

## Human Values – a Missing Link in Doctor Patient Relationship

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### Abstract

*The value quotient in doctor patient relationship has taken a beating as it is becoming more commercial and business oriented than human oriented. Due to this change in holistic relationship the equation between the doctor and the patient is fast changing. Doctors believe in delivering the professional service and the values in Doctor-Patient relationship is fast depleting. The doctors may be unable to spend quality time with the patients which might result in huge communication break. Spending precious time with the patients strengthens the values in doctor patient relationship. The communication rupture between the doctors and patients affects the rapport between and cannot be considered as healthy. In this respect it is interesting to notice different factors responsible for doctor-patient relationship through a research question, 'whether human values are missing in doctor-patient relationship?' The study also identifies significant factors responsible for creating such a sacred relationship with the application of Exploratory Factor Analysis (EFA).*

**Key words:** Human values, Doctor-Patient relationship, Trust, Communication, Loyalty, Consultation

### 1. Introduction

The doctor-patient relationship forms one of the foundations of contemporary medical ethics. The relationship stands for human values and professionalism. Due to various contextual factors the good communication between the Doctor and the Patient is not happening as expected. The value quotient in doctor patient relationship has taken a beating as it is becoming more commercial and business oriented than human oriented. The statement cannot be generalized though; the general opinion by patient community is fear and lack of security. The Doctors also feel that the erstwhile doctor-patient relationship has no place due to super specialization, competition and lack of loyalty amongst patient community. Unlike other business deals the health care services directly involves the life of the people that is unbeatable to any truth on this earth. In this respect values seem to be the missing link between doctor-patient relationships. Establishing the good rapport with the patients is truly significant from the perspective of both doctors and patients as it yields to win-win situation in terms of better health care services and expansion of patient base to doctors. The Doctor-Patient relationship is so much psychological that the vicinity and concern by the doctors itself restores good health and confidence in the patients. This helps to enhance the resistance mechanisms and better prognosis of the disease in patients. Doctors believe in delivering the professional service and the values in Doctor-Patient relationship is fast depleting. The doctors may be unable to spend quality time with the patients which might result in huge communication break. Spending valuable time with the patients strengthens the values in doctor patient relationship. Since the underlying relationship is fundamental to the profession of doctors of any speciality and also for the wellbeing of the patients this research paper gives insight in to the ways to strengthen the doctor patient relationship by identifying communication gap between patients and the doctors if any. The study also identifies significant factors responsible for creating such a sacred relationship with the application of Exploratory Factor Analysis (EFA).

## 2. A brief literature review on Doctor Patient Relationship

Literature gives an idea regarding the existing studies conducted in the relevant area by identifying the research gap.

Heisler et al. [1] stated that the patients developed self-management and effective communication bridge provided the doctors share disease related and treatment related information with them. Takayama and Yamazaki [2] stressed that informal conversation with the patients instills confidence in the patients by making them think that they are being understood by the doctor. The patients felt a sense of mutual participation with the time spent by the doctors with them and were motivated to self-participate in enhancing the association. Doctors also need to be sensitive to the emotional state of the patients. The mindset of the patients in recognizing their relationship with their doctors significantly influences the level of their satisfaction with them. If patients feel that their doctors are communicating openly with them by allaying their fears they feel highly satisfied with them as they perceive the doctors are concerned about their health. If the patients recognize a positive connection with the doctors their satisfaction level with the doctors and their treatment increases [3]. Neuwirth [4] stated that exceptional communication was a fine professional etiquette. Author suggested that communication skills could be garnered and developed by practice. In the ever changing medical environment, interactive dialogues could be lost amidst fierce competition. Doctors face the challenge of keeping themselves updated with the latest medical modalities and a latest treatment which naturally casts overcast on effective communication skills. Effective communication leads to less litigations and medical cases. However an effective communication could be a challenge for doctors when the patients are in emotionally disturbed situations. Zachariae R, et al. [5] stated that better listening ability the doctors exhibited there was an enhancement in confidence level of the patients. Authors showed that patient distress was minimal and patient self-efficacy was high with attentiveness and empathy by the physician. Kim et al. [6] stated that informal and casual communication will make the patients amenable for treatments without resistance. Thus it shows that friendly conversation and spending time with the patients to some extent always leads to patient obedience.

A value based doctor-patient relationship is reliant on interpersonal relationship between the patient and the doctor. Kirshner [7], in the Primary Care Assessment Survey model, stated that measures of the interpersonal relationship had a significant link with communication, interpersonal care, background information of the patient, and trust. However quality of these relationships has taken a beating. Information technologies have greatly influenced the manner of health care delivery and the relationship between doctors and patients. Hart et.al, [8] analyzed patients' attitude regarding the discussion on spiritual issues with their physicians and they found that patients did not expect physicians to be their primary spiritual advisors. This also tells that physicians should be aware of and comfortable communicating with patients about religious or spiritual issues to put them in to ease. The qualitative study by Hellstrom et.al, [9] reported on the clinical experiences of doctors when meeting patients with fibromyalgia (FM). The findings stated that though doctors tried to comply with the wishes and demands of patients, to some extent they avoided perceptions of personal frustration. As per Carlsen et.al. [10] general practitioners who shared decision making between with the patients influenced positively referral decisions that helped in solving the medical problem through healthy doctor-patient interaction. Fox et.al. [11] stated that work-related pressures and susceptibility to health problems mean that many general practitioners will, at some stage, experience the role of patient. Thus the empathy in this relationship empowers the patient that really strengthens the doctor patient association. Caccavo [12], tried to understand the content of doctor-patient communication in primary care. Commonly presented problems such as respiratory, psychological and musculoskeletal complaints had open coding to identify subject matter discussed by general practitioners. Arborelius [13] studied the experiences of GPs and listed the comments by the patients. The comments were analyzed using an exploratory qualitative approach. Findings stated that the good GP acts like an ordinary person and treats the patient as an equal. The personal relationship with the GP also influenced the choice and course of medical interventions. Jones et.al. [14] conducted a research on one hundred and six general practitioners and questioned their attitudes to health education to their patients. The GPs expressed that it was a necessity for the health education of their patients but they encountered difficulties

in carrying this out.

Broom [15] stated that increasing consumerism, the rise of complementary medicine and the emergence of the Internet have reduced the power and status of medical profession. According to Andreassen, et. al. [16] communication via computers, e-mediated communication was affecting the circumstance of patient-doctor communication, moving core elements of the relationship. Broom [17], explored the effects and roles of the Internet as a source of empowerment and control. It was found that some medical specialists viewed Internet-informed patients as a challenge to their power within medical encounters and, as a result alienated patients who used the Internet. Nwosu and Cox [18] presented the results of a study of 300 randomly selected obstetricians and gynecologists in the United Kingdom to assess their perception of Internet usage by patients on the doctor-patient relationship. Results showed that consultants felt that the Internet has made patients better informed than them. Most respondents thought that all doctors should be Internet trained to deal with this crisis. Kivits [19] also investigated how use of the Internet by the patients affects the relationship between doctors and patients. Telemedicine offers huge opportunities to improve the quality and convenience of health services. This mediation was explored through Mortet.al. [20], in U. K. tele-dermatology clinic. Diagnostic image transfer enabled medicine at a distance, by making the patients avail of the best services.

Fochsen, et.al. [21] stated that gender was identified as an influencing factor of doctor's decisions. This was a significant result for female patients, whose voices were not heard in the medical encounter. Liza McCoy [22] studied outpatient health care from the angle of women and men who live with HIV. She has concluded that the information and communication technology has given new twist to patients as well as the doctors. A study conducted by Moore et.al. [23] assessed the impact of the doctor-patient relationship on participants' avoidance of treatment. They segregated these patients based on medical or psychological problem. Authors found that the waiting time was the reason for avoidance of the treatment. This shows that if the patients are made to wait outside then the habit of avoidance might strongly prevail over them.

Cocksedge and May [24], conducted a study to understand family doctors' constructs of long-term therapeutic relationships with patients in primary care. They stated that personal and continuing relationship with the patients was the main link in doctor patient relationship. Silber [25] stated that Doctors were in continuous touch with their adolescent patients on many different levels and with varying degrees of intensity. Keeping in touch with adolescent patients was the bridge in doctor patient relationship. Shaw [26] did a research on psychiatric patients, and explored general practitioners' perceptions of complex patients and the effects of management of such patients. He presented the evidence of medical irritation with patients and the doctors cannot treat any patient as difficult or easy as patients represent the same set for them. Perloff et.al. [27] took a study to investigate the role that cultural competency training on doctor-patient communication and in health care disparities. There could be some amount of bias between minority patients in the form of linguistic asymmetry. Authors suggest Cultural competency training for the doctors for effective professional practice. Werner and Kirsti Malterud, [28] stated that doctors can even support their patients to come out of trauma and develop strengths and positive attitude which helps patients to take the treatment in open mind. Authors also stated that patient empowerment can be taken as the moral responsibility of the doctors. Benedetti [29], stated that 'Placabo effect' was important in any medical treatment and that the words and attitudes of doctors and nurses could have great impact on the patient. Patients showed a positive response towards the treatment with the talk and the touch of the doctors. This shows that the doctor-patient relationship is most sacred of all relationships just like the mother-child bond. According to Sharma [30] the patient may be a child, student, friend and mentee to the doctor on different occasions.

The literature throws light in to doctor -patient relationship from different perspectives. The study considers the communication by the doctors, time spent with the patients as the components of human values.

Doctors receive patients from varied background. Effects of extraneous factors such as Gender, Qualification and Employment factors and patient affiliations in influencing doctor-patient relationship are explained by Ganesh et.al. [31]. The authors have come out with the finding that gender, qualification, employment factors as well as patient's affiliations do play a role in influencing doctor patient relationship though not drastically. They have further analyzed if there is any difference between the doctors of ten different specialties viz., medicine, surgery, ophthalmology, ENT, orthopedics, dermatology, Gynecology, radiology, cardiology and psychiatry in giving equitable treatment to their patients. ANOVA shows that  $F = 0.837$   $P = 0.587 > 0.05$  which shows that there is no significant difference between the specialists giving equal treatment to the patients. Doctors might also have to spend different amounts of time with different types of patients due to the type of the sickness and severity and complications in it. It might be the feeling of some patients that doctors were not paying equal attention to the patients irrespective of their background. A micro study in the Indian context will throw abundant light in the field of knowledge to enhance the Doctor- Patient relationship as very few studies have been conducted so far.

### 3. Statement of the Problem

The study takes in to account different factors responsible for doctor-patient relationship through a research question, 'whether human values are missing in doctor-patient relationship?'

In order to unearth the research gap and to find the answer to the research question the study aims to fulfill the following objectives.

### 4. Objectives

The micro study, Human Values –a Missing Link in Doctor Patient Relationship had the following objectives to fulfill.

1. To understand the factor structure which enables grouping of variables based on strong correlations and also to spot problematic variables in the study.
2. To know whether Doctor patient relationship is sustainable based on reduced factors such as Time, Trust, Technology, Consultation, Gender and Doctor-Patient relationship.

### 5. Methodology and Sample Design

The scope of the study is restricted to Mangalore region. It comes in Dakshina Kannada District of Karnataka state, India. Since there are more than six medical college hospitals in Mangalore, there is no dearth of specialist doctors and consultants. Since Mangalore is considered as health care hub next only to Bangalore in Karnataka, there is a heavy rush of patients from whole of Karnataka, Goa and northern Kerala. Doctors from ten different specialties were chosen amounting to 50 in number who were the respondents in the study who were administered with the Likert's 5-point rated structured questionnaire. Stratified proportional sampling technique was adopted and 20 patients from each of the above category were selected from a tertiary teaching hospital leading to the sample size of 202. Sample size of the patients represented 10 per cent of the population. The data were subjected to Exploratory Factor Analysis (EFA).

### 6. Findings and Discussion

#### 6.1. Factor structure and Analysis

Exploratory Factor Analysis (EFA) was performed for determining the correlation among the variables in a dataset. The study aims to provide a factor structure which enables grouping of variables based on strong correlations and also to spot problematic variables in the study. By applying EFA to the present study we can understand the important factors necessary to explain the relations among a set of indicators and with estimation of factor loadings. Factor analysis in the present study involves the relationship between

observed variables and the underlying latent factors. Since many variables are reduced (grouped) into a smaller number of factors, these variables reflect the causal impact of the latent underlying factors.

**Priori Hypothesis:** Time, Trust, Technology, Consultation, Gender and Doctor-Patient relationship determine the Doctor- Patient Relationship.

In the present study researcher has tried to reduce 21 variables of Doctor patient relationship into a parsimonious set of six factors that account better for the underlying variance (causal impact) in the measured phenomenon. Factor Analysis was used to test a priori hypotheses, whether the Doctor patient association is sustainable based on reduced factors such as Time, Trust, Technology, Consultation, Gender and Doctor-Patient relationship. Following paragraphs show the segregation of factors and the variables that are grouped under each of the factors and are coded for analysis purpose which is mentioned in the bracket.

**Time:**

1. Doctor spends enough time in educating about the disease.(**Time1**)
2. The waiting time with my doctor is long and sometimes it becomes the reason for changing the doctor.(**Time2**)

**Doctor-Patients Relationship:**

1. My doctor gives equal treatment to all the patients irrespective of our background.(**Drpt1**)
2. The personal relationship with the treating doctor counts a lot in taking treatment.(**Drpt2**)
3. Power and status of an individual influences the doctor patient relationship.(**Drpt3**)
4. Doctor's skill is significant in sustaining Doctor patient relationship.(**Drpt4**)
5. Irrespective of my affordability I should be offered the best possible treatment options.(**Drpt5**)

**Gender:**

1. I feel comfortable with the doctor belonging to the same gender.(**Gen1**)

**Trust:**

1. My doctor is a caring human who listens, understands and is concerned with my health.(**Tr1**)
2. I feel great psychological strength and confidence once my doctor treats me.(**Tr2**)
3. My doctor builds a good rapport with the patients irrespective of their religion, caste and region.(**Tr3**)
4. I do not stick to a single doctor for the treatment of my identical sickness.(**Tr4**)
5. Patient satisfaction is important for maintaining the strong Doctor patient relationship.(**Tr5**)

**Technology:**

1. Telecommunication has given me an opportunity to contact my doctor on real time basis.(**Tech1**)
2. He encourages patients to learn from internet.(**Tech2**)

**Consultation:**

1. Communication and health care facilities have enabled me to understand my health conditions better.(**Cons1**)
2. Being the patient I should be allowed to ask as many questions as I want about my disease.(**Cons2**)
3. Doctor should not mind if Patient requests for a second opinion.(**Cons3**)
4. Doctor always discusses with me different treatment options available.(**Cons4**)
5. Doctor does not mind if I communicate apart from regular visits.(**Cons5**)
6. He always discusses the nature of seriousness of disease with the patients.(**Cons6**)

From the factor grouping the study has come up with a model 1 which displays that the Doctor–Patient (DR-PT) association depends upon six identified factors and the underlying variables.

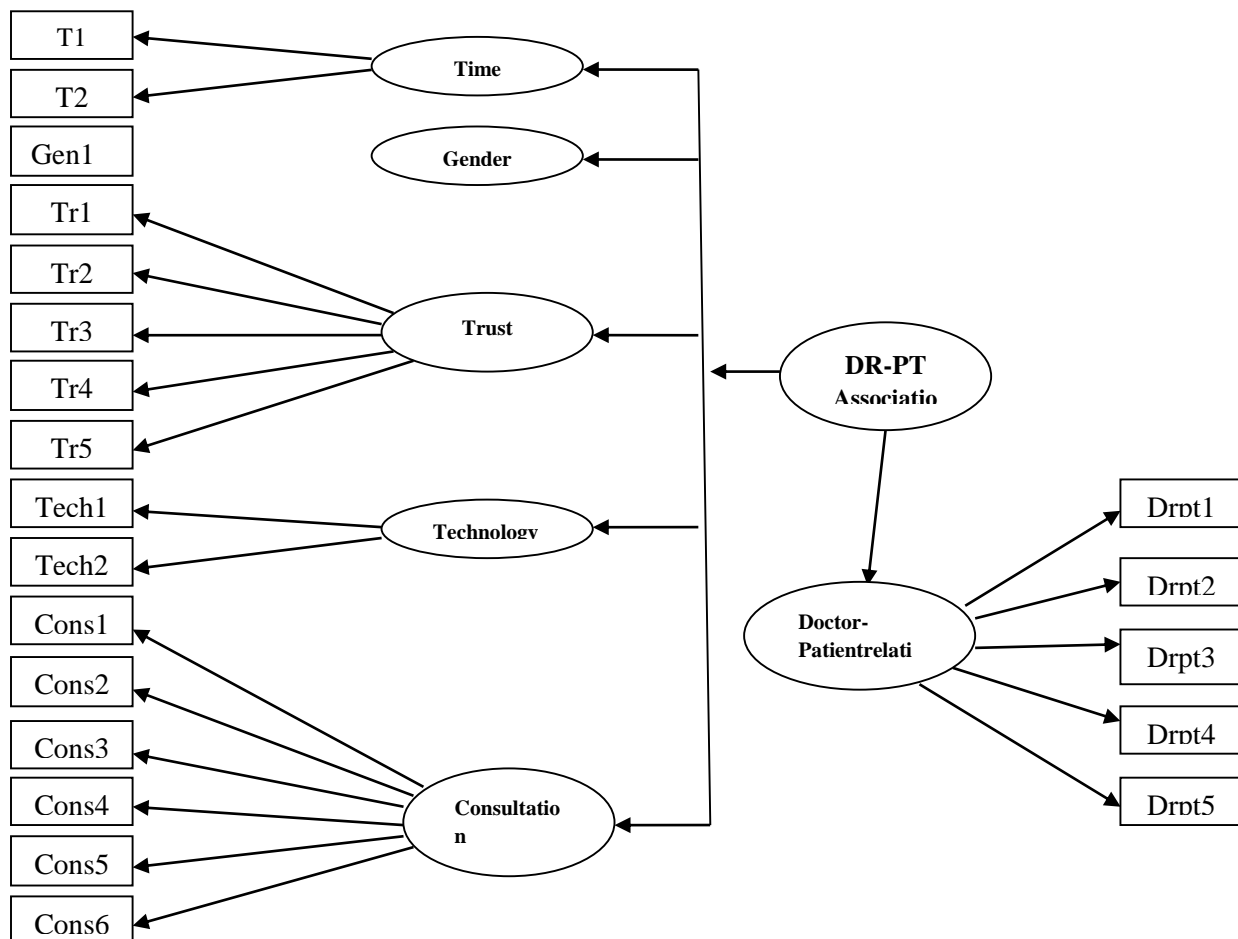
Normalcy of the selected 21 items was maintained on an average. Reliability test was applied to know the consistency of the item-level errors within a single factor is depicted in Table 1.

**Table 1.**Reliability Statistics

Cronbach's Alpha	N of Items
0.732	21

Cronbach's alpha should be above 0.7; although, ceteris paribus, the value will generally increase for factors with more variables, and decrease for factors with fewer variables. Cronbach's Alpha of 21 variables that are included in six factors is .732 and shows that the reliable set of variables are consistently been loaded in six of the factors.

**Model 1.**Doctor–Patient (DR-PT) association factors with variables



With a view to understand whether Exploratory Factor Analysis (EFA) is suitable to the data under study, KMO and Bartlett's Test was applied and the results are shown in Table 2.

**Table 2.**KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.722
Bartlett's Test of Sphericity	Approx. Chi-Square	768.760
	df	210
	Sig.	0.000

A significant result ( $0.000 < 0.05$ ) indicates matrix is not an identity matrix; i.e., the variables do relate to one another enough to run a meaningful EFA. Therefore we can apply EFA for the data given.

The data below shows the criteria for KMO Statistics.

- Marvelous: .90s
- Meritorious: .80s
- Middling: .70s
- Mediocre: .60s
- Miserable: .50s
- Unacceptable: <.50

KMO value is 0.722 it can be grouped in Middling with the standard 0.70 based on KMO statistics. Since the value is greater than 0.60 EFA test can be applied however; the accuracy of the results might fluctuate.

Communality is the extent to which an item correlates with all other items is depicted in Table 3. This is the proportion of each variable's variance that can be explained by the factors. Communality ( $h^2$ ) can be defined as the sum of squared factor loadings for the variables. Removal of lower extracted values (below 0.4) was done as these variables were not loading significantly on any of the six factors.

**Table 3.** Communalities<sup>a</sup>

	Initial	Extraction
Cons1	0.230	0.277
Cons2	0.183	0.351
Cons3	0.291	0.329
Cons4	0.351	0.404
Cons5	0.410	0.464
Cons6	0.342	0.702
Drpt1	0.351	0.999
Drpt2	0.185	0.221
Drpt3	0.335	0.374
Drpt4	0.256	0.335
Drpt5	0.239	0.292

Gen1	0.211	0.268
Tech1	0.226	0.228
Tech2	0.182	0.200
Time1	0.258	0.204
Time2	0.331	0.494
Tr1	0.205	0.213
Tr2	0.253	0.257
Tr3	0.361	0.376
Tr4	0.349	0.467
Tr5	0.242	0.211

Extraction Method: Maximum Likelihood.

**Table 4.**Rotated FactorMatrix

	Factor					
	1	2	3	4	5	6
Cons4	0.601					
Cons5	0.597					
Tr3	0.544					
Cons3	0.499					
Time2		0.671				
Tr4		0.585				
Gen1		0.469				
Drpt3	-0.413	0.432				
Tech2						
Drpt1			0.952			
Tr1						
Cons1				0.499		
Drpt2				0.404		
Tech1						
Tr2						
Cons6					0.773	
Drpt5						
Time1						



Cons2						0.561
Drpt4						0.456
Tr5						

Extraction Method: Maximum Likelihood.

Rotation Method: Varimax with Kaiser Normalization.<sup>a</sup>

a. Rotation converged in 9 iterations.

Rotated Factor Matrix is depicted in Table 4 which represents convergent validity. However there is negative factor and crossload. Drpt3 is having a negative loading and is also crossloaded, thus it has to be removed. We remove the negative and crossloaded items by selecting the least extracted items in the communalities table. The significant factor loading for the sample size of 202 in the present study is 0.40. The rule is that variables should relate more strongly to their own factor than to another factor. Therefore in this respect Discriminant validity to know the extent to which factors are distinct and uncorrelated is determined in FEA. Rotated Factor Matrix in Table 4 has come out with discriminant validity. The second method to examine was the factor transformation matrix, as shown in Table7.

**Table 5.**Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.690	19.419	19.419	1.753	9.226	9.226	1.738	9.145	9.145
2	2.070	10.896	30.315	1.890	9.949	19.176	1.437	7.562	16.707
3	1.490	7.843	38.158	1.101	5.795	24.971	1.285	6.761	23.469
4	1.234	6.496	44.653	1.435	7.553	32.524	1.223	6.439	29.908
5	1.139	5.993	50.646	.892	4.696	37.220	1.159	6.100	36.008
6	1.041	5.480	56.127	.701	3.688	40.908	.931	4.900	40.908

Extraction Method: Maximum Likelihood.

Extracting too many factors may present undesirable error variance but extracting too few factors might leave out valuable common variance. The eigenvalues and scree plot are used to determine how many factors to retain. Criterion used to determine the number of factors to retain is Kaiser's criterion that suggests retaining all factors that are above the eigenvalue of 1 [32].

The initial number of factors is the same as the number of variables used in the factor analysis. Six factors are retained and the reduced variables are nineteen. Eigenvalues represent the variances of the factors. Cumulative percentage states first six factors together account for 56.127 per cent of the total variance. Common variance of the six factors is 40.908 per cent. The output is shown in Table 5. Rotation Sums of Squared Loadings of the table represent the distribution of the variance after the varimax rotation. Varimax rotation tries to maximize the variance of each of the factors, so the total amount of variance accounted for is redistributed over the six extracted factors. After removing the negative and cross loaded

values iteration step is stopped and the Table 6 is obtained that depicts the rotated factor matrix which states the factors responsible for Doctor Patient Association.

**Table 6.**Rotated Factor Matrix

	Factor					
	1	2	3	4	5	6
Cons4	0.775					
Cons5	0.602					
Tr3	0.460					
Cons3	0.432					
Time2		0.718				
Tr4		0.612				
Gen1		0.424				
Drpt1			0.887			
Cons6				0.958		
Tr2					0.510	
Drpt4					0.436	
Tr5						0.881

**Table 7.** Factor Transformation Matrix

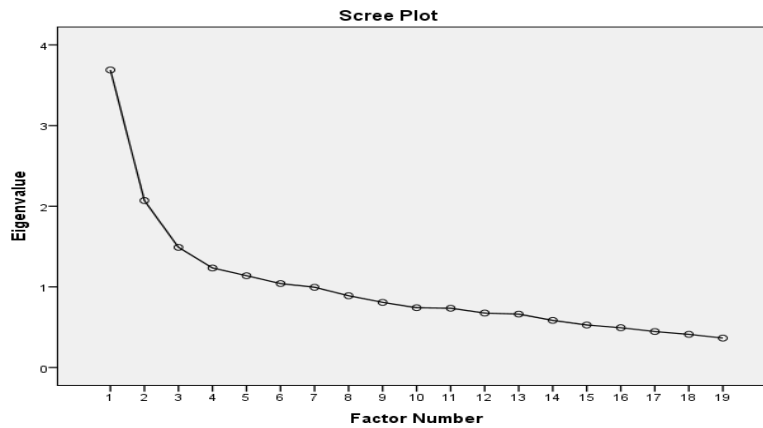
Factor	1	2	3	4	5	6
1	0.194	-0.172	0.062	0.958	0.100	0.026
2	0.269	-0.035	0.633	-0.149	0.283	0.651
3	0.249	-0.278	0.607	-0.109	-0.119	-0.683
4	0.771	0.568	-0.209	-0.049	0.123	-0.150
5	-0.413	0.752	0.427	0.212	-0.172	-0.081
6	-0.251	0.058	-0.015	-0.026	0.923	-0.285

Extraction Method: Maximum Likelihood.

Rotation Method: Varimax with Kaiser Normalization.

Table 6 shows that variables of trust are prevalent in all the factors of Doctor Patient Association such as Consultation, Trust, Doctor's skill and Patient's confidence and Patient's satisfaction. Table 7 shows SPSS output for Factor Transformation Matrix to determine if the chosen rotation technique was sufficient for this data. The factor transformation matrix shows the correlation between factor 4 with factor 1 (0.958). This shows that the Doctor Patient Association is mainly based on Interaction (factor 4) which in turn is highly related with the Consultation (factor 1) facilitated by the Doctors .

**Chart 1: Scree Plot**



**Table 8. Rotated Component Matrix**

Variables	Component										
	Rapport	Interaction	Medical Treatment	Communication	Confidence	Technology	Patient's Loyalty	Gender	Care	Concern	Equality
Spends enough time in educating/disease	0.522										
Equal TT to all irrespective of background	0.757										
Comfortable if DR of same gender								0.841			
Dr is caring and concerned										0.889	
Personal relationship				0.750							
Feel strong and confident after treatment					0.892						
Dr has good rapport with pts	0.794										
Power and status influence						0.697					

Telecommunication to contact Dr				0.742							
Long Waiting time as a reason to change Dr							0.556				
Do not stick to one Dr							0.804				
Dr's skill is imp.in Dr/Pt relationship					0.547						
I should be allowed to ask questions		0.667									
Dr should not mind if I request second opinion		0.795									
Irrespective of affordability I should be offered best tt			0.575								
Dr discusses different options			0.769								
Dr encourages pt to learn from internet						0.752					
Dr discusses seriousness of disease					0.521						
DR-Equal tt irrespective of back ground											0.881
DR-Comf. if Pt of same gender											
DR-Caring									0.859		

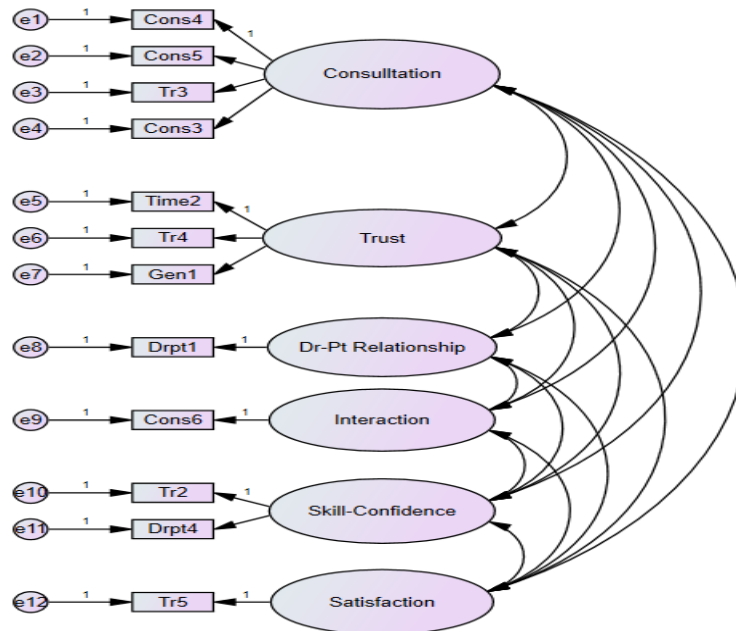
Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.<sup>a</sup>

a. Rotation converged in 19 iterations.

Principle Component Analysis for Doctor respondent samples revealed eleven components responsible for Doctor Patient Association. Table 8 reveals Rotated Component matrix. The components identified were Rapport, Interaction, Medical Treatment, Communication, Confidence, Technology, Patient's Loyalty, Gender, Care, Concern and Equality. There is lot of convergence between the components responsible for Doctor-Patient Association and also the factors responsible for the same. Priori Hypothesis holds true as the factors such as Time, Technology and Gender became part of Doctor-Patient relationship.

## Model 2. Fit for CFA



The explored factors were named as Consultation, Trust, Doctor–Patient (Dr-Pt) relationship, Interaction, Skill-confidence and Satisfaction which are depicted in 2: Model fit for Confirmatory Factor Analysis (CFA). Skill of the Doctors and Confidence shown by the patients in their doctors and also the satisfaction the patients derive from the doctors during and after the treatment become the most significant factors in Doctor Patient Association as explored by EFA. Therefore the research priori hypothesis was accepted as the factors such as Time, Technology and Gender became part of Doctor-Patient association which was subsumed in Dr-Pt relationship, Interaction and Consultation. Based on the rotating factor matrix CFA can be performed.

### Fit Indices and their applications

There is a controversy regarding fit indices. According to Barrett [33] fit indices do not add anything to the analysis and only the chi square should be interpreted. This says that if there is a miss specified model it cannot be a bad model. Hayduk et. al. [34] argue that cutoffs for a fit index can be misleading and subject to misuse. The analysts believe in the value of fit indices, but caution against strict reliance on cutoffs. The present study has explored the factors responsible for Doctor- Patient relationship and gone to the level of EFA the Rotated Factor Matrix and Factor Transformation Matrix have taken care of the convergent and discriminant validity.

### 7. Discussion

Doctors' job and the role have become very much demanding and challenging. From the findings of the study the human values in doctor patient relationship is undamaged with the trust and loyalty extended by the patients. The doctors who have open communication and spend their costly time with the patients keep up the human value quotient in doctor patient relationship. Good communication is good business practice. However, doctors may not be able to spend quality time with each patient every time as they need to allocate time for different patients with different complications. Therefore, most of the time the doctor patient relationship is restricted to pure medical treatment, rather than to instilling the psychological strength in to the patients. If patients move from one specialist to another for second, third and several rounds of opinion it is indicative of lack of trust in the specialist doctors. As trust acts as an important construct in doctor-

patient relationship, losing it is nothing but fading values.

## 8. Conclusion

The missing link of human values needs to be connected by the trust and confidence expressed by the patients and the communication channel practiced by the doctors. Due to certain emergent situations if doctors are not able to spend more time with the patients, they need not act in a hurry to change the doctor as doctor patient relationship is more based on technical brilliance of the treating doctor rather than just doctor's way of speaking nicely to the patients. In a similar way if the patient wants to take the second opinion from other doctor it must be taken in a sportive spirit by the treating doctor hoping to improve his diagnostic and treating skills provided he gets the follow up. As the foundation of medical ethics is to maintain holistic relationship with the patients irrespective of gender, caste, qualification and income it becomes the primary responsibility of the doctors to keep up the human values by upholding the dignity of the profession.

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