

# The Doctor and Medical Student's Perspectives of the Doctor-Patient Relationship: An analysis of communication

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## Abstract

This pilot qualitative study of the doctor and medical student's perspective of the doctor-patient relationship has a specific focus on communication through analysis of their perspectives on communication, limitations, and stresses based on seven semi-structured interviews. The research identified an acceptance of patient empowerment, with homologised relationships, but time limitations hindered addressing the psycho-social issues of the patient. Notably emotional detachment and depersonalisation was favoured by the interviewees as the best mechanism to handle stress. The study identifies that even in the early stages of the life of the doctor the hospital environment causes stress and exhaustion. This highlights the need for alleviation of time pressures within the medical framework and that modern, integrated support and guidance is made available to doctors in order that stress does not impinge on the doctor-patient relationship.

**Key Words:** Doctor-patient relationship, communication, stress, time limitations, depersonalization, empowerment

## Introduction

In today's economic climate there is much discussion around lack of resources, and as healthcare represents one of the largest expenditures in the world for governments, where the National Health Service (NHS) accounted for just over 8 percent of the UK GDP in 2010 and in Ireland the Health Service Executive (HSE) 9.2 percent (OECD Health Data 2012). With reports of service withdrawals and suicide among junior doctors' leads us to ask what is the doctor's perception of the healthcare system and how does this affect the doctor patient relationship?

The doctor-patient relationship is a social system in which roles are defined. Social iatrogenesis highlights the need for patient empowerment (Illich 1976), where people care about the medical experience that their doctor has, but do they realise the impact that the doctor's *actual* experience might have on the doctor themselves and hence the patient?

Junior doctors are 'seen as essential to maintaining services because of a lack of senior consultants', where there is heavy reliance on junior doctors who *still* are working outside the European Working Time Directive (Cullen 2013). Approximately 7,000 junior doctors are employed by the NHS and 4,500 by the HSE, but with one in four junior doctors dropping out of NHS training after two years (Medical Programme Board 2010), and with findings of 23 percent not applying for the next stage of training (Temple 2010), this could be seen as a waste of state expenditure and training resources. However *why* do these dropout rates exist after the effort to gain a place within medical school? This research analyses the perspectives of junior doctors and medical students to provide insight into their decision making and practices in relation to patient care, through the hypothesis that doctor/patient satisfaction in health care delivery is affected by the prevalence of

culturally determined hierarchical biases and each medical practitioner's capacity to negotiate a high pressure working environment.

## Communication

Patient satisfaction is achieved through the communication behaviours of doctors; their dominance, concern about the psycho-social issues of the patient, illness perceptions, concordance between the doctor's communication style, the patient's need for attachment, and the patient's attitude (Frostholm *et al.* 2005, Clever *et al.* 2008, Frederiksen *et al.* 2010, Cousin *et al.* 2012, Rathnakar *et al.* 2013). There are varied expectations and levels of patient satisfaction due to the omnipresent socio-cultural matrix where the doctor-patient relationship is influenced by different cultural interpretations; class, gender roles, ethos, language, and religious affiliation (Haugh and Lavin 1981; Nápoles 2009; Kelly-Irving *et al.* 2011; Verlinde *et al.* 2012).

As the doctor's perception is what leads to patient satisfaction and clear evaluation during clinical judgement, there must be no 'negative space' for communication; 'silence and related verbal and nonverbal actions, such as emotional detachment, may be intended to minimise the risk of injury to the doctor, the patient, or both'. However, this behaviour has the potential to 'produce a reactive sense of loneliness or abandonment in patients, reducing the quality of decision making and the health care experience' (Buetow 2009:81). However, from the doctor's perspective, 'silent times potentially benefit the patient as part of the therapeutic aims, enabling the patient to carry out an 'internal search' (Gibbins-Issac *et al.* 2012:1), identifying empowerment within the doctor-patient relationship.

## Empowerment

The doctor-patient consultation previously had a set format, 'in assuming the sick role, the patient expects to offer cooperation and compliance to the doctor, in return for some assurance that attempts will be made to relieve the

distress' (Leigh and Reiser 1985:35). This approach has now in the main been overhauled as a growing number of patients' recognise their power within the relationship, where due to 'the global spread of modernity, social interactions between patients and their (modern) doctors exhibit an impulse towards role convergence and consequent homologisation in clinical encounters' (Buetow 2009:102). The patient now understands both the benefits *and* the risks of modern medicine, desiring all information before placing their trust in the doctor (Horton 2003:40). This implies that the patient is now the 'service user' and 'the client', where there is supposedly a more 'equal relationship between the professional and the purchaser of a service' (Scambler 2008:110). The medical model has evolved from paternalism to individualism (Ha *et al.* 2010). Information exchange and the health consumer movement have led to the current communication model of shared decision making and patient-centred communication (Ha *et al.* 2010:38)

The power of the doctor is seen to have been subdued through McKinlay and Arches (1985) theory of 'proletarianisation' identifying that a development of 'managerialism' within the healthcare system has reduced the doctor's control over clinical decision-making, along with the occurrence of deskilling due to technological developments (Scambler 2008:256). However, even within this 'managerialism' the essentiality of the doctors' services and skills enhances the doctors' status above all other professions due to their 'prolonged training in a specialised body, abstract knowledge and an orientation towards providing a service' (Cockerham 2007:189).

The status of a doctor can be biased as the enrolment of medical students has shown to not be equally represented, where 'relative to the general application profile to UK universities fewer applicants from lower socio-economic (parental occupation) groups apply to enter medicine' (Powis *et al.* 2007:1237). This therefore leads to an imbalance within the medical system, whereby the perspective of the doctor usually comes from a hierarchical stance. Research observing what happens during a consultation showed, 'physicians perceived they explained and listened more to patients from higher social classes', but gave lower social class individuals more 'other help', where they also 'examine more and give less advice to patients from lower social classes. However, the patients did not share these perceptions' (Willems 2005:142). This illustrates the communication barrier between the doctor and the patient due to socio-economic status and cultural stereotyping, suggesting that depending on the patient's social status an assessment of comprehension is perceived or not perceived. Health care professionals' 'lack of knowledge regarding patients' health beliefs and life experiences are important factors in the care of patients' (Lee and Coulehan 2006:691). Therefore, doctors' education of socio-economic and cultural circumstances, as well

as health beliefs, needs to be analysed to concord trust and patient enablement (Banerjee and Sanyal 2012).

### Stress

Levels of stress amongst medical trainees can vary (Shah *et al.* 2010), but failure to cope with stress has negative consequences for patient care and work performance. Stress can result from both pressure and a lack of control, leading to burnout. The term 'burnout' is used to describe a situation where someone is no longer performing well in their position. It is important to focus on the fact that they are *no longer* performing well, implying that they did perform well in the past. Burnout is the response to ongoing stress, where the individuals' coping resources have gradually depleted (Schwenke 2012).

In analysis of three private university-affiliated hospitals Millman found 'many doctors were willing to criticise their colleagues for errors in small group discussions and behind the other's back' however, they 'were strongly reluctant to criticise another doctor's mistakes at any official meeting' (Cockerham 2007:237). This was due to 'fear of reprisal' or a 'recognition of common interests', observing that a 'gentleman's agreement' existed among the hospital doctors to overlook each other's mistakes' (Cockerham 2007:237). Perhaps this is a recognition that within a competitive environment burnout among doctors is a predominant feature. Burnout is said to develop over time (Schaufeli *et al.* 2011:248) however, findings have shown that even within medical school 11 percent of students each year have serious thoughts of dropping out, which is associated with burnout (Dyrbye *et al.* 2010).

Among doctors the three key elements of burnout are; emotional exhaustion, depersonalisation and a lack of personal accomplishment (Schaufeli *et al.* 2011:250), where the long term impact of burnout has serious consequences, 'not only for the doctors involved and their families, but also for their patients and the health care system at large, for instance, because of medical errors and replacement costs' (Prins *et al.*, 2009; Spickard *et al.* 2002). The 'etiology of burnout lies in the situation, *i.e.*, in the structure and environment of organisations and professions, and not in the characteristics of clinicians themselves' (Deckard 1994:746). It is situations such as medical school that shapes students attitudes, values and behaviours, a preconceived ideal image (Becker 1961; Haidet *et al.* 2008). Perhaps Millman's theory on 'fear of reprisal' might stem from medical school, upholding medical ideas and ideals, and not wanting to disrupt proximal relationships.

Even though medical students have shown to be more vulnerable to illness as they 'experience high levels of stress, which adversely affects academic performance, professionalism, and health' (Estabrook 2008:65), the fear of reprisal is a barrier which prevents students seeking help, due to confidentiality concerns and fear of academic jeopardy (Estabrook 2008:66). This fear of reprisal carries through to the hospital, which can result in overload and burnout.

The process of depersonalisation can be used as a coping mechanism (Henning *et al.* 2009), where within research high scores have indicated the 'development of an uncaring attitude and the tendency to treat patients as

impersonal objects' (Deckard *et al.* 1994:749). If the doctor views the patient as an object, aiming to diagnose and treat without attachment or distinction, perhaps emotional exhaustion might decrease. Research has found that younger doctors were significantly more likely to be classified as experiencing higher levels of emotional exhaustion than older doctors (Deckard *et al.*'s 1994:749).

Depersonalisation may be viewed as an 'inappropriate coping response to the stresses of medical practice and the organisational structures in which they occur' (Deckard 1994:752). Doctors' burnout can be attributed to a sense of frustration and failure (Redinbaugh 2001:188). Health care professionals do 'engage in some coping behaviours that protect them from burnout, such as viewing work as a challenge, a sense of accomplishment from work and organising one's tasks' (Redinbaugh 2001:188). The stress of performance and dedication can counteract on accomplishment.

Medical students are facing threats of medical dominance declining, such as 'the emerging competitive threat from other health workers' (Nettleton 2008:216) gaining prestige within communities and with less reliance solely on the doctor's perspective. But a cycle does exist where doctors and others 'respond by changing *their* behaviour in order to circumvent the controls that are placed on their actions by others' (Annandale 2005:235). The doctor is expected to maintain performance, providing correct diagnosis and treatment, achieving optimal patient care, even in the face of time pressures and stressors which have been identified as prevailing contributors to incidents involving poor patient care (Firth-Cozens 1997:109).

### Methodology

This qualitative pilot study is based on seven semi-structured interviews with four junior doctors who had graduated from a selection of universities in Ireland and three medical students training in universities within the United Kingdom. Six of the participants were female, one was a male medical student, and all participants were in their twenties. This representative sample aimed to generate data to give an authentic insight into peoples' experiences (Silverman 1993:91), where just one case can lead to new insights (Frank 1995) as it is recognised that any such case is an instance in social reality (Crouch and McKenzie 2006:493). The interviews ranged from forty-five minutes to one hundred and ten minutes. Questioning whether health care delivery is affected by the doctor's approach to the patient, the research assessed the junior doctor and medical student's perspectives and perceptions on the obstacles and aspects within the hospital environment which challenged them, leading to a series of hypotheses;

1. Doctors recognise that the needs of the patient have changed
2. Doctors emotionally detach
3. Doctors emotionally detach as a coping mechanism
4. Doctors suffer from stress
5. Doctors attribute their stress to the framework of the work

environment

6. Doctors responsibilities impede on patient care

The interviews were recorded using a digital recorder, transcribed, anonymised, and analysed identifying the typology of the responses. The interviewees were given pseudo-names with MS (medical student) or JD (junior doctor) beside their quotes. The transcriptions were coded to find consistencies and variations, resulting in comparisons and emerging categories. The data was then processed and analysed to show the findings of the research. Since the goal was not to generalise from a random sample of participants to the entire population, as in a quantitative study, the relatively modest sample size was considered appropriate and adequate for this pilot study. The study was approved by the University College Dublin Human Research Ethics Committee (Humanities) in Ireland.

### Findings

This research provided insight into the doctor-patient relationship, specifically the matter of communication. The key themes identified were time constraints, empowerment, and emotional detachment.

#### Time Constraints

The interviewees placed a strong emphasis on the time constraints and limitations placed on doctors and how this creates barriers in communication.

*People come with very high expectations, which can be difficult, because there's only so much we can do in this amount of time. (Katie, JD)*

*One of the biggest barriers of communicating within the hospital is that doctors have so little time, and people would have no problem sitting down and spending a good hour with a patient if they had the time, but it's just impossible in your working environment. (Gill, JD)*

#### Communication Skills and Patient Empowerment

The communication skills of the interviewees indicated a lack of knowledge in relation to generational and social issues.

*Sure I was made to kiss a crucifix two days ago in work. A patient asked me to bless myself with her crucifix and I was like 'I don't actually know how to bless myself', so then she was like 'sure just give it a kiss', which was probably very much against health and safety and infection control, but anyway. (Juliet, JD)*

The need for a more honest and open relationship with the younger generation was identified, while possibly disregarding that elderly people may in fact be also capable of seeking and investigating choices and alternative options too.

*Younger people prefer to be told and then they can investigate, they'll look up different options themselves, then discuss it with the doctor, and then*

*you can say 'maybe this wouldn't be right for you. It's very different for different patients. (Juliet, JD)*

The need for patient empowerment was recognised by the interviewees, especially in the area of mental health.

*In psychiatry they're trying to move away from paternalistic towards empowering the patient, because there really is no point in getting a patient dependent on somebody else to make all their decisions for them (Emily, JD)*

#### *Empowerment and Authority*

The research identified a generation to generation communication pattern existing within the hospital framework, with consultants seen as the inner-core, holding supreme authority and by this methodology their communication skills are reproduced. However, there were contrasting opinions on the status of the consultant, for example one interviewee viewed consultants as god-like figures and was in awe of them;

*Experienced consultants will be able to diagnose even really rare things, based on their knowledge and their own previous experiences, so pattern recognition. I worked with a neurologist who could diagnose somebody from the end of the bed – he was just amazing! (Emily, JD)*

Whereas another interviewee saw the flaws of consultants trying to appear godly;

*As a medical student you can tell when a doctor is giving an answer to a question they don't really know the answer to. I hope that when I'm a doctor I can be honest and not risk giving false information, wrong or confusing advice. (James, MS)*

The pyramid communication framework was noted to impinge on the confidence and stress levels on some of the junior doctors. When considering the other staff in the hospital environment, the relationships or networks brought conflicting opinions however, these opinions coincided with the level at which the interviewees were at. First year medical student Lisa was in favour of the role of the nurse carrying more responsibility, they 'could take over some of the roles of the doctor'. Whereas, junior doctor Emily did not want to 'dilute the role of the nurse', showing resistance towards sharing responsibilities. Moreover, there was considerable bluntness regarding the nursing staff.

*A lot of the nurses don't understand that on-call means that you're in hospital for thirty-six hours, they're like 'Are you just starting', and you're like 'No, I started this morning and I*

*won't finish until tomorrow night, and that's always the way' ...it would be nice if everyone understood what everyone else was doing ... there's a lot of nurses on the one ward kind of think that that ward is the only ward that exists. Whereas you're covering all the other wards. (Juliet, JD)*

However, teamwork does exist within the hospital framework, beginning to erode the hierarchical template.

*The better teams are the ones that work as a team, rather than the pyramid structure, because the pyramid structure is just this like hierarchy and it's kind of very old-fashioned ... it's now becoming much more of a team, and everybody kind of checks things, and you do have a lot of people that you can ask for help, as an intern anyway... I think definitely team is much better than the pyramid, it's way more effective. (Gill, JD)*

One of the main frustrations which emerged from the interviews lay with hospital management, with issues such as communication constraints, poor management, poor resources and funding, all taking effect on doctor-patient communication.

*Doctors can have good days and bad days, and with cuts in funding, low staff numbers and huge pressures on time, it's almost necessary to not treat patients as such. It's the most sought after skill to be able to make patients feel like you have all the time in the world when you've got a target of six minute appointments. This is the General Practice consultation target time in England...crazy. (James, MS)*

#### *Emotional Detachment*

Emotional detachment and depersonalisation from the patient were favoured by the interviewees as a best mechanism to handle stress.

*It has happened to me several times in my career that you get very upset about seeing a patient in distress, and then you really can't think logically because you're caught up in that. So you learn very quickly to sort of divorce your emotions from the task at hand. (Emily, JD)*

The need to retain a barrier emerged again;

*You have to definitely keep a barrier there, cause you can't get too involved, and especially as since I'm going into paed's that's going to be a really big thing, don't step over the line and become too involved with the patients, which will be really difficult cause you know kids, and family and parents, you have to be involved to a certain extent. (Gill, JD)*

The hospital environment is demanding and competitive.

*Patients have unrealistic expectations of what to*

*expect in a public sector, you can't offer hotel service.*  
(Louise, MS)

Stress impinged upon sleep.

*I lose sleep at night, cause I'm like 'Oh my God, I forgot to do something.* (Gill, JD)

Where a genuine fear lay with the impact that sleep deprivation could have on professional performance.

*It's inhuman. That used to really scare me when I was working thirty-six hour shifts, and at the end of it you would just know that you're not in a good position to be making any sort of decision, and you miss things, and you think you've done something that you haven't. It's very, very scary.* (Emily, JD)

Emily did not display a strong confidence in her capabilities under pressure, whereas junior doctor Katie did express a realism about coping within stressful situations.

*You have to deal with it or you get out, you can't do the job if you're constantly worried about being sued or missing things, because you have to be okay with the fact that you can only do your best, and even if that means that sometimes things get missed or sometimes you'll slip up, or sometimes you'll make mistakes, which it does, you're okay with it, you've done your best.* (Katie, JD)

Reassured by the external locus of control religious belief for some of the interviewees assisted in relieving their stress levels, by prayer on an overall level. It is essential to note that the hospital environments offered only one form of support for all our interviewees, The Chaplaincy. The findings of this research showed that of all the interviewees, never had one ever visited the Chaplaincy for emotional support or guidance, and furthermore it was noted that at no point could any of the interviewees ever envisage having the time to engage with the Chaplain.

*There is apparently the Chaplain services but I've never heard of anybody ever using them. I mean you really just kind of count on each other to talk things over with your colleagues. I mean I think those things are there, but you don't have time first of all to head off and sit and chat to someone for half an hour like, you're bleep will be going off, and you just can't go and do that.* (Juliet, JD)

Time was the prevailing factor eliminating counselling and spiritual guidance from attending the Chaplaincy.

*You're made aware of the chaplaincy, but I never ever had time to go down there.* (Emily,

JD)

The role of colleagues was seen as the main support system, where junior doctor Juliet spoke of the reliance on each other.

*So you just kind of rely on each other, which you know it works because everyone is going through the same things.* (Juliet, JD)

### Discussion

The research showed an acceptance of patient empowerment, with homologised relationships, but time limitation hindered communicating with and addressing the psycho-social issues of the patient.

#### Communication Barriers

This research supports Clever *et al.* (2008) findings on the barriers created within doctor-patient communication, principally wishing to maintain a positive doctor-patient relationship; accepting the needs of patients have changed with a responsibility to make the patient feel like they are being 'listened to', enabling patient empowerment. However, although they accepted the importance of their responsibility in not making the patients feel like they were 'burdening' them, they recognised that the paternalistic approach of consultation still held place along with the humanistic approach. The majority of the interviewees expressed that if they were the patient they would like a 'mix of the two'.

Clever *et al.* (2008) focused on the need for doctors to talk about psycho-social issues, encouraging the patient to ask questions. The interviewees acknowledged that the art of listening was important, however blamed their lack of every-day communication with patients on time constraints, potentially initiating emotional detachment. This links to Buetow's (2009) theory of 'negative space', where the interviewees described how they formed barriers to emotions, often explaining the need to 'divorce' emotions to maintain logic. The interviewees described how time constraints and pressures led to 'negative communicative space' as they recalled the time pressures of getting information from patients for the exams, and due to completing their 'secretarial' tasks there was a lack of communication between them and the patient. Buetow (2009) 'negative physical space', was also seen through the status within the division of labour, as the interviewees held scepticism about the skills of other staff members, especially nurses taking on more responsibility, additionally displaying frustration in the manner that the hospitals were managed. The negative physical space was also in regard to the facilities for staff; the 'Ress' was the only place of relaxation mentioned, mainly for the purposes of sleep, and also poor eating facilities, with a lack of staff canteens and a lack of set lunch breaks. One interviewee stated that in the hospital there was 'no adequate breathing space in the place'. Buetow (2009) also discussed 'negative longitudinal space', in which her research suggests that in order to minimise discontinuities in doctor-patient communication contact should be made *via* electronic communication. This finding was supported by medical student James who saw that optimal patient care could be achieved through

technology, such as email, for patients to ask doctors quick questions. Junior doctor Emily also saw the potential of technology in communication, preventing negative longitudinal space within society, suggesting that a universal health number be provided to all citizens to make the health system more efficient; enabling doctors to work more effectively with less secretarial tasks.

#### *Empowerment*

Buetow, Jutel and Hoarse's (2009) theory of 'homologisation' of doctor-patient interaction, was seen within the interviews, with the impulse towards 'role convergence'. However, within this research although the interviewees recognised the empowerment of the patient, they also made a distinction between age generations and etiquette expectations. Juliet described how she saw the older generation preferring a more paternalistic style to their consultation, while younger generation researched and posed questions within the consultation. Medical student Louise noted how there was a pro-forma approach to generations, such as calling them 'Mr.' or 'Mrs.'. The interviewees, in the main, did note that an equal relationship between the doctor and the patient was positive recognition of the importance of space and time for the patient to 'query' and air their opinions leading to a 'positive relationship' with them. The theory of 'homologisation' might stem from McKinlay and Arches (1985) theory of 'proletarianisation', creating perhaps more equality within the doctor-patient relationship; where although 'managerialism' and technology reduce the doctors' control, the communication between colleagues may result in quite the opposite.

#### *Ability to Relate*

Powis *et al.* (2007) discussed the lack of applications to medical school from lower socio-economic groups, leading to an imbalance of social backgrounds in medical schools; resulting in barriers within doctor-patient communication. Medical student James recognised that although the governments are trying to widen access to medical school, the majority of students are still from middle and upper class backgrounds, which can draw an individual to only think in one 'box'; potentially leading to socio-economic and cultural stereotyping. Within this research there were no negative references to; the socio-economic status of patients, cultural stereotyping or religious affiliation. Research on the perceptions of doctors and patients during a consultation, emphasised active listening, support and giving advice; but found that doctors perceived they listened and explained more to patients from higher social classes (Willems 2005). These findings were not represented in this research, as this research illustrated listening and advice as more age associated, than class associated.

Tervalon and Murray-Garcia's (1998) research found that doctors lack knowledge about the health beliefs and life experiences of patients. The

interviewees overall lacked conclusive knowledge on religious beliefs, faith and complementary therapies, with some expressing their wish to improve their knowledge if time swayed in their favour. Breen *et al.* (2009) believed that to improve communication doctors need to be taught styles and approaches for patient-centred care. This research identified that the teaching of communication passes on from generation to generation of doctors, led by their superiors, therefore new styles and approaches would have to be taught on an overall level, inclusive of all generations. This generational pressure leads to competition, as Colthart *et al.*'s (2008) research found that appraisal had influenced the career development of general practitioners in their study. This research found that doctor-patient communication was hindered by the interviewees following the commands of their superiors wishing to gain appraisal and accomplish the tasks assigned to them.

The status division of labour was identified through Hall's (1968) analysis of the power structure of formal and informal relationships between doctors. Throughout the interviews an awareness of their superiors, the consultants, was eminently illustrated; where the interviewees displayed awe at their god-like skills, but also there was an awareness of the limitations and errors that could occur due to portraying a god-like stance. This reflects Egnaw and Wilson's (2011:99) findings that 'role modelling alone is insufficient for helping students acquire exemplary doctor-patient relationship skills'; good and bad role models were identified where lack of transparency was seen as a barrier to quality role modelling and helping students in their relationship skills. Doctor-patient communication would benefit from 'more continuity in training and imbedding in the daily working contexts of doctors' (van Dalen 2013:292), as it has been noted that pre-clinical and clinical relationship skills curricula are not coordinated (Egnaw and Wilson 2010:199).

#### *Support*

In noting the *only* form of support offered to all the interviewees was The Chaplaincy, of which not one of the interviewees had ever availed of. Should support not be *within* the working environment? Awareness of human limitation is important in establishing trust and faith between the doctor and patients (Anjali *et al.* 2013), and as treatment moves away from a disease centred approach to focus on holistic, patient centred care where there is a need for attachment (Frederiksen *et al.* 2010, Rathnakar *et al.* 2013), there is increased pressure on doctors' adaptive behaviours and practices to improve health outcomes and doctor-patient communication (Thydeson *et al.* 2010, Veldhuijzen *et al.* 2013).

#### **Conclusion**

The research identified an acceptance of patient empowerment by the junior doctors and medical students, with homologised relationships, and also that time limitations hindered addressing the psycho-social issues of the patient. Consideration of psycho-social issues could be revised in order that doctors maintain awareness of cultural practices and ethical principles.

The framework of the hospital environment, as discussed in this research, has highlighted both the stress

and exhaustion that exists, even in the early stages of the life of the doctor. Although the HSE has agreed a timetable for implementation of the European working time directive from January 2014, which provides for a right to work no more than 48 hours in a week (Cullen 2013) this research notes that there needs to be a more modern, integrated, psychological support and guidance system available to doctors, so that stress does not impinge on the doctor-patient relationship. There is no panacea that can create a positive, rewarding environment. A supportive and understanding hospital framework is instrumental in career development, resolving problems, and management that is fully involved in removing obstacles to career satisfaction and performance, allowing a doctor to perform at their highest level. This is what can reduce or prevent employee burnout. Confidential support systems in other countries have been found to be very effective in isolating problems and offering wider support for junior doctors without the fear of feeling judged, for example is the Australian Medical Association (AMA Victoria 2013) Peer Support Service, in Victoria. The implementation of stress management workshops for all junior doctors could also be considered as this has been found to be helpful, but this was found to only be well attended if

scheduled into an existing program of regular meetings (Appleby 1997), which has been conducted in New Zealand (Davis 1999).

Furthermore, this research has highlighted key areas which at some future point may contribute positively to alleviate some of the time pressures within the medical framework. The areas highlighted were; the recognition and advancement of teamwork, the recognition and utilisation of hospital staff skills and the reality of delegation, the adoption of a universal health care number within the health system, the development of a patient-friendly electronic communication system, and the development of the existing community based medical care centres.

To conclude, this research has given insight with meaningful understanding from the perspective of the doctor, through the interviewees, and without exception showed that time pressure was the predominant issue impacting all areas of the doctor-patient relationship. The high levels of stress, especially due to time constraints, experienced by junior doctors affect their well being and decision-making which ultimately impact on patient care. A combination of support services within the health service, education in stress management and assessment of resources are vital to enable better coping strategies for upcoming doctors facing the demands placed on them within the current strained health services.

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