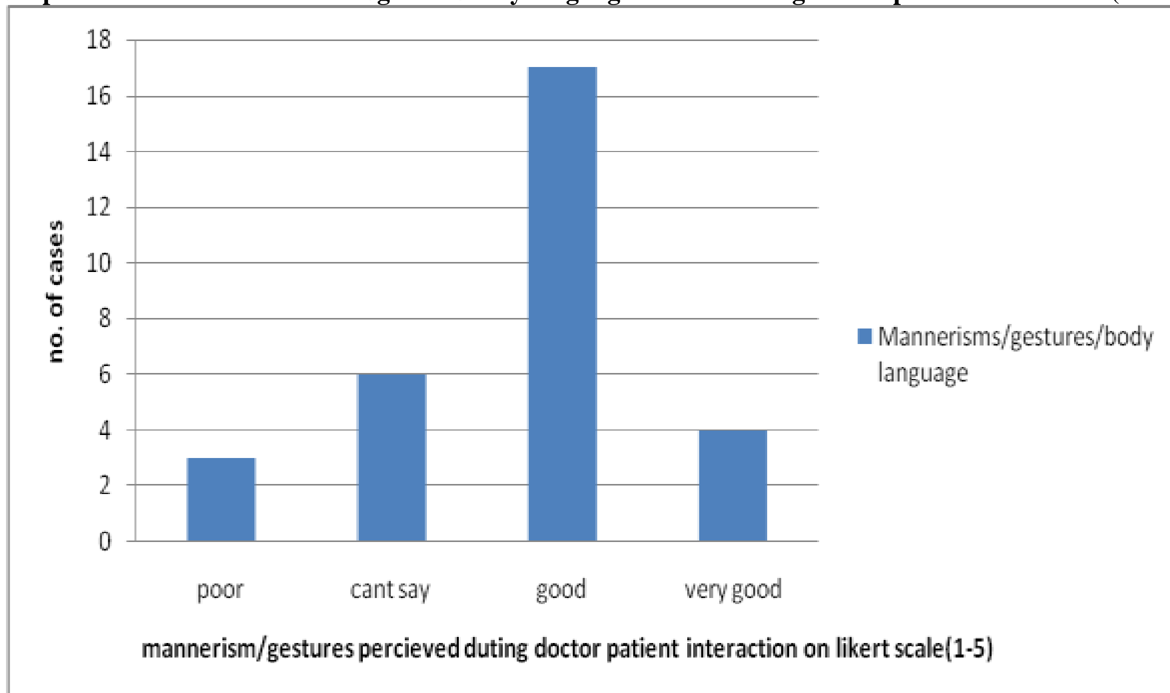
Graph number V: Trust perceived in doctor patient relationship (n=30)



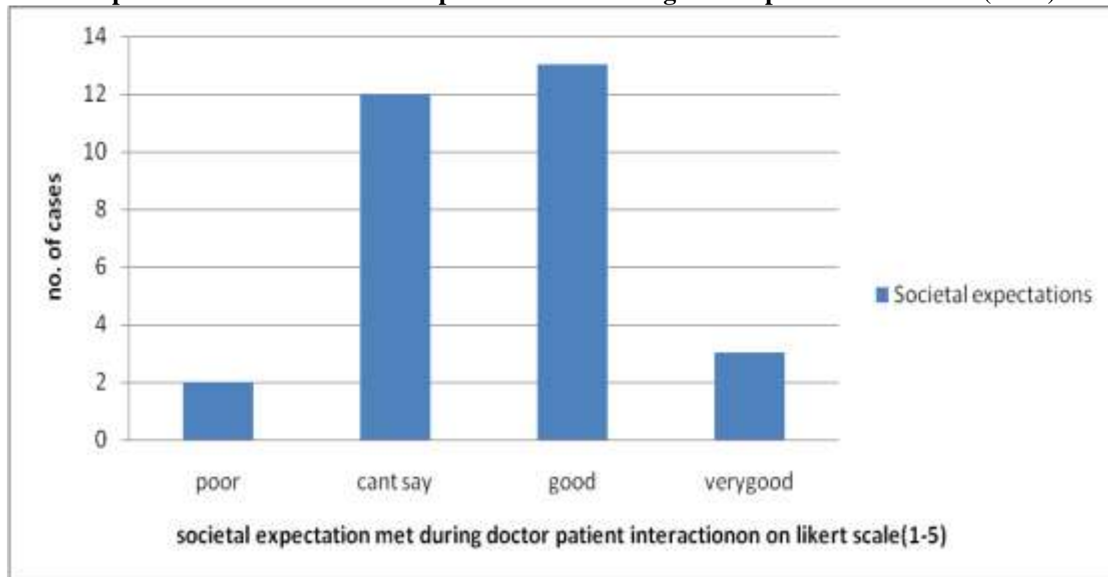
Graph number VI: cultural competence influencing doctor - patient relationship. (n=30)



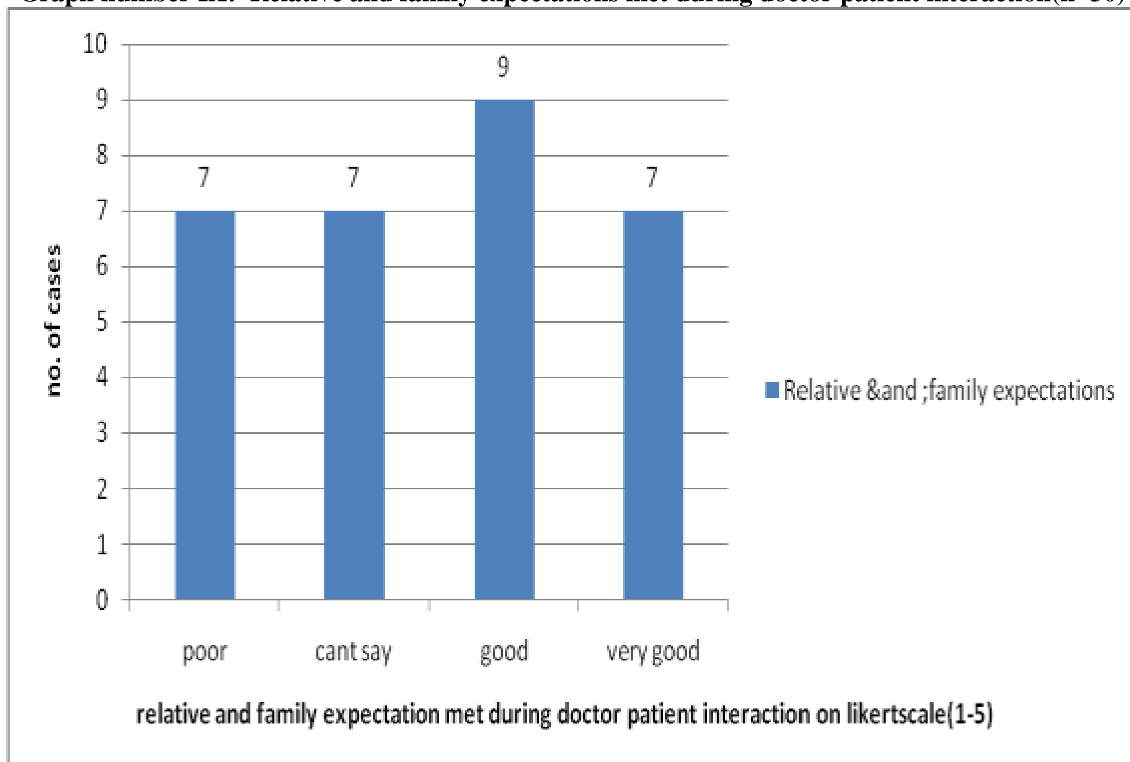
Graph number VII: Mannerism/gesture/body language noticed during doctor patient interaction (n=30)



Graph number VIII: Societal expectation met during doctor patient interaction.(n=30)



Graph number IX: Relative and family expectations met during doctor patient interaction(n=30)



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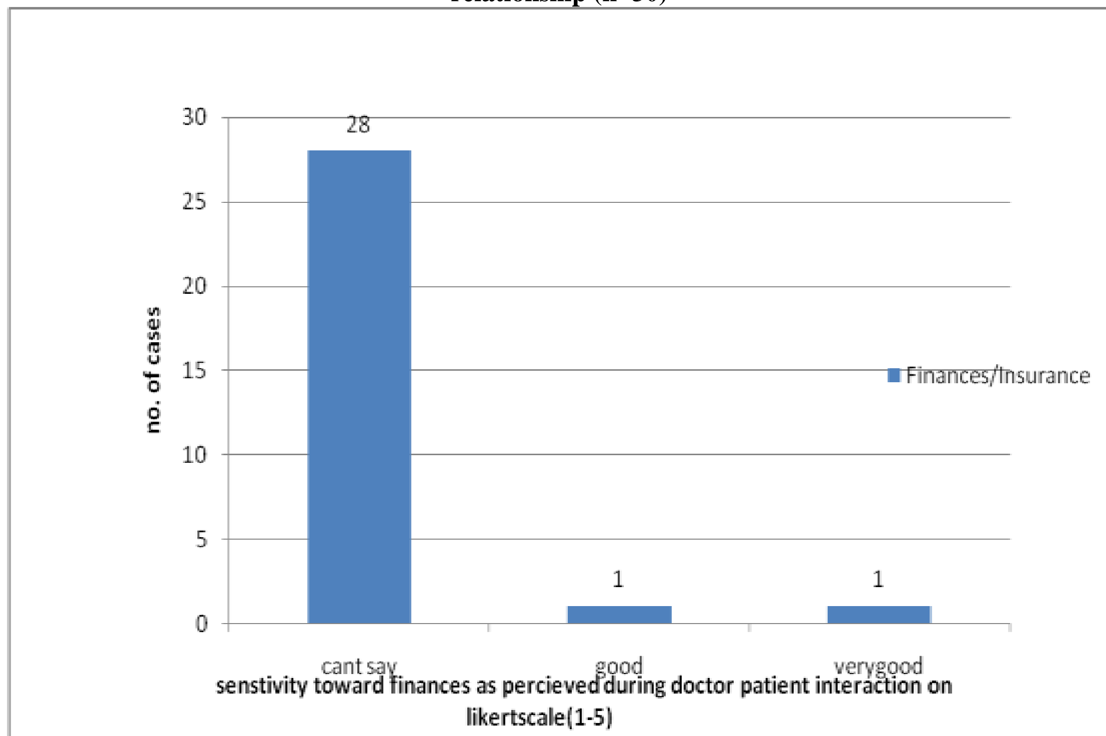
Graph number X: Sensitivity towards finances/insurance perceived during doctor patient relationship (n=30)



Graph number XI: Health care facilitiesas perceived by patient (n=30)

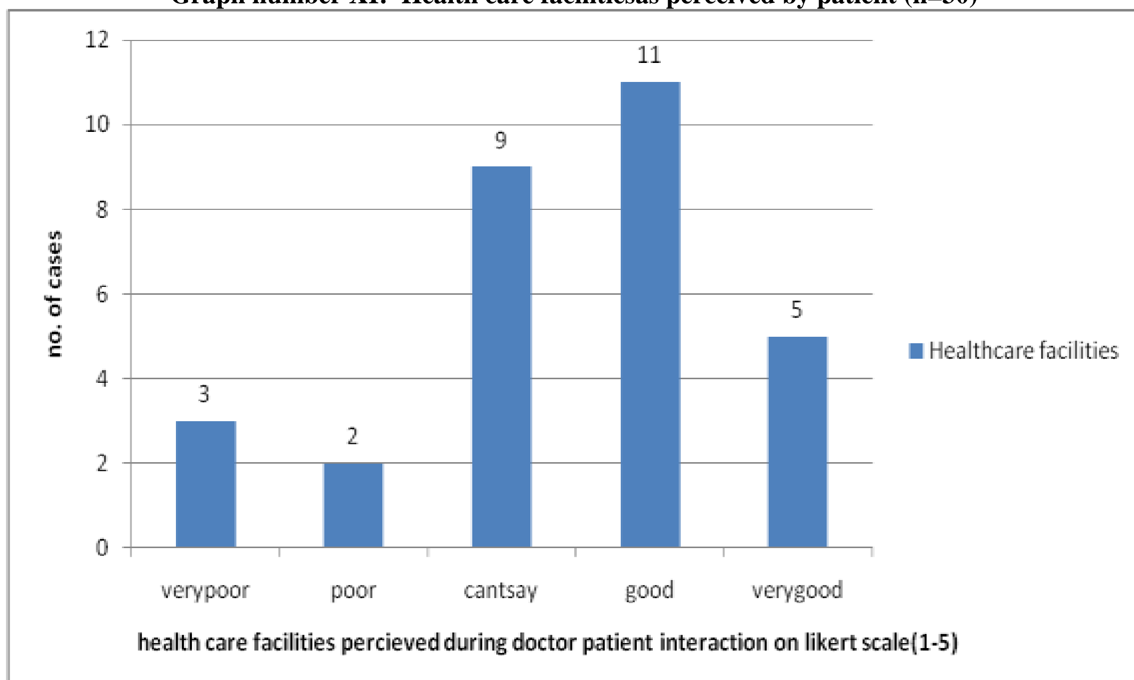


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Table number III:Descriptive Statistics of different factors with likert scale (n=30)

Descriptive Statistics	Mean ± Standard Deviation
Communication skills	4.20±1.34
Trust	4.13±1.16
cultural competence	3.17±0.95
Mannerisms/gestures/body language	3.73±0.828
Societal expectations	3.57±0.774
Relative ∧ family expectations	3.53±1.106
Finances/Insurance	3.10±0.403
Healthcare facilities	3.43±1.165

Table number IV:Mean difference of different factors affecting communication with respect to gender as per the patient's outlook-(n=30)

Variables	Sex	N	Mean± Std. Deviation	P-value
Communication skills	Male	26	4.23±1.366	0.756
	Female	4	4±1.414	
Trust	Male	26	4.15±1.156	0.811
	Female	4	4±1.414	
cultural competence	Male	26	3.23±0.992	0.355
	Female	4	2.75±0.5	
Mannerisms/gestures/body language	Male	26	3.65±0.846	0 .184
	Female	4	4.25±0.5	
Societal expectations	Male	26	3.62±0.752	0.389
	Female	4	3.25±0.957	
Relative and family expectations	Male	26	3.69±1.087	0.042*
	Female	4	2.5±0.577	
Finances/Insurance	Male	26	3.12±0.431	0.602
	Female	4	3±0	
Healthcare facilities	Male	26	3.35±1.164	0.304
	Female	4	4±1.155	

Values P<0.05 were taken as significant*

Table number V:Association of Communication with respect to gender as per the Doctor's outlook-(n=30)

Association denotes the relation between two variables influencing doctor patient relationship with respect to gender.

	Likert Scale (1-5)	Sex		Total	P-value
		Female	Male		
Communication skills	**1**	0	2	2	0.696
		0.0%	7.7%	6.7%	
	2	1	3	4	
		25.0%	11.5%	13.3%	
	4	1	3	4	
		25.0%	11.5%	13.3%	
	5	2	18	20	
		50.0%	69.2%	66.7%	

Values P<0.05 were taken as significant*

Association between gender (male and female) and communication skill is **insignificant** as denoted by P-Value-0.696, which ideally should be (<0.05) means doctor polite and caring nature does not varies with the gender of patient and the doctor treat each patient equally.

Table numberVI:Association of "Trust" with respect to gender as per the Doctor's outlook-(n=30)

		Sex		Total	P-value
		Female	Male		
TRUST	1	0	1	1	0.7960
		0.0%	3.8%	3.3%	
	2	1	2	3	
		25.0%	7.7%	10.0%	
	3	0	3	3	
		0.0%	11.5%	10.0%	
	4	1	6	7	
		25.0%	23.1%	23.3%	
	5	2	14	16	
		50.0%	53.8%	53.3%	

Values P<0.05 were taken as significant*

Association between gender (male and female) and trust is **insignificant** as denoted by P-Value-0.7960, which ideally should be (<0.05).means doctor has equal trust on both male and female and he is equally honest to both male and female and he consider them equal.

Table number VII: Association of 'Cultural competence' with respect to gender as per the Doctor's outlook-(n=30)

	Cultural competence	**Sex**		Total	P-value
		Female	Male		
Cultural competence	2	1	7	8	0.398
		25.0%	26.9%	26.7%	
	3	3	9	12	
		75.0%	34.6%	40.0%	
	4	0	7	7	
		0.0%	26.9%	23.3%	
	5	0	3	3	
		0.0%	11.5%	10.0%	

Values P<0.05 were taken as significant*

Association between gender (male and female) and cultural competence is **insignificant** as denoted by P-Value-0.398, which ideally should be (<0.05), means that doctor cultural competence does not change with patient gender he has respect for all culture and does not discriminate patient on the basis of caste, creed and culture.

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Table number VIII:Association of 'Mannerisms/gestures/body language' with respect to gender as per the Doctor's outlook-(n=30)

		sex			
		Female	Male	Total	P-value
Mannerisms/gestures/body language	2	0	3	3	0.5460
		0.0%	11.5%	10.0%	
	3	0	6	6	
		0.0%	23.1%	20.0%	
	4	3	14	17	
		75.0%	53.8%	56.7%	
	5	1	3	4	
		25.0%	11.5%	13.3%	

Values P<0.05 were taken as significant*

Association between gender (male and female) and mannerism/gesture/body language is **insignificant** as denoted by P-Value-0.5460, which ideally should be (<0.05),means doctor's,attitude, manner and emotions does not vary according to gender of patient they are equal for each patient.

Table numberIX:Association of 'Societal expectations' with respect to gender as per the Doctor's outlook-(n=30)

		Sex			p-value
		Female	Male	Total	
Societal expectations	2	1	1	2	0.377
		25.0%	3.8%	6.7%	
	3	1	11	12	
		25.0%	42.3%	40.0%	
	4	2	11	13	
		50.0%	42.3%	43.3%	
	5	0	3	3	
		0.0%	11.5%	10.0%	

Values P<0.05 were taken as significant*

Association between gender (male and female) and societal expectation is insignificant as denoted by P-Value-0.377, which ideally should be(<0.05) means that sometimes the society thinks that male patient should be given priority than females in receiving treatment but the doctor does not think as society thinks and he does not judge the people on basis of caste gender etc.

Table number X:Association of 'Relative and family expectations' with respect to gender as per the Doctor's outlook-(n=30)

		Sex			p-value
Relative and family expectations		Female	Male	Total	
		50.0%	19.2%	23.3%	
	3	2	5	7	
		50.0%	19.2%	23.3%	
	4	0	9	9	
		0.0%	34.6%	30.0%	
	5	0	7	7	
		0.0%	26.9%	23.3%	

Values P<0.05 were taken as significant*

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Association between gender (male and female) and relative and family expectation is insignificant as denoted by P-Value-0.153, which ideally should be (<0.05) means as there is a belief in the society that male should be properly cured as male is dominating he have to go to work and earn his livelihood and the female has to sit at home only she can receive treatment later, but the doctor doesnot think the way the relatives think he treat his all patient equally and give them equal priority.

Table number XI:Association of 'Finances/Insurance schemes' with respect to gender (n=30)

		sex		Total	p-value
		Female	Male		
Finances/Insurance	3	4	24	28	0.848
		100.0%	92.3%	93.3%	
	4	0	1	1	
		0.0%	3.8%	3.3%	
	5	0	1	1	
		0.0%	3.8%	3.3%	

Values P<0.05 were taken as significant*

Association between gender (male and female) and finance/insurance is insignificant as denoted by

P-Value-0.848, which ideally should be (<0.05) means the government has launched various health schemes for poor people who can't receive the treatment these insurance schemes are not given according to gender for patient these schemes are for everyone and all poor patient has a equal right on these schemes and doctor tells to each and every patient about the schemes run by the government.

Table number XII:Association of 'Healthcare facilities'and gender (n=30)

		Sex		Total	p-value
		Female	Male		
Healthcare facilities	1	0	3	3	0.188
		0.0%	11.5%	10.0%	
	2	0	2	2	
		0.0%	7.7%	6.7%	
	3	2	7	9	
		50.0%	26.9%	30.0%	
	4	0	11	11	
		0.0%	42.3%	36.7%	
	5	2	3	5	
		50.0%	11.5%	16.7%	

Values P<0.05 were taken as significant*

Association between gender (male and female) and health care facilities is insignificant as denoted by P-Value-0.188, which ideally should be (<0.05) means health care facilities are equal for both male and female there is no discrimination between male and female in terms of health care facilities.

Table number XIII: Correlation between Health care facilities and factors affecting doctor-Patient encounters (n=30)

CORRELATION

Variable	Health Care facilities	
	Pearson Correlation Coefficient	P value
Communication skills	0.667	0.000**
Trust	**0.**565	**0.000****
Mannerism/gesture/body language	0.625	0.001**
Societal expectation	0.483	0.007*
Relative and family expectation	0.671	0.000**

Values P<0.05* and P<0.001 **were taken as significant*

III. DISCUSSION:

In the study there were 3 females and 27 males (fig-1).There were 24 patients from medicine and rest from departments of Paediatrics, Pulmonary medicine, dermatology and Radiotherapy (Fig-2). Ninety percent of doctor patient interactionshowed agreeable behavior and 10% showed disagreeable behavior.(Fig 3).

There were various direct and indirect factors affecting doctor - patient interactions as assessed using 5 point likert scale (Fig 5,6,7,8,9,10,11,and table 3 and 4)

"Mutual respect, trust and faith" were perceived as agreeable behavior. In one of the interactions, the patient mentioned "doctor you are like God to me on this earth".(table1) Similar behavior was found in the study done by Amitav banerjee et al. which revealed that patient's trust in the physician, leads to better interaction, irrespective of the socio- cultural determinants.[3,6, 14, 15, 21,22,27]Therewas not only respect for the patient but also the doctor conveyed to students that they should respect the patient to earn that respect as in one interaction doctor told that "Patient are your real guru respect them."(table1)

In one of the interactions, the patient was highly thankful to doctor when doctor explained him how to measure the dose of medication for the child aged 4 years and insisted upon the significance of taking medication regularly. Patient was thankful to doctor as no one had explained to him earlier how to measure the dose as per weight and ageof the child.

In anotherinteraction, the doctor told "You must take medication in appropriate dose and on a regular basis" (table1)and this generated enormous trust in the patient.. [2,5,16] Ina study byRidd M et al.it was reported that the"depth of patient–doctor relationship comprises four main elements: knowledge, trust, loyalty, and regard"[7,12, 13,24,28]

Our study revealed that the doctorwas also aware of societal norms and expectations .He spoke in the language that patient understoodwell. "The doctor talked to me in my language".(table1) The doctor modulated his conversation and the interaction in a manner that helped maintain confidentiality and did not divulge the information to others.In a study by Bowling, Ann et al.,a great emphasis has been laid ona robust doctor-patient relationship which forms the basis of healthy interactions and trust, ensuring a more satisfying treatment .[11,18,23,27,32,34]The patient also felt that the doctor was very competent and understood the societal norms and taboos. The doctor made the confidentiality by taking patient to a separate chamber for taking history.

The doctor's consideration for economic status of patient is another virtue that the patient appreciatedwhen he says "doctor I am a poor person I can't afford the treatment but if you have not told us about the schemes rum by government for the benefit of poor people I won't be able to get

that benefit and receive the treatment".(table1)Patient also appreciated the health care facilities and expresses that the wards were neat and clean, the nursing staff attended to them all the time the patient who came through the scheme 'AYUSHMAAAN BHARAT' has equally satisfaction from health care facilities

Doctor maintained a good eye contact with patient and doctor was a good listener and he was very responsiveto queries and did not get irritated or frown during the interaction.

Doctor was also aware of expectation of family, especially when it comes to patient of pediatric age group,the patient was worried about the prognosis of disease as the child was suffering from tetanus and the prognosis can be grave. The doctor understood the gravity of situation and explained well to the patient the treatment of diabetes in a child required lifelong treatment and when this was told to the patient, the initial acceptance was poor but when doctor explained complications of disease and need for strict compliance the family was convinced and trusted the doctor and started to take the medicine regularly similar behavior was observed in previous study done byVon Bultzingslowen I, Eliasson G, Sarvimaki A, et al. and observed that doctor are trustworthy as perceived by patient.[17,19,20,25,30]

A disagreeable behavior was also encountered where the patient expressed annoyance after he developed rashes due to a medication. He argued that the doctor should have warned him before about the possibility of adverse effect. "You did not mention that this medicine will cause me these rashes and I am not feeling well"(table1),a similar behavior was studied byHa JF, Longnecker N et al. where he mentioned much patient dissatisfaction and many complaints are due to breakdown in the doctor-patient relationship.[3,21,22,26]

Asfrom association of communication we can see that the factors influencing doctor- patient relationship have an average of (>3) that is good for the healthy relationship.So we can say that most of doctors have good communication skills, trust cultural competence, mannerism/gestures/body language and the health facilities are good and appropriate.. [23, 24,29]

Relative and family expectation in males has a central tendency of 3.69and overall variability is 1.087while in females it has a central tendency of 2.50 and overall variability of 0.577. The relatives and family's expectation are significant with respect to gender,the relatives of a male patient have much more expectation from doctor, that the patient should be treated properly with due respect and care and should have proper facilitiesas (P-value is 0.042). (table4)

However, the doctor was not biased towards any gender during Doctor-patient interaction Communication skills in males has a central tendency (average) of 4.23 and overall variability is 1.36 while in females it has a central tendency of 4.00 and overall variability of 1.41 but the communication skill does not depend on the gender of patient as P-value is 0.756 which signifies that the communication skill is statistically **insignificant**. (Table-4)

The association between Communication, trust, cultural competence, mannerisms and gestures, societal expectations, relatives and family expectations, finances and Health care facilities was insignificant, implying that these factors did not affect the doctor's perspective or treatment ((Table-5 -12)

As from the above data (table 4) no other variable(Trust, cultural competence, mannerism/gesture/body language, societal expectation, finances, health care facilities is statistically insignificant as all variables have a P-value (>0.05).with respect to gender

Correlation basically denotes the strength of relationship. From above data (table 13) we can interpret that there is positive correlation between health care facilities and among different variables that are communication skills, trust, mannerism/gesture/body language, societal expectation and relative and family expectation which means that variables are directly related to health care facilities for example if communication skills of doctor are improved then health care facilities show improvement and this will strengthen the relation between doctor and patient.

FUTURE COURSE OF ACTION-

Doctor should be **confident and polite** in nature because polite nature of doctor can make the patient comfortable and he can share his problems with the doctor and they should **trust** each other and should be honest to each other in addition the Government should make more schemes like **'AYUSHMAAN BHARAT'** for the poor people so that they can afford the treatment and enjoy their lifeand Doctor should also be able to maintain **confidentiality**because many patientsdo not come to doctor in thinking that if we will go to doctor then everyone will know about the condition like (HIV) and then no one will talk with us and we will be isolated by the society and at last.Doctor should not be greedy and should not always try to make

money by prescribing unnecessary investigations and drug.
Suchbehavior of doctor would lead to a healthy doctor-patient relationship in future.

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REFERENCES:

[1]. McGillivray, Thomas E. “Advancing the Culture of Patient Safety and Quality Improvement.” Methodist DeBakey cardiovascular journal vol. 16,3 (2020): 192-198.
[2]. Mendoza, Michael D et al. “The seventh element of quality: the doctor-patient relationship.” Family medicine vol. 43, 2 (2011): 83-9.
[3]. Morzinski, Jeffrey A et al. “Students' Critical Incidents Point the Way to Safer Patient Care Transitions.” WMJ: official publication of the State Medical Society of Wisconsin vol. 115,2 (2016): 81-5.
[4]. Shapiro, Johanna. “Perspective: Does medical education promote professional alexithymia? A call for attending to the emotions of patients and self in medical training.” Academic medicine : journal of the Association of American Medical Colleges vol. 86,3 (2011): 326-32.
[5]. Hulka, B S et al. “Communication, compliance, and concordance between physicians and patients with prescribed medications.” American journal of public health vol. 66,9 (1976): 847-53.
[6]. Banerjee, Amitav, and Debmitra Sanyal. “Dynamics of doctor-patient relationship: A cross-sectional study on concordance, trust, and patient enablement.” Journal of family & community medicine vol. 19, 1 (2012): 12-9
[7]. Roter, D L et al. “Communication patterns of primary care physicians.” JAMA vol. 277,4 (1997): 350-6..
[8]. Krumholz, H M et al. “Prognostic importance of emotional support for elderly patients hospitalized with heart failure.” Circulation vol. 97,10 (1998): 958-64.
[9]. Elo, Satu, and Helvi Kyngäs. “The qualitative content analysis process.” Journal of advanced nursing vol. 62,1 (2008): 107-15..
[10]. Emanuel, E J, and L L Emanuel. “Four models of the physician-patient relationship.” JAMA vol. 267,16 (1992): 2221-6.
[11]. Tongue, John R., Howard R. Epps, and Laura L. Forese. "Communication Skills for Patient-Centered Care. Research-Based, Easily Learned Techniques for Medical Interviews That Benefit Orthopaedic Surgeons and Their Patients." Journal of Bone and Joint Surgery 87.3 (2005)652.
[12]. Razzaghi, Mohammad Reza, and Leila Afshar. “A conceptual model of physician-patient relationships: a qualitative study.” Journal of medical ethics and history of medicine vol. 9 14. 8 Nov. 2016
[13]. Akerkar SM, Bichile L S. Doctor patient relationship: Changing dynamics in the information age. J Postgrad Med 2004; 50:120-2.
[14]. House, J S et al. “Social relationships and health.” Science (New York, N.Y.) vol. 241,4865 (1988): 540-5.
[15]. Beach, Mary Catherine et al. “Relationship-centered care. A constructive reframing.” Journal of general internal medicine vol. 21 Suppl 1,Suppl 1 (2006): S3-8.
[16]. Chin, J J. “Doctor-patient relationship: a covenant of trust.” Singapore medical journal vol. 42, 12 (2001): 579-81.
[17]. Zolnierek, Kelly B Haskard, and M Robin Dimatteo. “Physician communication and patient adherence to treatment: a meta-analysis.” Medical care vol. 47,8 (2009): 826-34.
[18]. Biglu, Mohammad-Hossein et al. “Communication Skills of Physicians and Patients' Satisfaction.” Materia socio-medica vol. 29,3 (2017): 192-195.
[19]. Hall, M A et al. “Trust in physicians and medical institutions: what is it, can it be measured, and does it matter?.” The Milbank quarterly vol. 79,4 (2001): 613-39, v.
[20]. Agarwal, Aakash Kumar, and Beth Brianna Murinson. “New dimensions in patient-physician interaction: values, autonomy, and medical information in the patient-centered clinical encounter.” Rambam Maimonides medical journal vol. 3,3 e0017. 31 Jul. 2012.
[21]. Baker, Richard et al. “Exploration of the relationship between continuity, trust in

regular doctors and patient satisfaction with consultations with family doctors." Scandinavian journal of primary health care vol. 21,1 (2003): 27-32.

[22]. Kerse, Ngaire et al. "Physician-patient relationship and medication compliance: a primary care investigation." Annals of family medicine vol. 2,5 (2004): 455-61..

[23]. Bowling, Ann et al. "Patients' experiences of their healthcare in relation to their expectations and satisfaction: a population survey." Journal of the Royal Society of Medicine vol. 106,4 (2013): 143-9.

[24]. Ridd, Matthew et al. "The patient-doctor relationship: a synthesis of the qualitative literature on patients' perspectives." The British journal of general practice : the journal of the Royal College of General Practitioners vol. 59,561 (2009): e116-33

[25]. DiMatteo, M R. "The role of the physician in the emerging health care environment." The Western journal of medicine vol. 168,5 (1998): 328-33.

[26]. Ha, Jennifer Fong, and Nancy Longnecker. "Doctor-patient communication: a review." The Ochsner journal vol. 10,1 (2010): 38-43..

[27]. Goold, Susan & Lipkin, Mack. (1999). The doctor-patient relationship - Challenges, opportunities, and strategies. Journal of general internal medicine. 14 Suppl 1. S26-33.

[28]. Weng, Hui-Ching. "Does the physician's emotional intelligence matter? Impacts of the physician's emotional intelligence on the trust, patient-physician relationship, and satisfaction." Health care management review vol. 33,4 (2008): 280-8.

[29]. Chipidza, Fallon E et al. "Impact of the Doctor-Patient Relationship." The primary care companion for CNS disorders vol. 17,5 10.4088/PCC.15f01840. 22 Oct. 2015, doi:10.4088/PCC.15f01840.

[30]. Siddiqui, Shahla et al. ""What families want - an assessment of family expectations in the ICU"." International archives of medicine vol. 4 21. 22 Jun. 2011

[31]. El-Haddad, Carlos et al. "Understanding Patient Expectations of Health Care: A Qualitative Study." Journal of patient experience vol. 7,6 (2020): 1724-1731.

[32]. Hall, J A et al. "Communication of affect between patient and physician." Journal of health and social behavior vol. 22,1 (1981): 18-30.

[33]. Stewart, M et al. "The impact of patient-centered care on outcomes." The Journal of family practice vol. 49,9 (2000): 796-804