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Department of Public and Social Policy

Master's Thesis

2024 **Salome Vadachkoria**

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Department of Public and Social Policy

Patient Perspective on Physician Patient Relationship in Primary Care Comparative Analyses Netherlands and Georgia

Master's Thesis

Author of the Thesis: Salome Vadachkoria

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Supervisor: prof. Zuzana Kotherova, PHD

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Declaration

1. I hereby declare that I have compiled this thesis using the listed literature and resources only.
2. I hereby declare that my thesis has not been used to gain any other academic title.
3. I fully agree to my work being used for study and scientific purposes.
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In Prague on

29.07.2024 Salome Vadachkoria

Abstract

The primary care sector is one of the pivotal entities in the health care system. As a gatekeeper, primary care is the first point of contact for the patients and their families. The primary care has a holistic role in the patient care. It provides preventive care, treatment, rehabilitation and palliative care. The primary care services take into consideration not only the disease, but also the bio-psychosocial aspects of the patient's life. Increase in the chronic, non-communicable disease frequency across the globe, increases also the demand on the health care sector. Secondary and tertiary units of the health care are very expensive for the countries, therefore more accent is on the primary care. Different countries have various levels of the primary care development. Among them the Netherlands is known to have an" ideal'' model of the primary care. Factors that make the system well-functioning in the Netherlands is high level of the physician patient relationship and a Patient Centred Care (PCC). On the other hand, countries as post-Soviet Georgia have developing primary care system with many challenges. Comparison of these two countries was conducted on the contextual factors and a conducted survey. Patients' perspective on interaction with the primary care and healthcare professionals is the key for well-functioning primary care, patients' trust, loyalty, respect and better health outcomes. Exploration and analyses of these factors is added value to research in primary care with recommendations provided. There are limited literature specifically exploring the physician patient relationship model in Georgia. Comparison revealed challenges for the Georgia in terms of policy formation, stuff trainings, PCC development, organisational and geographical coverage path, that Netherlands follow with primary care development is an advanced development path, that shows organisational, infrastructural, monitoring and PCC priorities, that can be taken into consideration by Georgian health community.

Keywords

Primary Care, Patient centred Care, Physician Patient Relationship

Název práce

Pohled Pacienta na Vztah Mezi Lékařem a Pacientem v Primární Péči, Srovnávací Analýzy Nizozemí a Gruzie

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Table of Contents

Introduction

The intention of this thesis is to explore the physician patient relationship model in primary care sector in Georgia and to do the comparative analyses with the model in Netherlands. Through the lens of patients' perspective and contextual factor analyses different aspects of the primary care system will be revealed, compared and analysed. Patients' perspective on the physician patient relationship dynamics is perceived of special importance, as it determines the patients' trust, loyalty and satisfaction as well as the treatment outcomes. The study intention is to identify system and process gaps and explore potential future improvement and research opportunities in Georgia for the primary care and physician patient relationship development.

Patients' perspective and opinion on the interaction, that they have with their physicians is the key factor, that determines health outcomes and patients' wellbeing. The appropriate relationship, communication, empathy and loyalty between physicians and patients are core components of holistic or bio-psychosocial care of individuals (Mino. C.J., Lert. F., 2005). Physician patient relationship, defined as communication and interaction between the health care professionals and patients is crucial to strengthen trust, improve the rapport building in the medical context and strengthen the treatment compliance. In the primary care sector of the health care system, where patients have the first interaction with physicians, it is essential to have physician patient relationship on a professional and holistic level. In general, it is considered, that the more severe the disease is, the more is the need for respect, open communication and honesty from interdisciplinary professionals in the health sector, family members, and surrounding environment (Mino. C.J., Lert. F., 2005). In addition, modern medical care changes across different countries are progressive. Changes are reflected in more and advanced developments in medical treatment methodologies, increase in chronic and non-communicable disease frequency, changes in the understanding of the disease profile. All these factors contribute to more emphasis on the holistic spirit in the treatment process. The holistic spirit approach involves bio-psychosocial care of patients, care that understands the patient and his or her surrounding environment and expresses empathy and support in all biopsychosocial aspects (Mino. C.J., Lert. F., 2005).

Hence, health care and primary care first of all, cannot be solely based only on medical service-based model, rather health care needs to be holistic, involving biopsychosocial care as well (Mino. C.J., Lert. F., 2005)

The primary care is the sector, that will take the burden of chronic and non-communicable disease prevalence increase, across the globe. The primary care is considered to be the most cost effective and efficient sector to manage individuals' health concerns. Physicians in primary care need to have competencies to gain patients trust, loyalty and belief in their professionalism. The holistic physician patient relationship is pivotal for the primary care, otherwise it will not be able to perform its core function, that is holistic care of patients.

The bio-psychosocial care implementation would be impossible without an appropriate physician patient relationship. As we connect the concepts, the physician-patient relationship is an essential aspect of the clinical care, that makes foundation of holistic, patient centred medical approach. Patients' perspective on how they see and perceive their interaction with the primary care and its physicians is a key factor for patients trust and adherence to physician's recommendations.

The good physician patient relationship can bring the trust, loyalty and respect that opens the venue to care for a patient holistically. It is important to mention, that the strong physician patient relationship is linearly and positively linked and correlated with the improved patient treatment outcomes. Overall, the importance of the relationship between physicians and patients is one of the determinant factors for the patients' well-being. How patients perceive the relationship and what they see as challenges, is the key for trust and rapport building between a patient and a physician. it is also essential to understand the contextual factors that influence this relationship directly or indirectly (Johnson. T. 2019).

The thesis starts with the background section, that describes the Primary Care (PC), its functionality and presents the overview of the health systems of two countries, Netherlands and Georgia. In addition, in the background section physician patient relationship is further explored and the Patient Centred Care (PCC) is introduced. Analyses of these concepts and contextual factors brings to the description of the main intention of the thesis research: To explore and compare the physician patient relationship in primary care in selected two countries. Background section is followed by the theoretical framework, in order to better understand the theoretical bases for the thesis research. After the theoretical framework, contextual factor analysis is presented, to get more insights on the surrounding environmental factors, potentially affecting the physician patient relationship. The following methodology section describes in detail the research question and sub questions, design and methodology of the thesis, eligibility criteria and ethical considerations. Methodology section also describes how the data collection proceeded and how the data was analysed. The results section presents the findings and interpretation of the thesis research process. Findings and interpretations are presented for Georgia and Netherlands survey data, also comparison of the Georgian and Dutch primary care contextual factors in the primary care and correlation of these findings with the research questions of the thesis is explored. Discussion and conclusion sections at the end of the thesis unite the concepts and give the main findings and conclusions for the thesis. Limitation section presents possible limitation aspects.

1. Background

The background chapter outlines the function and importance of the primary care in medical sector, reviews examples of Netherlands and Georgia. Before the analyses of the components of the primary care as an entity, it is essential to understand the primary care sector and its functionality. General concepts will be briefly described with the examples of country models, Netherlands and Georgia in separate sections. After structural and functional overview of the primary care, the following sections of the thesis will explore the physician patient relationship in primary care and review the concept of a Patient Cantered Care (PCC), that can be called “ideal” model of the physician patient relationship. Why it is important and how it is applicable to the primary care.

Overview of the Primary Care: Examples of Netherlands and Georgia

The primary care as a term was first observed from 1920th in The Great Britan. The primary care has quickly been identified as a hub for regionalized services and a centre for health care in many countries (Mibank. Q. 2005). In 1978, on the World Health Organisation (WHO) congress of the primary care, 134 countries agreed on declaration stating, that health is a physical, mental and social well-being and that primary care is essential and should be accessible to everyone across the globe (WHO, 2023). The primary care ensures, that people receive all possible services starting from the prevention to treatment, rehabilitation or palliative care. It has been considered as a most efficient and cost-effective area of the health care to improve peoples' well-being. The strong primary care makes country's health care system more resilient and prepared for possible crisis situations (WHO, 2023). The primary care is an entry point of the patient into the system in many health care models of the different countries. In its strong and developed model, It is a person centred care, that supports the first contact with the patient and provides an accessible, continuous and comprehensive services. The primary care sector has a significant function in terms of prevention of different diseases by implementing or spreading the information on different screening or preventive programs. The treatment of complex conditions, assistance with social issues, and a continuous follow up on acute or chronic illnesses are also included in the portfolio of the primary care (WHO, 2023). The research evidence of the health-promoting influence of the primary care shows, that the primary care affects many different health determinant factors for an individual, medical and non-medical. It is a person centred, holistic and with this, the most effective way to ensure population health. The evidence shows that the well-functioning primary care helps to improve the population public health parameters as: disease incidence and prevalence, population morbidity and mortality, child and maternal mortality and many other aspects (WHO, 2023). The primary care is characterized by a key role of the primary care physicians, but also the involvement of the nurses and other specialists is reflected in the strong collaboration. The primary care doctor has the mandate to determine patient referral requirement to other health disciplines and has a gatekeeper competency. The primary care entity is distinguished from other aspects of the health services delivery systems with its unique gatekeeper role (Starfield. B. et. Al. 2005).

The Primary Care (PC) is considered as a whole, society approach to health and well-being of the individuals, their families and overall societies. It is committed to social justice, equity and solidarity. WHO encourages the countries to shift the resources appropriately, in order to develop the different components of the primary care and with this ensure a health coverage for the whole population. it is considered as a part of the integrated Primary Health Care (PHC) concept together with preventive public health services. The treatment, rehabilitative and palliative care services provision from the primary care happens throughout the course or life cycle of the patient and his or her family. PC takes into consideration how to serve minority groups, individuals with disability and psychological or mental issues. The primary care is based on the ecological model of human development, that pays attention to environmental and non-medical factors that affect the disease course. Therefore, most important is that the disease course and outcome can also be changed with this holistic approach. The primary care role is also spread to patient and family empowerment and promotion of the self-advocacy and patient rights protection. This may reflect in patient associations and advocacy groups, that are actively supported by the primary care unit. As an example, breast cancer woman groups, family support groups that are involved with the primary care. Therefore, primary care has a central role at different stages of the patient and health provider interaction (WHO, 2023).

The Primary Care (PC) strengthening with implementation of different policies is a priority direction across many countries. Developing the PC is the way to achieve universal coverage of patients, as the primary care means affordable and inclusive care with multidisciplinary team. In the well-developed model of PC medical care, rehabilitation, palliative care should be available across different geographical areas, especially rural regions. In summary, services should be accessible for vulnerable and marginalised groups, education of the population on preventive care measures and physicians trained on providing empathetic and holistic support are aspects to be included in the comprehensive model of the PC (Van Weel C, Kidd M.R 2018). Empathetic and supportive approach from the physicians with open communication and interaction is the core component of the developed PC. Therefore, consideration of a very strong communication and interaction skills trainings are to be envisioned when developing a primary health care sector.

Primary care has high expectation and is facing many financial, demographic, social and

health related risks and challenges in many countries in Europe. Technology advancements make hospitals less useful for longer stays of patients. Exceeding certain number of days in hospital is very expensive for the health care budget. Therefore, disease management protocols change and recommend short-term hospital treatments, that can be reimbursed by the governmental programs. Therefore, It is considered, that a strong primary care system is capable to reduce health care costs and improve health care outcomes due to facts, that primary care can provide services, that will prevent disease complications and will reduce the probability of the patient to be treated in hospital, which is more expense related and complicated. Many diseases can be treated on an outpatient bases, preventing hospital stay expenses and complications, that are related to hospital stay infectious disease. (EOHSP, 2015).

Countries across the European region have different histories of the primary care development. Some countries had to go through the extensive changes with the post-soviet Semashko model and assemble the family doctor structure for primary care sector, as in Georgia. Other countries had successfully developed very effective primary care model as Netherlands. Strength of the process of the primary care in terms of access, continuity, coordination and comprehensiveness was studied and data was ranked in the European Observatory report on the primary care diversity component. In this report, Netherlands has the first place in the ranking structure (EOHSP, 2015). Consequently, it is interesting to overview these different categories of primary care on country models in closer view.

The growing importance of the primary care is recognised and acknowledged by many countries, however primary care has different level of development and even in many developed European countries it is not considered to be on a high level. Although, the Dutch primary care system was in attention from international stakeholders as it is considered as a well-functioning, organised system on a low cost. The most effectively developed primary care model across Europe. System is very accessible during office hours and has a system for out of office hours collaboration. Patients do not pay any co-payments in primary care. It is highly encouraged to transfer patients from hospital sector to primary care, this is supported by the financial incentives as well. Delegation of the tasks is also successful from primary care physicians to nurses. There is a regional collaboration on different disease programs and system monitoring is also well established

(Faber MJ, Burgers JS, Westert GP, 2012). In Dutch healthcare system, primary care is considered as a backbone for the healthcare overall. In addition, a health governance is nowadays closely focused on improving and further developing the organizational structure, integration and a full transparency of the primary care. Policies are implemented in order to improve the organization of acute care segment within the primary care. This is accomplished by strengthening the diagnosis and treatment centres, the aim of which is to increase the coordination between the several disciplines working in primary care. This also increases the coordinating role of health care providers within the primary care. Further development direction for the Dutch primary care aims to increase innovation and patients voice in the system Increase in patient participation in the decision-making process and making health care more transparent for patients, are priorities for Dutch primary care (Kingos. D.S., 2015). The optimal delivery of preventive care programs and health promotion is also given particular attention in policy debates. Netherlands health policy is particularly attentive to physician patient relationship in primary care, collaboration of different disciplines and increase of coordination role of the primary care system (Kingos. D.S., 2015).

The primary care in Netherlands is the best and ideal model of primary care among European Union countries. The primary care policy formation in Netherlands is based on an integrated approach and different stakeholders have a role in this process such as: National Primary Care association, patient and consumer organisations and Royal Dutch Medical Association. Involvement of the broad stakeholder groups shows open and inclusive approach to policy formation and decision making. Patient experiences climate is also very sensitive to patient rights protection. In all clinics, there are patient associations to strengthen the patient's voice. Informed consent procedures and confidentiality are fully covered principles. System is fully patient centred (Kingos. D.S., 2015).

All citizens are able to be covered by the primary care and select their general physician based on their choice, although municipal restrictions exist and overload of the physicians for accepting the new patients may be an issue occasionally. Relationship between physician and patient is open, empathetic and professional, that brings loyalty from the patient side (Kingos. D.S., 2015). Therefore, it is recognised that emphasis is on the patient centred primary care in Dutch system, that is working in culturally competent manner,

providing solutions together with patients by having thorough, open discussions with them. Dutch PC system is considered as relatively well-developed primary care model. Dutch PC has among the best efficiency and quality, comprehensiveness and coordination (Kingos D.S. 2015).

The well developed, and close to ideal primary care model in Netherlands has the high level and well-developed patient centred care. In Netherlands, such a strong primary care can take the load of raising medical costs and lower overall expenses for the health care system. The 90% of the care provided to patients is accomplished in primary care with minimal budget costs of 4%. Very strong primary care is built with a strong physician patient relationship model, with developed patient centred care as in Netherlands (Ahmed. A. et.al 2022).

On the other hand, in countries where society was under the Soviet Semashko model of the health system, the primary care was more centralised, boreoarctic, and less emphasising patient centeredness principles. The possibility for a patient to have an open communication with the doctor was low as it was considered that patient did not know medical terminology or science and could not understand the doctor's explanations. Semashko model of health care was a dominant model and physician was indeed head of the hierarchy and bureaucratic system. Therefore, it was obvious in these countries with such Semachko model, Georgia as an example, that health care was more of a vertical hierarchy with limited space for patient's opinions and holistic approach. The system used to work on the "under the table" payments. If a patient and his or her family needed attention from the doctor or other healthcare providers, the patient was expected to pay extra money to personnel. It was difficult for a patient to find a fair solution for an issue within the closed decision-making structures and corruption-oriented workforce. An example of such a closed system is Georgia. Discussion can be devoted to the Georgia's post-soviet developing primary care system. This transitional period for the country Georgia shows interesting dynamics for primary care development. Coming from such a system, that was demolished only very recently in 1990th, health care professionals were not in many cases equipped with good communication skills, partnership was not a pivotal driving element for care. The attitudes of this model are still prevalent among Georgian health care community (Rukhadze. T. 2013).

In Georgia, reforms of the primary healthcare system started in early 2000th. Reforms were supported by the participation of the support donor organisations. The process started with a construction and rehabilitation of both new and existing outpatient clinics. Numerous primary care clinics and organisations were rehabilitated and equipped with the newer devices. Parallel to this process family physicians and nurses trainings were initiated. However, these early reforms gave the system very generic and basic features with the reforms resulting in the improvements of the the technical parameters and aspects of the primary care system. Rural outpatient clinics were also transformed, buildings renewed and visual appearance changed. Not all of the rural clinics were rehabilitated, but significant portion, at least in regional big cities and populated municipalities. Those outpatient facilities were reorganised as seperate entities, some of them were privatised, agreement contracts were signed with physicians and nurses to accept state healthcare programmes and patients. On a regional level, primary healthcare outpatient facilities were integrated with emergency medical services and infrastructures. Newly established medical centres became service providers. In the cities, privatisation process of the old, so called polyclinics facilities became very active. Secondary and tertiary medical institution privatisation also was actively ongoing. Affordability, trained personnel, infrastructure, efficiency were the main directions for the reform. Howerver, the reforms implemented in the primary care system in Georgia had no significant effect on outpatient service quality or changes in the attitudes or approach of the system to patients. Referals or patient utilisation level of the primary care in Georgia is still very low. Nowadays, Georgia occupies the last place at the bottom of the list of the WHO's European countries with the number of referrals to outpatient medical institutions per capita. Only 50.9% among those individuals who visited the medical institutions due to any health problems, actually selected primary healthcare institutions as the first choice and first contact with the healthcare system (Verulava. T. 2020).

However, despite the still existing gaps, reform of the health care system and the primary care was the response of the government and society to changing health systems, transition to market economy and recommendations from WHO. The strategy of the health care policy in Georgia followed the international mainstream, new policies were implemented. However, development is still in process. Reforms does not include many components for

professional communication, patient centred care principles, psychosocial support or related trainings for health care professionals. Fundamental changes in attitudes of disease-based model are at the very early stage of progress. Model is still “deficit” and medical treatment focused. Empowerment of the patients and families is not recognised as an important care component, there are not enough knowledge and competencies as well (Rukhadze. T. 2013). Literature and research studies specifically exploring primary care physician patient relationship are very limited in Georgia.

However, positive changes are also ongoing and worse to mention in the process of development. Recent changes are mostly related to policy document updates. Primary Health Care Governance, as part of the changed commitments towards primary health care is strengthened by the framework of the Health System State Concept. As part of these initiatives, a draft of the Primary Health Care Development Strategy 2016-2026 was prepared by the Global Alliance for Health for Georgia. This draft strategy is the recent, renewed attempt for the reform. It aims to strengthen family medicine sector and further develop adequate, cost effective and sustainable primary health care. Strategy is set to define and better integrate roles of the primary care into health sector (WHO, 2023).

Other characteristics of the system in Georgia are rural and urban specificities of services. Primary care services are available throughout the country via ambulatory clinics, majority private 95% and 5% publicly owned. Ambulatories are distributed in cities and 7 rural areas. However, rural and mountainous municipalities lack infrastructure and ambulatories to ensure uniform access. In some places individuals must go from one village to another to get the primary care support. Certain big companies, that own ambulatory clinics are private and operate together with public providers to deliver primary health care services in various settings in Georgia. The state representatives are participating in providing and purchasing primary health care services under the control of the Ministry of Labor, Health and Social Affairs. Private clinics provide better services. However, accessibility is still restricted to private insurance companies and their beneficiaries. In addition, continuity of care is not sufficiently ensured. Limited follow up from doctors on screening programs or

paediatric vaccinations and follow up on disease management is not consistent. Informational education of families or awareness raising on disease programs is very low, especially in rural areas The scope of family doctors practice is narrow and reimbursement salaries also low compared to minimum ware range (WHO, 2023). Primary health care services are meant to include maternal and child health services, immunization services, reproductive health care, screening, some activities in health promotion and disease prevention at the population and individual levels, basic laboratory tests, palliative care, rehabilitation, psychiatric community-based care and check-ups. The Health Services Department of the Ministry of Labor, Health and Social Affairs determines the priorities and the annual budget for these programs. The criteria for setting priorities are not explicit. Programs are not promoted for population to know and se e available services (Goginashvili K. et al 2021).

Overview of the Primary Care sector importance and examples of Dutch and Georgian contexts of the primary care development bring us to the topic of physician patient relationship importance in primary care.

Physician Patient Relationship in Primary Care

As mentioned in the country examples, a strong physician patient relationship is especially important in primary care. This determines further primary care processes and patient health outcomes. Access and referral of a patient to the different care services is important, however more important is each encounter of the patient with a physician and a relationship with the primary care doctor. These interactions determine how all available services will be accessible for individuals. In the study on physician patient relationship, it was observed, that patients with more disease and multimorbidity had less quality and positive functional relationship with their primary care physicians (Olaisen. R. H. 2020). Therefore, emphasizing more involvement, communication efforts, requirements for more empathy and resources to manage multimorbidity well. The physician patient relationship is also a core component of patient centred care and how this multimorbidity can be

managed.

The patient relationship with a health care professional in the primary care, or the receipt of important services of primary care is dependent on communication process with the patient. How doctor gets into relationship, expresses empathy and builds trust. Moreover, the research literature shows that primary care, in comparison to specialty care, should be associated with a more equitable distribution of health services to the population (Starfiel. B. et. Al. 2005). More people should be able to get access to primary care services. This finding, that is true in both cross-national and intra-national studies proves, that specifically the primary care should ready and prepared to serve the big proportion of the population. In addition, diversity of cultural, ethnic groups, age groups is significant among patients and primary care should be able to serve those different groups equally. Therefore, patient centred model, where communication is on a very highly empathetic and professional, can give primary care sector main components to perform its main function and serve the diverse population groups. This is the method by which primary care improvs population health. The ways to improve overall health and reduce differences in health across different population subgroups is therefore obvious. Therefore, the importance of primary care sector to be developed, fully equipped and having trained professionals, not only in medical but also non-medical and communication skills is of paramount importance for the country's economy and health care cost reduction (Starfiel. B. et. Al. 2005).

John G. Scott et. Al. (2008) studied physician patient relationship in the primary care. In the study they defined "healing relationship" between physician and a patient, that was characterized by trust, nonjudgmental emotional bond, appreciating own power as physician and controlling it and displaying commitments to care. Although, in this study primary care physicians were selected based on their reputation and cases of caring relationships with patients, this is not representing the whole primary care system and is only selected circumstances and cases. However, this healing relationships demonstrated 45% of the positive patient treatment outcomes (John G. Scott et. Al. 2008).

In patient centred care it is important, that physicians have good interpersonal skills to be able to build trust-based healing relationship with the patient. Previously, physician patient relationship was not adequately valued as equally important to medical care, but nowadays in developed countries as Netherlands, this aspect is of paramount interest and significance. Strong relationship improves medical outcomes and competitive environment among health care providers also gives more motivation to doctors for the service improvement to their patients (Berger. R. Et. Al 2020).

There is a citate in the article by the author which states: “A patient–physician relationship is sacrosanct where the patient reposes trust and confidence in a physician to cure, protect against, or palliate illness. The patient has feelings, wishes, desires, hope, and, sometimes, ambivalence or defiance.” (Honovar. SG 2018). This description perfectly shows the philosophy of a good and healing relationship need. How to approach a patient and what to see in the care process. The deep and understanding relationship is frequently absent to the level that is described by this author and therefore clinical practice examples, articles and other evidence suggests, that physicians often remain emotionally distant to patients. They are technical in their approach, concentrate on organ or tissue focused medical treatment model. Healthcare organizations increasingly refer to patients or consider them as “customers” with a meaning of routine cases. In this approach, it is obvious, that monetary considerations are inappropriately prioritized over empathetic, professional medical care. There may some cases, when medical professionals may take advantage of patients’ vulnerabilities. For example, cases when patients may be minority groups or may have language barriers to understand information adequately. This and other similar instances compromise reputation and trust to the health care provider (Honovar. SG 2018).

“The patient will never care how much you know, until they know how much you care” – Terry Canale (2000 American Academy of Orthopaedic Surgeons Vice Presidential Lecture), citation mentioned in the article, fully describes the full picture of the physician patient relationship concept (Graham. B. et. Al. 2019). In theoretical principles and in practical professional settings, physician patient relationship is interplay between trust,

vulnerability and authority. Physician is service provider and makes decisions on the treatment and has a power of being an information carrier and decision maker, patient on the other side is being vulnerable, needs assistance, treatment and therefore needs to trust the physician. Hence, trust becomes the key factor for the interaction and treatment process. Along this lines, with changes in the primary care system models in many countries, reforms put more accents towards making primary care service provision processes becoming more patient cantered and emphasizing shared responsibility. In all circumstances, communication becomes the way to get in therapeutic relationship and further support the trust process (Graham. B. et. Al. 2019)

What is a Patient Centred Care

Modern medical care changes and progressive developments in medicine, with more emphasis on holistic spirit, has grown in response to the universal challenge of the care of patients with acute, chronic and life-limiting illnesses (Mahara.G. 2023). Health care cannot be solely based only on medical service-based model, rather health care is holistic, involving bio-psychosocial care as well. Along with contextual and conceptual changes, healthcare systems in many countries are gradually transforming from biomedically-oriented, disease and treatment directed systems, into more person-centred care (PCC) oriented model (Ahmad. A. M et al 2023). To adequately address and understand an illness, patient is viewed in context with bio-psycho-social approach. Therefore, individual's health problems and experience of illness is approached holistically. Netherlands holds among the first places on a ranking of such holistic characteristics, after United Kingdom (EOHSP, 2015).

Worldwide, person-centredness has been more and more recognised over the years and is considered as a core component of high-quality and efficient healthcare system. Demand for changes is growing. Pivotal factors, that make a foundation for these change movements are the growing and increasing demand for access to care, more technological developments, and the rising costs for healthcare services. Patient centred approach in

primary care is a factor, that helps to address non-health related causes of a disease and finds better solutions for physical illness. As a result, it could reduce costs of more expensive inpatient or hospital-based medical care. A core component of PCC is to create a partnering relationship between the care recipient and a healthcare professional. In this model the unique needs of the care recipient are the driving point for the provision of care. PCC is recognised as a core value of primary care. This is the model implemented in the Dutch primary care system (Ahmad. A. M et al 2023). Dutch primary health care system is also considered as one of the most developed among European Countries (Van Weel C, Kidd M.R 2018).

One of the studies on the Dutch primary care discusses a research conducted in the Netherlands to explore the concept of the person-centred care (PCC) in primary care settings. The study specifically focuses on how PCC model encompasses the services for the patients with low health literacy and those from diverse ethnic and socioeconomic backgrounds. The study is based upon a previous rapid release review (RRR), that explored how PCC can function in various international contexts and cultures. In this study, the aim was to validate and compare the relevance of the findings from the review specifically in relation to the Dutch healthcare system. To summarise, this research emphesizes the importance of directing person-centred care approaches to adapt to the local context. PCC should tbe implemented by taking into consideration the specific requirements of patients with varying levels of health literacy, diverse backgrounds, minority groups. Relevance is also important within the Dutch primary care system. The findings once again emphasize, that collaborative interaction between healthcare providers and patients, physician patient relationship with cultural sensitivity, and the integration of technology are crucial factors in achieving these goals (Ahmad. A. M et al 2023).

Different studies has been conducted on the physician patient relationship, that concentrated on the physicians perspective of the relationship. A comprehensive analysis of patients‘ trust in primary care physicians, looking from the perspective of physicians themselves is important. Both sides of the relationship are important to look at during the

analyses of the physician patient relatioship as a process. Both sides have a critical role in healthcare delivery and outcomes (Greene. J & Wolfson. D. 2023). This interesting study looked at the physicians‘ perspective on trust. The study goal was to explore physicians' perspectives on patient‘s trust. Compare contrasting opinions within the literature, that focuses on patients' trust in physicians. It is interesting to understand how physicians appreciate the patient’s trust and how they seek to earn patient‘s trust. What are the challenges that are predominant in this process. This perspective will also help to understand the patients perceptions as well (Greene. J & Wolfson. D. 2023) . The research was conducted with semi-structured interviews with physicians and an expert, who was experienced in patients‘ issue analyses. In the findings, it was obvious, that patients‘ trust was valued by physicians. All the participating physicians homogenously responded and emphasized the foundational importance of patient trust. Physicians described patients‘ trust as an essential component for patient adherence to treatment recommendations, positive health outcomes, patient loyalty and overall patient satisfaction. Physicians ability to effectively deliver healthcare services and fullfill their professional responsibilities was dependent on patients‘ trust. This outcome emphesizes the finding in the literature on trust and its role in the Patient Centered Care (Greene. J & Wolfson. D. 2023).

It is underscored in this research article and also in the overall literature, that the potential of enhancing the patient trust, improves healthcare outcomes for the patients and increases the patient satisfaction. In addition, that can mitigate physician burnout by supporting more rewarding professional interactions. The analysis provides interesting insights into the complexities of patient trust from the viewpoint of physicians. Challenges faced by physicians in this process, strategies to enhance trust are valuable findings for the improvement of the healthcare delivery and medical training (Greene. J & Wolfson. D. 2023).

Patient centred modern approach as described in the thesis is more developed and implemented in Netherlands model. This model is defined as a model that focuses on patient wishes, decisions and respects patient rights (Ahmad. A. M et al 2023). In this

model, the ideal physician patient relationship has certain characteristics. It is important to have an open two-way communication between physician and patient. Research describes that there are four main aspects of the relationship (Constand. K.M. et.al 2014). Communication has a significant, pivotal effect on all the four aspects of the meaning of the patient physician relationship, this on the other hand is vital for the patient satisfaction. Those four aspects are:

Trust – those patients who trust the physician has the highest level of satisfaction, knowledge – patients always indicate a high level of satisfaction when the physician's communication is open and gives the patient an opportunity to share the information and understands their concerns to specifically address them.

Respect – as a perception of physician's friendliness, warm relationship, emotional support, and care are known factors to be directly associated with patient satisfaction.

Loyalty – which is the continuity of care improves patient satisfaction.

In addition to these aspects of physician patient relationship, longitudinal care, when patient sees the same doctor with stable continuity of communication and medical treatment, when consultation with the patient happens with the same doctor. These are the main process components by which doctor patient relationships are promoted. All these aspects significantly promote communication and trust (Constand. K.M. et.al 2014).

In 1998, the American Academy of orthopaedic Surgeons conducted a survey on this topic, which found as a result, that patients perceived technical skills as important in the interaction with doctors, but they valued communication skills equally and significantly important as well. According to this survey, while 75% of the surgeons themselves believed that they had communicated sufficiently with their patients. Only small portion, 21% of the patients actually expressed satisfaction with their surgeons' communication skills. This is interesting gap in this regard. This gap in perception between the surgeons and their patients clearly shows how important is the health care professional's

understanding and perception of the patients' needs and feelings. This survey showed that the most important aspects were in categories such as listening and caring, and the time spent with the patient (Constand. K.M. 2014).

Stewart et al noted, that the physician's attention, diligent attitude to patient and caregiver, and sincere attempts to get knowledge of the patient's pain and emotional state is positively correlated with physical complaints or disease symptoms resolution. In this study the outcome measure was defined as a resolution of symptoms or recovery from disease. In a follow-up meta-analysis study on doctor-patient communication and affected health outcomes, the author noted, that different outcomes are affected, such as frequency of visits and emotional health in addition to symptom resolution (Stewart. M. A. 2018). Quality of communication during anamnesis process, sense of empathy, and management of patients' complaints goes beyond the creation of just the formal treatment plan without content. Therefore, it is important how physician communicates with a patient and caregivers, while taking the history, gathering information influences loyalty, how often, and if at all, a patient will return to that same physician (Stewart. M. A. 2018).

Furthermore, the PCC involves communication between doctor and patient, that is meant to express a doctor's willingness to include a patient in the decision-making process, to provide a patient with information programs, and to ask a patient about his or her explanatory model of illness, the perception of the disease as influenced by personal customs and belief. What the patient feels, how his or her life and immediate environment are affecting the disease process. What is his or her opinion about the treatment, is there an agreement between a physician and a patient on treatment. If patient understands everything that is provided by the physician. These are some of the important questions health care provider should consider in primary care.

Physician Patient Relationship and Patient Satisfaction

Patient satisfaction is the reflection of the system in which patient receives the medical care. Patient satisfaction is defined as “the degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective, or beneficial” (Friedel. E.C. et.al 2023). Patient satisfaction is affected by the parameters, that are components of the Patient Centred Care (PCC). The four components, that are reflected in physician patient relationship mentioned also as parts of PCC. There are four determinants for patient satisfaction:

- Trust Friedel et al found that, among patients with chronic debilitating disease as systemic lupus erythematosus as an example, those patients who trust and “like” their physician had higher levels of satisfaction. In another study with patients having the Parkinson’s disease, the perceptions of their physician’s trustworthiness were the drivers of patient satisfaction (Friedel. E.C. et.al 2023).

Strategies to build the trust are described in literature in different components. First of all communication is considered as an important foundational aspect. Healthcare professionals themselves underscore the significance of clear communication and compassionate care in building trust with the patients. Components of the effective communication are active listening, utilisation of the patient understandable language when explaining medical information, treating all patients with empathy and equality. Personalised approach, clear focus of the physician during interaction with the patient, understanding what are the priorities of the patient, fosters deep connection and rapport building between the physician and the patient (Greene. J & Wolfson. D. 2023).

Belief and empowerment of the patient is also important. Expressing belief in patients' abilities, empowering and encouraging patients’ participation in the decision-making processes are identified as essential in building mutual trust. Building trust through effective mutual interaction, which includes listening attentively and responding

appropriately to patient concerns, is pivotal. Patients are more likely to feel satisfied with their care, when they trust their healthcare provider. The importance of the patient empowerment, and acknowledgment of their roles and responsibilities, opportunities and freedom of choice makes patients actively involved in their own healthcare (Greene. J & Wolfson. D. 2023)

- K**nowledge.** Professional knowledge is an important part of a physician patient communication by no means. Therefore, it was discovered, that when doctors became aware of patient complaints, medical issues and addressed them appropriately, with a professional attitude and knowledge, patients' expectations, patient satisfaction level has increased consequently. This same tendency was observed when doctors allowed a patient to be more open and share more information. When a doctor allows a patient to share more information (Johnson. T. 2019).

To analyze in more detail the importance of professional knowledge in a physician patient relationship and its impact on patient satisfaction, it is essential to know, that professional knowledge gives first critical steps for successful interaction, enhances communication and facilitates trust. Doctors' proficiency, competencies in navigating and solving patients' complaints and medical issues, gives a crucial foundational support in supporting an effective communication, that is the start of trustful future relationship. Consequently, proficiency is linked to higher levels of patient satisfaction in the chain of this events. (Greene. J & Wolfson. D. 2023).

Encouraging patients to express themselves openly and providing them with information they need are essential components of a patient-centered approach. This approach leads to increased patient satisfaction by fostering a collaborative and supportive healthcare environment. Trust and Satisfaction are affected by the knowledge and communication. Along this lines, professional development and training including the training in communication skills, cultural competence and patient centered approach principles positively affects the trust and satisfaction. Therefore, emphasizing the need for ongoing

professional development for healthcare providers (Greene. J & Wolfson. D. 2023).

As a summary, the conclusions from the analyses emphasize the pivotal role of professional knowledge and effective communication in building trust and patient satisfaction.

- Regard. Respectful approach naturally can cause positive feelings. When physicians express friendliness, warmth, empathy, emotional support, and caring attitude, this have been associated with patient satisfaction. Patients appreciate and value the respectful approach. Their response is positive to healthcare providers who demonstrate these qualities. That enhances their overall satisfaction with the healthcare experience.

Again to conect the concepts the association with patient‘s satisfaction is strong. With the respectful approach from physicians, patients are more prone to feel respected and understood when they perceive, that their physician expresses respectful, empathetic, and supportive attitude (Johnson. T. 2019).

There are certain elements, that characterise a respectful approach: Friendly attitude and creation of a welcoming and warm atmosphere during visits and interactions with the patient. Warmth as mentioned, when a physician shows a genuine support and concern. Physicians respectfull attitude is reflected in verbal and non-verbal interactions.

Empathy means, when an understanding and sharing of patients' emotions and thoughts is open and a physician can truly feel and understand the concerns. Emotional support is expressed when the physician provides reassurance, empowers the patient and makes environment comfortable during difficult times. Caring attitude means demonstrating genuine interest in patients' well-being and health outcomes (Greene. J & Wolfson. D. 2023).

Impact of these factors when fully implemented is positive on the physician patient relationship. A respectful approach with all its components, supports a positive doctor-

patient relationship built on trust and mutual respect. Patients are more likely to engage actively in their healthcare as a result. Patients follow the treatment plans when they feel respected and cared for by their physician.

In summary, it is emphesized, that a respectful approach from physicians, characterized by friendliness, warmth, empathy, emotional support, and a caring attitude, positively influences patient satisfaction. It underscores the pivotal role of interpersonal skills in healthcare delivery and the benefits of fostering supportive doctor-patient relationships (Greene. J & Wolfson. D. 2023).

- Loyalty. Patient's satisfaction increases, when doctors express loyalty towards their patients. They feel more satisfied when doctors offer support with long term commitment. This is a continuity of care, that is reflected and improves patient satisfaction.

Expressing loyalty towards patients, through promoting continuity of care and a long-term commitment, positively affects the patient satisfaction. Patients perceive themselves more respected and cared for, when they feel, that their physician is honest and committed to solve their ongoing health issues and improve the well-being for the long term (Johnson. T. 2019).

Continuity of care is a reflection of well organized system, that promotes loyalty from the patients side. The patient's satisfaction is increased, when the care provided involves consistent and uninterrupted support from the same healthcare provider or team over time. Patients benefit from building a relationship of trust and loyalty with their healthcare provider on a long-term bases. As a result, patients overall healthcare experience is positive in time. Factors such as effective communication, empathy, personalized care, and shared decision-making are directly correlated with expressions of loyalty from the patient side. These factors contribute to building a strong doctor-patient relationship based on important values of PCC and mutual respect (Greene. J & Wolfson. D. 2023).

In summary, the significant impact of doctor's loyalty and continuity of care on enhancing

patient satisfaction is obvious. It emphasizes the importance of supporting long-term relationships and commitment in healthcare sector to improve overall patient experiences with the system and outcomes for patients.

Patient satisfaction and patient reflection on the experience they get in the system is the most important factor, that can determine further loyalty of the patient, health behaviors, compliance to the treatment and outcomes of the health condition. Patients' perception of physician 's attitude, empathy and understanding has a very strong influence on the level of evaluation of the physician-patient relationship. How patients see the process. These factors determine patient's trust, belief in doctor's competencies. Therefore, that help to emphasizes and see the importance of patient believes in physician's will and empathy in constructing trustful, healing and harmonious relationships between physicians and patients (Wu Q, Jin Z, Wang P. 2021). The Healing physician patient relationship, that leads to trust, loyalty and respect is the patient centred care. This can be identified as an ideal relationship, built by communication, open and empathetic physician patient relationship. Healthcare providers can enhance patient satisfaction by consciously incorporating these elements into their interactions with patients.

Healthcare policy and practice has a significant influence on promoting physician's professional trainings and preparation in PCC principles. This could potentially result in better preparation of health care providers, better health outcomes for patients and more positive patient experiences. Training programs and professional development concentrated on communication skills, empathy, and patient-centered care can help primary care providers improve their approach and patient outcomes.

Healthcare providers can boost patient satisfaction by prioritizing continuity of care and demonstrating loyalty. This can be accomplished through consistent support and commitment. Practices that promote long-term relationships between patients and healthcare providers are beneficial for both patient satisfaction and healthcare outcomes.

This underscores the importance of maintaining a patient-centered care approach that prioritizes respectful and empathetic communication. Continued research and implementation of best practices in patient communication can further optimize patient satisfaction and quality.

2. Theoretical Framework

In 1992, Ezekiel and Linda Emanuel presented and explained the four different models of physician patient relationship. Authors explain different principles, that are important in physician patient relationship: patient autonomy, physician obligations, role of patient values and the goal of this relationship (Johnson. T. 2019). Different systems and policy arrangements emphasize these principles differently. Therefore, we may encounter different forms of physician patient relationship. Four models are formulated based on these principles: Informative model, where physician is a competent medical expert, patient has a choice and control over interventions. In Interpretative model, physician is more a counsellor and is exploring and interpreting patient values to offer a selected intervention. Deliberative model is when physician is as a friend or teacher, patient is more open to revision and discussion. There is a self-development component in terms of the medical care for the patient. The last one is a paternalistic model. This model is about physicians being more as a guardian, promoting health and wellbeing of the patient despite patient preferences or interest (Johnson. T. 2019). An ideal model would be an informed physician, professional willingness to share with the patient but also respect to patient opinion, feelings and patient rights. Health care sector is also differentiated in terms of structure and specifics. Different issues are important for various units as: primary care, inpatient care, emergency care etc.

The application of these principles to different healthcare entities underscores, that various healthcare settings, it is primary care, inpatient care or an emergency care, these principles are utilised differently, based on the structure of the setting and specific requirements that exist. This suggests that the „ideal“ physician-patient relationship is a balance of the

physician's expertise with respect for patient‘s opinions, feelings, and rights.

What is important is that the recognition and acknowledgment, that healthcare policies and organizational structures may influence how these principles are applied in practice. The balance between the principles should be close to the patient-centered approach where physicians communicate effectively, share information transparently, and involve patients in decision-making.

In conclusion, a comprehensive overview of the theoretical underpinnings of physician-patient relationships, emphasizing different models based on principles such as patient autonomy, physician obligations, and the role of patient values. It underscores the importance of adapting these models to various healthcare settings while striving for an ideal relationship that respects both medical expertise and patient rights.

3 Factors Affecting Physician Patient Relationship

This chapter describes and summarizes factors affecting the physician patient relationship. Factors that are the centre of the research of this thesis. Contextual factors operate and affect the physician patient relationship in the primary care (Cavinsky. C. E., 2003). The First factor can be patient characteristics, that are significant as predictors of communication and physician patient relationship. Patients’ disease condition, severity of symptoms as pain, Activities of Daily Living (ADL): bathing, eating, dressing, transferring, and toileting are determinants of condition severity. Also, patients’ degree of bowel and bladder continence may put a strain on a patient and caregiver. Equally important is patients’ behaviour, angry or aggressive behaviour, psychological state, in some extreme cases tendency of harm to self and others (Cavinsky. C. E., 2003). Therefore, communication and trust between patient and health care professional is critical to prevent negative outcomes. In different countries health care system is on a different level of development, therefore level of development for communication in health care sectors also varies. More personalized approach to health care will develop health care

system more, certainly that will improve the patient outcomes.

Among patient related factors, disease profile is one of the important factors. Disease demographic and profile of disease has changed in recent decades. Chronic diseases (NCDs) are one of the major health and development challenges of this century, in terms of both the human suffering they cause and the harm they inflict on the socioeconomic fabric of countries, particularly low- and middle-income countries. The world's population is ageing. Improvements in health care in the past century have contributed to people living longer. However, this has also resulted in an increase in the number of people with chronic diseases, including dementia, Multiple Scleroses, Cancer, Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease etc. These types of chronic illnesses are characterized by fluctuations in trajectory, uncertainty in prognoses, extended disease timelines and stress. The functional status of a Dementia, stroke and COPD patients declines steadily until it reaches a poor and dependent condition (WHO,2014). Maintaining a peaceful environment can help calm patients and is often best achieved in the comfort of effective communication between health care professional and patients (WHO,2014). Caregivers of these patients experience stress reflected in physical and psychosocial symptoms. In case of dementia for example, psychotic behavioural and depressive symptomatology of patients leads to double caregiver burden (Castilo. M.C., Woods. B., Orrell. M. 2013). Of course, this burden is reflected on primary care as more this type of patients come for treatment or follow up to family doctors.

The second is related to health care system setting. Sectors of the health care system also affect and shape the model which is operating in a particular system setting. Family medicine is a field of medicine where a family doctor is a main point of contact and gatekeeper of the patient to health services and different interventions. Primary care sector of heath care system is a place, where a family doctor has a central role. Family doctor has interaction with patients and their families. This is a first point of contact of families with health care in general and physician patient relationship in this setting has a major and decisive role (Dawkins. B. et.al. 2021).

The third one can be identified as communication. In general, physician patient relationship and dynamics refers to the communication pattern between patient and health care provider. In this dynamic not only the information is crucial what is communicated, but also the way and approach it is communicated. Verbal and non verbal communication is a part of this process. This process to be successful, trust should be the hallmark of communication. Additionally, trust of the physician and a patient is a factor, that is considered more influential than satisfaction with services, or adherence to services (Johnson. T. 2019).

Fourth is the role of the trust as one of the princinple factors. Trust is recognised as very significant component for successful communication in healthcare settings. It underscores, that effective communication cannot exist without trust between the physician and the patient. Trust strengthens the reliability and effectiveness of communication exchanges. It implies that a trusting relationship may positively impact patient outcomes and experiences more significantly. Correlation between trust and satisfaction is important to explore. Trust between the physician and a patient has more influence than just a satisfaction with services or adherence to medical recommendations. Hence, as the evidance underscores, the effective communication in the physician-patient relationship goes beyond the rooutine exchange of the information between physician and a patient. It involves building trust through both verbal and non-verbal communication. Trust is identified as a cornerstone that significantly influences patient outcomes and experiences, highlighting its importance in healthcare delivery (Johnson. T. 2019).

Trust is an important defining component of the physician patient relationship as mentioned and the communication is the way to strengthen the trust. Effective communication is the way to improve patient and physician satisfaction level in the service context. Research shows, that effective communication reduces medical errors, abolishes patient complaints and claims about medical negligence and misconduct, also this process improves patient adherence to medication and treatment regimens. Overall clinical outcomes, physical and mental health related symptoms and complaints are positively

impacted, that leads to the improvement of the disease outcome itself. Medicine had lot to do with paternalistic approach in previous years, however as with time it is more distanced from this model, the practice of patient-cantered medicine, when patients are treated as an individual person and responsibility and power is shared, that forms a therapeutic alliance between health care professional and a patient. Effective communication becomes the facilitator in cementing the new equation of equality and partnership in patient physician relationship (Johnson. T. 2019).

Challenges to building trust are also significant. Systemic issues that are frequently mentioned are challenges such as patients' negative past experiences with the healthcare system, including instances of discrimination or disrespectful treatment. These experiences often led to a general distrust that extended to individual physician-patient relationships.

Time constraint in healthcare is a frequesnt isseu. The time pressure within healthcare settings was identified as a significant barrier to building trust. Physicians expressed the need for more time with patients to establish rapport and address their concerns adequately (Johnson. T. 2019).

On the other extreme, lack of support from health care professionals and uncertain communication, lack of support from caregivers, may lead to physical and mental issues in patients. For example, depression is one of the psychosocial issues frequently encountered among chronic disease patients. Cancer patient caregivers experience different levels of burnout and mental disability. Boyuong. et.al. (2013) described depression in 897 cancer patient caregivers, with 82.2% depression prevalence in its different degrees. Therefore, next factor can be identified as mental state and disease burden of the patients' caregivers, that is reflected also in the reduction of the social support circle of the patient. Argyriou et. Al. (2011) described the high prevalence of anxiety and depression in his study about quality of life of advanced COPD patients and their caregivers. Showing, that daily care challenges with intense workload due to patients' physical and sometimes cognitive disability, leads to emotional burnout with time. Stroke survivors experienced difficulties

with daily living activities, deficient communication with family members and doctors, therefore burden was increased and related to different psychosocial and physical symptoms. Therefore, efficient communication is of paramount significance is such severe cases.

Although, patients and their caregivers comprise important component of the relationship with health sector. Caregivers sometimes are a sole decision maker in some systems and cultural contexts. Due to severe symptoms of some chronic disease, for example dementia, stroke and COPD patients on the stage of the disease when they need a daily routine care, their caregivers experience equal or more phsycho social difficulties, depression and stress burden. Patients and their caregivers are at increased risk for developing emotional distress and other psychopathologic reactions, such as guilt, anger, resentment, and a sense of inadequacy when facing disease challenge. Social and environmental factors interplay with other variables and determine patient needs and level of physician involvement. Social support from other family members, friends or formal support systems is an important cornerstone. Social environmental factors also include financial strain. How much hours caregiver spends on caregiving and if a patient is involved in functional activities and has a financial income (Adelman. R.D 2014).

Health care system infrastructure and resources are factors, that stand aside from patient role. Longer communication and knowledge of the patient's problem, institutional memory about the history of the patient is crucial. Different setting may allow different levels of communication. If the physicians' resources are limited, they may not be able to build trust and have effective communication with the patient or caregivers.

Therefore, different factors as patient characteristics, disease profile, context of the health care system, patient trust, caregiver support are some of the determining factors for overall physician patient relationship

4. Methodology

This chapter describes the problem definition of the thesis and scope of the research. Objectives and research aim will be described together with thesis design and research methodology. Target group description and the eligibility criteria will be reviewed and followed by data protection ethics.

Scope of the Research and Problem Definition

Physician patient relationship is a key component of the PCC in primary care. Patients' perspective on the interaction with the primary care system and health care professionals is equally important. There are limited studies in Georgia, that explore a physician patient relationship in primary care. Georgia is a developing country with health system in transition and it is essential to have more research data on the topic.

Through the literature analyses it is obvious, that there are differences on the level of physician patient communication patterns in Netherlands and Georgia. Many external and internal factors that have been described, determine the differences. It is interesting to look into more detail in differences and explore how patients see and feel the primary care doctor services provided to them. All these aspects are built through the communication from doctor with the patient and caregiver. However, physicians and health care professionals usually lack the skills of well-built communication. They receive limited formal coaching in patient communication skills. Although, physician and health care professional clinical practice involve interaction and performance of many sessions of patient communications in their professional role. In addition to the deficit of formal training in communication skills, strict reliance on clinical tests and investigations, defensive nature of medicine and clinical practice, clinical and financial target interest conflicts and also the influence of social media in different forms, it is print, electronic, or social media platforms, they may act as barriers and depart from the core human interaction values between the physician and the patient.

Main research question for this thesis is:

-What is the level of physician patient relationship in primary health sector from patient perspective in Georgia in comparison with Netherlands?

Speaking about the level of the physician patient relationship, it is operationalised in four main factors as described in the section above. Those are Trust, Knowledge, Respect and Loyalty. Based on the information that will be collected in the framework of this thesis, It will be possible to speak about the level of the physician patient relationship expressed in numbers through the analytical system to be used, described in detail in the methodology section.

Different sub questions arise also from the main research question and give possibility to explore contextual factors.:

-What is the level of development of four main patient centeredness components trust, knowledge, Respect and Loyalty? What is the difference in these four components between two countries?

-What are the contextual factors in Georgia that affect physician patient relationship in primary care?

Exploration and analyses of these questions will be added value to research in primary care with recommendations provided. There are limited literature specifically exploring the physician patient relationship model in Georgia.

Therefore, the main goal of this research thesis is to do a comparison on a physician patient relationship in primary care between Georgia and Netherlands. Netherlands model of primary care as described is close to ideal model of the primary care. Ideal model defined as patient centred model. It will be than possible to compare the two countries based on the same parameters. As a result, the physician patient relationship model in primary care

in Georgia can be seen in analytical perspective and it will be possible to see how far the existing model is from patient centred, modern approach and what are the gaps in policy to help improve the process.

Study Design and Methodology

The study is of comparative design, cross sectional qualitative research. Questionnaire is used to collect data from patients. Questionnaire collects patient age, gender, if patient has any chronic disease, and patient opinion on different aspects of physician patient relationship in primary care. Aspects that have been mentioned as the key components of the physician patient relationship: Trust, Knowledge, Loyalty, Respect. This data is used to explore further age, gender or disease status effect on physician patient relationship dynamics. Questionnaire is anonymous and does not contain any personal identification data.

The data is analysed through thematic analyses using combined inductive and deductive approach. As one of the methodologies of qualitative research it will be useful to see common themes (Braun, V. & Clarke, V. 2012)

Participants are selected by snowball sampling by networking with different groups and patient associations. Participation is fully voluntary. Data collection happened in May 2024. Analyses conducted after the data collection by the thematic analyses.

Patient's experience, satisfaction and believes about the physician's empathy are the detrimental factors for the healing relationship to be built. Physician patient assessment questionnaire was used and validated in Netherlands among 110 patients and 55 Epilepsy clinics. Ther questionnaire showed to reflect on physician patient relationship from the patient's perspective. This tool, the PDQR-9 questionnaire, attached to the thesis as appendix, was considered very useful and valuable to monitor physician patient relationship in primary care. (Van der Feltz-Cornelis. M.C et. al 2003). Similar studies in primary care sector in Georgia are very limited. It will be valuable for primary care

development to explore patients' perspective on similar topic. Professional knowledge of the physician and how this knowledge is used to help the patient and how the communication skills and empathy is expressed to build the trust with the patient are factors that will be measured and compared between the two countries (Stewart. M. A. 2018).

In health care research, the patient-doctor relationship as perceived by the patient is considered important. The patient-Doctor Relationship Questionnaire (PDRQ-9) that was validated in Netherlands was used as a guide and template to create the questionnaire for this study. The PDRQ-9 was developed out of the Helping Alliance Questionnaire of Luborsky, a scale that measures the therapeutic alliance in psychotherapy, considered to be valid for therapeutic relationship of doctor and patient. The PDRQ-9 questionnaire used in this study has been validated and proved to be useful for evaluation of the physician patient relationship in the primary care from the patient perspective. The questionnaire consists of questions on communication with a primary care physician, accessibility of the primary care services, physicians' willingness to help and symptom management of the disease. (Van der Feltz-Cornelis. M.C et. al 2003). As it was used in Netherlands in two different settings for primary care and Epilepsy clinic. It was proved to show the meaningful difference and be validated. (Van der Feltz-Cornelis. M.C et. al 2003). The reliability and validity of the PDRQ questionnaire was proved, but further studies will also give useful information.

Study Target and Eligibility Criteria

Study target in this investigation is primary care level patients. Patient perspective as a service recipient is always important to here.

Eligibility criterial:

-Participants are adult female or male patients >45 years. The age group when disease prevalence is higher and doctor visits may be more frequent. Literature focuses on the

clinicians perspective in the physician patient relationship, however patient perspective is of a primary importance. Patient's satisfaction with the service, treatment outcomes, context and model of physician patient relationship and level and quality of the communication are important and determine the patient loyalty to the system.

-Participant has to have experience of getting services in primary health care clinic or service provider in Georgia

The study is mainly conducted in capital Tbilisi, and also another more regional city Kutaisi. The sample size is minimum 50 primary care beneficiaries in urban and rural clinic

Data Protection Ethics

The study is conducted and implemented in accordance with the Georgian Data protection Act and the principles of medical ethics.

The respondents participate voluntarily in the research. They get a study-specific information and questionnaire in an electronic form by email or by paper form and the Informed Consent Form (ICF) to sign. A participant is considered enrolled when the study-specific Informed Consent Form (ICF) is signed.

Ethics committee of the Charles University reviewed and approved he thesis proposal, informed consent and participant rights and safety protection aspects of the thesis

5.Results

Survey Conduction in Georgia

50 respondents participated in the thesis research. 32 participants were female and 18 were male participants. Respondents in this research participated anonymously in the study.

Participation of the respondents was based on purely participants' interest to the research. After explaining the thesis research, those who were interested were provided the questionnaire together with the informed consent forms. In all cases, participants completed the questionnaire without difficulties, fully understanding the content of the document. All participants were over the age of 45 years. ~~But~~ participants age variation was from 50 to 68 in most cases and with singular cases of participants aged 80 years. Half of the participants had chronic disease requiring continues monitoring and follow up by a medical professional. Half of the participants were from capital city of Georgia – Tbilisi and half from a city in the eastern part of Georgia – Kutaisi. Kutaisi is less populated city than the capital, Tbilisi. Selection was not based on gender or any other factors other than age. Participants had the option of completing the survey either online or on the paper format. Older participants mostly chose the paper form, overal 15, of which 10 were female and 5 were male. Participants who were able to complete an online survey form, where provided the link to the survey questions. The survey form had 9 questions. It was adapted from the PDRQ-9 physician patient relationship questionnaire. The validated questionnaire used in the primary care sector in Netherlands. The questionnaire contained questions designed in a way, that enables to explore and analyse physician patient relationship and have conclusive answers on trust, loyalty, respect of patients. Information about the ongoing study was distributed in the primary care clinic. Anonymity also ensured and helped, that patients do not give the socially acceptable answers to the questions (Van der Feltz-Cornelis. M.C et. al 2003).

Survey Results in Georgia and Their Interpretation

The results of the survey complement the differences between the primary care systems in the Netherlands and Georgia at the level of infrastructure or management, as described in background section of the thesis, and provide a broad picture of the Georgian primary care system in a broader context.The survey data emphesizes several pivotal aspects of the physician-patient relationship, that impact trust and satisfaction in the primary care. The

most important findings obtained can be outlined as follows:

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1. Communication barriers: 40% of respondents feel, that their primary care physician does not fully understand them and that patients can not express fully their concerns. That finding indicates potential problems with communication and trust. The root causes may vary and may originate from patients being unable to fully express their concerns due to different subjective reasons or having difficulties in understanding the physician's advice.

2. Accessibility issues: A significant proportion, 80% of respondents, report issues and difficulty in obtaining appointments with their primary care physicians in a timely manner. This suggests systemic issues with accessibility in the primary care, may be an indication of unorganised system, overloaded services that can in itself contribute to patients feeling neglected or undervalued.

3. Perceived willingness and support: 36% of patients perceive their physicians as unwilling to help. Reasons for such results could be again the high workload, a superficial attitude, or inconsistent care provided. This erodes trust and affects the patient’s confidence and belief to recieve appropriate care.

4. Dissatisfaction with symptom Management: 32% of respondents feel that their symptoms are not managed effectively. That suggests dissatisfaction with the quality of care, potential gaps of the primary care system in addressing patient needs.

5. Chronic Disease Management: Half of the respondents have chronic diseases requiring frequent consultations, emphasizing the importance of consistent and effective care.

Overall, these insights underscore the importance of enhancing communication, accessibility, and overall quality of the primary care to build trust and improve patient satisfaction in primary care settings. It is important to think about what can we learn and how this results can be interpreted. Let’s look deeper at each of the findings.

The first result reflects barriers to communication. In the data collected from the survey, 40% of respondents indicated that their primary care physician may not be understanding

them well. This may indicate not fully trusted communication, barriers to communication and sense of not being heard from the patient perspective. Therefore, having possible misunderstandings in the communication. Patient may not be able to express own concerns fully or it may be difficult to understand physician's opinion on a particular subject. How can this be interpreted and what conclusions can be made? Answer may be, that communication barriers between physicians and patients can compromise quality of the care provided in the primary care sector. In addition, these barriers can significantly impact the patient satisfaction, especially if patients cannot express themselves and cannot get the assistance needed. Alongside to patient satisfaction, communication barriers are a challenge to building trust between a patient and a physician. Trust, as one of the aspects of the research thesis is negatively affected based on the results. If we analyze this aspects deeper, in cases when patients perceive, that their primary care physicians do not understand their concerns and there is not enough communication, or communication quality is poor, that can lead to a deterioration in a care continuum. Frustration and less visits to the doctor. As a result, patients perceive that their issues or concerns are not heard or are not perceived seriously. Patients perceive less engagement from their physician. Physicians' ability to be able to provide appropriate care is therefore compromised. As we can follow the interpretation, logical flow of consequences follows each other.

These communication barriers reflected in the results, make it questionnable how empathy or support is provided. If patients feel their concerns are not heard, therefore open communication, active listening, empathy is not adequately provided. Again this erodes sense of trust, that is the main component of the PCC as mentioned in this thesis.

Second result is related to accessibility of the primary care physician services. Most of the respondents around 80%, indicated that it is very difficult to get appointment with a primary care doctor on time, when it is required to meet the doctor. Sometimes, when necessary, patients need to wait, call many times and eventually it is impossible to get to the doctor appointment. Therefore, we can observe issues with accessibility, in addition to communication barriers. Patients voice is not fully heard by the system. The accessibility issues also affect negatively the trust and loyalty of the patients. When patient has no timely access to care and when they have difficulties in obtaining appointments on time, this situation is creating frustration and a sense of helplessness among patients. This is related to unreliable reputation for the primary care provider. Patients feel difficult to trust

the physician in such cases. This erodes loyalty as a result. Moreover, when patients cannot see their physician when needed, they may perceive the care system very unreliable.

Accessibility issues can direct patients to question and doubt the overall quality of the primary care as a system. Patients can not make an appointment and experience long waiting time, and they feel skepticism, and less respect to the service provider. It is very difficult not being able to get appropriate help when needed. Comfortable and timely access to the primary care services is a pivotal component of the patient satisfaction.

It is important, that the access to the primary care services are consistent, stable for the patient throughout the extended time period. Especially when chronic disease frequency is high. In the survey, half of the respodents had a chronic condition requiring continiues follow up. Consistent access ensures continuity of care, that in turn can foster trust. Based on the results, this continuity is disrupted as accessibility issues are significantly prominent and are on a relatively high level. Consistent access to a primary care physician is important for continuity of care, that in itself fosters a strong therapeutic relationship.

To summarise here, in the survey results we observed communication barriers, accessibility issues and these factors decrease patients satisfaction with the healthcare experience. Referring back to the main research aspect of this thesis, declined satisfaction often correlates with reduced trust and loyalty.

Patients who experience accessibility issues are more likely to seek alternative healthcare providers who offer better access and more convenient services. This shift can result in a loss of loyalty to the current physician and a decreased level of trust in their ability to meet the patient's needs effectively. In essence, accessibility is a critical factor, that is on the lower level based on the survey. Influence on trust and loyalty is negative. Therefore, improving access to care not only will enhance patient satisfaction but also strengthen trust and loyalty.

36% of respondents indicated that they do not see that their primary care doctor is always willing to help them. How this can be interpreted? Possibly A non-consistent approach, superficial attitude or a workload that may lead to an ignorance of the patient needs. Those aspects may be leading to patient's lack of trust that doctor will be able to help. Another 32% of respondents think, that a medical advice they were told by the physician is not

always helpful, or medical symptom management is not always sufficient. This may be a potential dissatisfaction with symptom and disease management. Patients perceive medical recommendations as not always helpful. Perceived willingness to help for these patients is low. This factor is of course reflected in trust and loyalty in the physician-patient relationship. Adherence to the treatment may be low, since patients do not percieve a doctor as helpfull. Trust is also negatively affected and therefore adherence of the patient to treatment recommendations may be low.

Half of the patients had indicated to have a chronic disease, because of which they need to frequently see and have consultation with the doctor. However, with low accessibility and barriers to communication as results show, how the symptom management for the chronic patients will be? Logically following, it may not be on a satisfactory level. Therefore, dissatisfaction with symptom management is obvious and can significantly impact trust.

Patients who are dissatisfied with symptom management might perceive that their care is not meeting their needs or expectations. Again, if we connect the concepts, results go to diminution of trust. In addition, chronic or unmanaged symptoms, that patients may have, sequentially leads to emotional and psychological distress. Emphesizing again, that when symptom management is inadequate, it can exacerbate feelings of helplessness and frustration. As a result, persistent dissatisfaction with symptom management will lead to patients to reevaluate their relationship with their physicians impacting their overall trust and loyalty. Since satisfaction is closely linked to trust, lower satisfaction levels correlates with reduced trust in the physician’s capabilities and the care provided.

To mitigate these effects, physicians can focus on improving symptom management strategies, maintaining open and empathetic communication, and actively involving patients in their care decisions. Addressing these concerns effectively helps maintain and strengthen trust in the physician-patient relationship.

Trust is a vital component of patient-centered care (PCC). High trust improves treatment adherence, diasease symptom management, and satisfaction. In the Netherlands, well-developed healthcare infrastructure supports better trust and communication. Conversely, in Georgia, especially in rural areas, deficiencies in infrastructure and service quality may

lead to lower trust levels, although private clinics in urban areas might offer improved services. When there is a trust between patient and physician, this is when the therapeutic alliance works, and health outcomes are better. Trust determines adherence to the treatment recommendations, symptom control, satisfaction with recommendations (Wu Q, Jin Z, Wang P. 2021). Trust is sometimes used to evaluate the quality of the provided care. Trust is affected by contextual factors and communication from the physician. Contextual infrastructural factors are on high level in Netherlands due to the fact, that system is more developed. Contextual factors are deficient in Georgia, especially in rural areas. In urban areas, private primary care clinics provide better sophisticated service and communication is better. However, this singular case does not make a majority and trust may be less prominent.

Concerns about medical knowledge also has been revealed in the Survey results. Concerns and isseus in regards to the physician's medical knowledge and communication skills affect patient loyalty and trust to the primary care provider. Effective communication between physician and patient and expertise shared by doctors are crucial for maintaining a helping therapeutic alliance and improving patient health outcomes.

Result interpretation in Netherlands

In the Netherlands, the situation regarding communication, accessibility, percieved willingness of support and symptom management in primary care is generally more positive, compared to many other countries, including Georgia, based on various reports and studies (Ahmed. A. et.al 2022). In the same areas, that we have explored with the survey in Georgia, Netherlands has much more advanced results. Comparative analyses of the two systems in terms of PDRQ-9 Survey results is presented, but also described how the Netherlands and Georgian primary care system differ with all other contextual factors and in what aspects, this gives the full comparative picture. The results of the survey are reviewed regarding the main research question of the thesis. In addition, factors of contextual comparison provide the detailed insights on differences among the countries.

On the first point of communication barriers that was revieled by the survey in Georgia, Survey in Netherlands, showss, that communication with doctor in primary care is open.

Patient-Centered Care is a core foundation of the Dutch primary care. The Dutch healthcare system emphasizes and nourishes the patient-centered care, which includes effective communication between physicians and patients. Dutch primary care physicians are trained and prepared to engage in open dialogues with patients, provide clear explanations on the patient understandable language, and involve patients in decision-making processes. Patients reflect on positive and open communication. Quality of interaction is on a very developed level. Patient survey indicates, that patients in the Netherlands generally experience interactions with their physicians, that is open. The emphasis on communication skills during medical training and continuous professional development, that supports this positive trend (Van der Feltz-Cornelis. M.C et. al 2003.

Care in the Netherlands is multidisciplinary, different specialists, but a nurse is usually a primary assistant to the primary care doctor and the system is oriented to take as much care and provide as much services as possible on the primary care level (Ahmed. A. 2023). Communication is better, physician has more opportunities to focus on the patient needs. In contrast to the Georgian model, where nurses do not take many responsibilities, not only on the primary care, but also on secondary and tertiary care levels.

In order to understand the disease well and the person who bears the disease burden, only looking through the biomedical lens from the doctor is not considered sufficient (Ahmed. A. 2023). In Dutch primary care system, that has been transformed to patient-oriented model, where partnership is created among physician and a patient. Challenges may also arise on the population side. Around 20% of the population is represented by immigrants, that may have language difficulties, or more understanding issues with services. However, system is inclusive and can serve the minority groups successfully (Ahmed. A. 2023). Partnership is created with the patients, and partnership is defined in this case as participation of patients in their disease management. Respect to patients' questions. These are characteristics of Patient Cantered Care (PCC) for what Netherlands is considered to be on higher level in relation to the primary care. This healing relationship characteristic of PCC is reflected in PDRQ questionnaire answers (Van der Feltz-Cornelis. M.C et. al 2003).

There are obviously not very significant geographical, urban and rural variation in the

accesibility structure of the primary care doctors. In some regional areas of Netherlands, there are shortages of the primary care doctors. This difference between the regions with the highest and lowest density of the primary care physicians is 16.7 primary physicians per 100 000 population. However, the difference is not felt on the service provision level (Kringos. DS. Et.al. 2015). In terms of disctance to reach a primary physician and infrastructure of the primary care clinics, it is all easily accesible for the patiens. Expressed in measurable terms, It can be said, that it is approximately 1 to 3 minutes drive by car from any point in the Netherlands to reach a primary care physician. The driving distance is very small and around 0.1% of the Dutch population have to drive more time than 10 minutes by transport to reach a primary care physician (Kringos. DS. Et.al. 2015). All this figures only prove the fact, that all components of the primary care are very cohesive to each other and structured. In general, treatment availability is also not an issue. There are no problems in the availability of medications for treatment. There are three types of pharmacies where patients can get treatment medications: public pharmacies, inpatient pharmacies and points where primary physicians can also dispence medications. The role of primary care doctor in this part of treatment medication discpensing is also important feature of the primary care structure in the Netherlands. Although, nearly 1900 public pharmacies cover approximately 92% of the population. The remaining 8% is served by dispensing family physicians. These structural and availability parameters make a context of the primary care also comfortable and suitable for patients, creating a satisfactory atmosphere (Kringos. DS. Et.al. 2015).

In the Netherlands, patients generally perceive support from primary care positively, but there may be some challenges. The Dutch primary care system emphasizes and strengthens accessibility, continuity, and a holistic approach.

However, there are areas of concern, where improvements might be necessary. Some report issues with wait times for appointments or difficulties in accessing care during off-hours. There can also be variability in the quality of care and communication skills among providers (Van der Feltz-Cornelis. M.C et. al 2003). Overall, the system is designed to be patient-centered, and efforts are continuously made to address any gaps in care and improve patient satisfaction.

On the fourth Symptom management aspect, as the Netherlands has a multidisciplinary model, communication is open and accessibility better, continuity of care is better and disease symptoms are managed better.

Disease profile of patients is a significant factor as mentioned in earlier sections. if loaded with different chronic disease, an individual may experience more issues with proper health management, more demand is created on the patient's side, more empathy and communication along with professional service is required from the primary care services providers. Physician patient relationship and approach should be more empathetic. More management skills, interdisciplinary approach and close communication to the patient and physician is paramount. Generally, long lasting chronic disease prevalence is increasing in Netherlands, as is the tendency in other countries as well. This will be challenge as well for Netherlands. Therefore, demand for care will be increasing with time. Long term care on the inpatient level is cost expensive and involvement of ambulatory and primary care services is also of big interest (Kringos. DS. Et.al. 2015).

The Dutch healthcare system's emphasis on communication, accessibility, and effective symptom management tends to result in high levels of patient trust and satisfaction. However, challenges such as regional disparities and occasional issues with appointment availability do exist, but these are generally less severe compared to those reported in other contexts. In the Netherlands, the situation regarding trust, loyalty, and respect in the physician-patient relationship is generally positive due to several factors inherent in the healthcare system (Van der Feltz-Cornelis. M.C et. al 2003).

As results indicate, the Dutch healthcare system fosters high levels of trust between patients and physicians. This trust is built on the quality of care, effective communication, and a focus on patient-centered practices. The emphasis on professional training and ethical standards contributes to a strong therapeutic alliance. Many Dutch patients maintain long-term relationships with their primary care physicians. The continuity of care is supported by the system, which encourages patients to stay with the same general practitioner for an extended period, enhancing loyalty. High levels of patient satisfaction with care contribute to loyalty. The Dutch system's focus on personalized care and effective symptom management supports this satisfaction and, consequently, patient

loyalty. The Dutch healthcare system is known for its patient-centered approach, which includes respecting patients' preferences, values, and autonomy. Physicians are trained to engage with patients respectfully and to consider their opinions and preferences in the care process (Kringos. DS. Et.al. 2015).

Overall, the Dutch healthcare system's emphasis on quality care, effective communication, and respect for patient autonomy contributes to high levels of trust, loyalty, and respect in the physician-patient relationship. While challenges such as variations in care quality and regional differences can occur, the general experience for patients in the Netherlands is positive in these aspects

Contextual factors comparison

Now let's have a closer look at different contextual factors. Health care organisation and context in which the primary care operates is also a factor that is reflected in the primary care professionals functioning and competencies. Dutch primary care is described as a backbone for the Netherlands health care system. This reflects how much the primary care is developed (Kringos. DS. Et.al. 2015).

To see and fully have a picture of the Netherlands primary care model, it is interesting to look at the work practice of primary care work. Teamwork in primary care, conferences are in interdisciplinary format, face-to-face meetings among family physicians and other primary care disciplines is very common practice, especially where there are big family care centers with different specialists particularly for physicians working in health centers with several disciplines in one building (Kringos. DS. Et.al. 2015). There is also frequent collaboration between primary care and medical specialists. For example, medical specialists commonly provide clinical lessons for primary physicians. It is also common practice for primary physicians to ask advice from medical specialists.

In terms of monitoring, there is a comprehensive system of public health care monitoring in the Netherlands. Component of this system is a Netherlands Information Network of General Practitioners, were 92% of the general practitioners nationwide are registered and enter the data. Thereafter, data from over 350 000 patients is automatically processed

through this network for monitoring purposes. Monitoring is conducted with different parameters as the incidence and prevalence of diseases, physician and patient behaviors, and delivery of care process (Kringos. DS. Et.al. 2015). There is also so-called Supply and Demand Monitor (VAAM), in which data is periodically collected and assessed in order to identify the demand and requirements of the health care in relation to specific diseases, specific demographic variables and the supply of health care for specific diseases (Kringos. DS. Et.al. 2015).

Along these lines, characteristics that primary care has in Georgia is different. It is a relatively new model developing in the past 30 years, after the dismantling of the Semashko model of health care. Semashko model was hierarchical, centrally planned model of health care（Kühlbrandt C.2014). Focus was increasing on secondary and tertiary care and no primary care. Gatekeeping function of the primary care doctor was not strong, rather patients could self-refer themselves to different secondary or tertiary care specialists. Specific training for primary care physicians was not operating and primary care doctors were without any advanced continued education programs. Nowadays, a mixed model is functioning. Old policlinics offer limited services, but there are also new primary care centres where primary care physicians can take more responsibilities. But these are mostly in urban areas. Rural areas have deficits in many services. Old ambulatory resources are poor and, in some areas, mostly villages, people have to pass a long distance before reaching to ambulatory policlinic, functioning as a primary care clinic（Kühlbrandt C.2014).

Choice to choose a primary care physician has been recognised as one of the changing pillars for post-Soviet countries as Georgia. People can choose despite their living area to select any primary care clinic and physician. However, follow up or continuity of care is not proper, as secondary or tertiary canters may not share information on patient treatment to primary care level or vice versa the follow up from the primary care side is also not performed（Kühlbrandt C.2014).

Nurses do not have as much role as an interdisciplinary group member as in Netherlands. Physician is the core service provider. Concentration and demand for primary care is not

on providing maximal services, but rather referring patient to specialty care. Partnership is not a prominent feature of the physician approach to patient. Patient may not be getting sufficient services if he or she is an ethnic minority group representative, not speaking the Georgian language for example (Goginashvili K. et al 2021). It is more an authoritative approach than partnership. Service and market level approach, to view service provision as a sole component of primary care is also not prominent.

There are lot of challenges, that have emerged and that make difficulties in ensuring the quality of primary care in the post-Soviet countries as Georgia. These are outdated infrastructure and equipment, especially in rural areas. Also the lack of health workers in rural areas.Mechanisms that monitor and ensure quality. There is no such an united data base as in Netherlands, that helps to monitor patient behaviors or physician's approach. Concern is also a lack of preventive programs for cardiovascular disease. Management of cardiovascular risk factors, that is the most prevalent diseases causing high morbidity and mortality, hense utilisation of high cost secondary or tertiary health services (Kühlbrandt C.2014).

This infrastructural, contextual, arrangement and political differences that exist among Georgian model and model in Netherlands is also reflected on the physician patient relationship. The Patient Centred Care (PCC) is a complex concept and phenomenon, that is made up of specific skills and competencies that physician should exhibit in order to provide services with PCC model. But also, contextual factors affect the process and contribute to satisfactory physician patient relationship. Netherlands is known for a well-developed primary care among developed countries.

Based on the survey results and comparative analyses of the contextual factors we can see prominent differences in physician patient relationship among Georgia and Netherlands, that was the research area of this thesis and the main research question. Physician patient relationship is more of a PCC model in Netherlands, however contextual factors are also very strong and could be a pivotal factor for a good physician patient relationship as well.

The fact, that post-soviet Georgia has moved from a central governance model to more horizontal and patient-oriented scheme is promising, but systemic changes with the full revision of the physician's work mindset to PCC model, only physician trainings will not be satisfactory.

Results In regard to sub questions:

-What is the level of development of four main patient centeredness components trust, knowledge, Respect and Loyalty? What is the difference in these four components between two countries?

-What are the contextual factors in Georgia that affect physician patient relationship in primary care?

It is clearly observed how the trust, knowledge, loyalty and respect are interconnected and one factor affecting the other. What is Netherlands priority, is that whole system is functioning cohesively to serve the patient and increase trust, loyalty and respect from patients. Contextual factors are invaluable. Accent devoted to development of PCC and commitment of the healthcare professionals to this concept in their daily work affects physician patient relationship in primary care in the Dutch system. Support from the governance and policy makers to ensure infrastructure and accessibility to the primary care contributes to the PCC principles. Multidisciplinary approach and actively involved nurses. Organisation of geographical coverage and electronic monitoring systems add synergic positive effect to the physician patient relationship and patients' perspective and feelings are similarly affected. Trust is higher, loyalty and respect expressed from the patients as a result. Those are the main factors that brake barriers to a full development for the high-level physician patient relationship.

6. Discussion

The intention of the thesis was to analyse the difference among two countries in terms of a

physician patient relationship in primary care. The analyses was facilitated by contextual factor analyses and a survey data collected from respondents in Georgia. Respondents who agreed to participate in the study voluntarily after introduction of the ongoing study. 50 Respondents responded from Tbilisi and another city Kutaisi.

In comparing the primary care systems of the Netherlands and Georgia, several key differences emerged, particularly in the context of Patient Centered Care (PCC), healthcare infrastructure, communication barriers and percieved willingness to help. The communication barriers interfere with patients‘ full expression of their concerns with the physician, They percieve, the physicians willingness to help is not satisfactory and their disease symptoms are not adequeately managed. Thess findings show, that compromises trust, respect and loyalty of patietns may be compromised significantly in Georgia.

As described in the literature appropriate relationship, empathy, partnership and communication is a core component of holistic or bio-psychosocial care of patients (Mino. C.J., Lert. F., 2005). Physician in the role of being on the health care sector side, being a representative of the system is responsible to provide the holistic, patient centred care. In the patient centred care trust and rapport building between a physician and patient is crucial. Physician patient relationship, communication between health care professionals and patients is key to strengthen trust, rapport building and treatment compliance. In the thesis survey results it has been observed that trust may be considered generally to be on the low level in Georgia to primary care professionals. Patients responded not being able to believe that physician is always willing to help, or they expressed not being fully heard and understood by physicians. Those aspects may give a picture of not an open communication and therefore lack of trust. Respondents did not give a positive response on physicians providing appropriate information on the available services and different programs. Respondents mentioned that access to doctor is not easy. As a proxy if communication is not sufficient, access is difficult, loyalty to the doctors is low.

In contrast, Netherlands obviously has a better infrastructure, governance, primary care

arrangement and patient centred care. Studies show Netherlands primary care as exemplary in European developed countries. Primary care in Netherlands being a backbone and foundation of the health care system (Kringos. DS. Et.al. 2015).

In addition, modern medical care changes, and progressive developments in medicine, increase in chronic diseases, changes in the approach to the treatment of the diseases with more emphasis on holistic spirit, has grown in response to the universal challenge of the care of patients with acute, chronic and life-limiting illnesses (Mino. C.J., Lert. F., 2005). Therefore, changes will be happening now in the near term and long-term timeframe.

Health care cannot be solely based only on medical service-based model, rather health care is holistic, involving phyco-social care as well (Mino. C.J., Lert. F., 2005). Therefore, the physician-patient relationship is an essential aspect of clinical care, that makes foundation of holistic, patient centred medical care. Strong physician patient relationships are linearly linked and correlated with improved patient outcomes. Therefore, as importance of the relationship between physicians and patients is one of the determinant factors for patient well-being (Johnson. T. 2019).

Netherlands Patient-Centered Care (PCC) and its components are crucual for the primary care. Hence, the Dutch primary care system emphasizes a patient-oriented model. That is characterized by a partnership between physicians and patients. As described in the Survey data, primary care physicians value the empathetic healing relationship with patients. They are well trained for respective communication skills. Patients get primary care services with less communication barriers (Van der Feltz-Cornelis. M.C et. al 2003).

What are the factors that contribute to the Dutch system to be on a high level of development. This is an important question to define the contributing factors and be able to use insight for other countries, as Georgia. Healthcare Infrastructure as a contextual factor contributes in making the environment for the physician patient relashinship to be better. The Netherlands has a well-structured primary care system with widespread accessibility

for patients. Geographic inequalities in physician distribution exist, but that do not significantly impact patient access. Patients can still reach a primary care physician within the area of 10 minutes by transport (Kringos et al., 2015). Additionally, there is a strong network for monitoring public health. This is performed by the Netherlands Information Network of General Practitioners. Organisation collects and analyzes data on healthcare delivery extensively (Kringos. D. et al., 2015).

Challenges still exist despite system strengths, the Dutch system faces difficulties, such as the need to manage an increasing prevalence of chronic diseases, that is a burden on the primary care system and the inclusion of a diverse population, including immigrants who may face language barriers (Ahmed, 2023).

Gerogias's primary care is in Transition. Georgia's primary care system is relatively new and has evolved significantly since the dissolution of the Semashko model of the soviet system. While there has been progress, including the introduction of new primary care centers, many areas still face deficiencies, particularly in rural regions (Kühlbrandt, 2014).

The Georgian system exhibits a more hierarchical approach compared to the Dutch model. Primary care in Georgia often lacks the multidisciplinary and patient-centered elements found in the Netherlands. Nurses play a less central role, and there is a stronger emphasis on referral to specialty care rather than comprehensive primary care (Goginashvili et al., 2021).

Significant challenges in Georgia include outdated infrastructure, insufficient healthcare workers in rural areas, and a lack of unified data systems for monitoring patient and provider performance. Preventive care, particularly for cardiovascular diseases, is also underdeveloped (Kühlbrandt, 2014).

Overall, The Dutch system is characterized by its patient-centered approach, strong healthcare infrastructure, and effective monitoring systems, contributing to a cohesive and accessible primary care experience. In contrast, Georgia's system, still transitioning from

its Soviet-era model, faces challenges related to infrastructure, rural healthcare delivery, and the integration of preventive care. The differences in these systems reflect varying levels of development and priorities in healthcare delivery.

Patients trust, respect and loyalty is determined by the context. If trained professionals are working in the less developed, challenging environment, fulfilment of the integrated PCC principles will be difficult. Also, if preparedness of the health care professionals is low in PCC principles, only contextual factor will be not sufficient. Governance of the system, resources devoted to have physician patient relationship on a high standard PCC level is thus a complex and multifactorial process.

Implications for the primary care practice and education are important to discuss. Some of the aspects, that became obvious include the support for a respectful workplace and culture, also it is important to ensure, that physicians devote time to patients, that is meaningful and helpful for patients interactions.

Education of the healthcare workforce, that should focus more on improving providers communication skills, cultural sensitivity and understanding of minority groups. Strategies to overcome the patient‘s mistrust.

Limitations

There are several limitations that should be acknowledged. During evaluation of this research, that compares the primary care systems as those in the Netherlands and Georgia it is a fact, that the study sample was relatively small. Generalizability of findings may not be strong as a result. The research involved the specific contexts studied in Georgia and Netherlands, urban and rural settings, different socioeconomic backgrounds that were not stratified. Therefore, it will be beneficial to conduct bigger study in Georgia involving different settings of primary care in multiple urban and rural areas. There is limited number of studies in Georgia in regard to physician patient relationship. Hence, more studies will

be an added value to the field development.

Data Quality and collection method variations in paper and online forms was consistent, however honest responces, and accuracy errors can not be fully excluded, that may reduce the reliability of comparisons. Bigger sample size could mitigate such variations.

Temporal factors that change over time can be included in the limitation section as well. The primary care systems evolve over time in both countiries. Therefore, there might be certain factors, that changed already, so findings may have certain percent of not reflecting current situation or future implications.

Cultural and Contextual Differences by no means exist between Georgia and Netherlands. Sociocultural factors and governance structures unique to each country may be more stratified in future research studies.

Bias as a systemic error aslways accompanies the research and confounding variables could be also considered. Controlling more fore the confounding variables for ohysician atient relationship or a primary care context can be accomplished in the future research. Research may be affected by biases in sampling as sampling was not a random selection process in this thesis.

Measurement challenges also may be encountered, when comparing the health care related parameters, such as patient satisfaction, healthcare accessibility across different healthcare systems as Georgia and Netherlands.

Complexity of Healthcare Systems should also be taken into consideration. Healthcare systems are multifaceted. The resarch is focusing on certain aspects as primary care in this case. Certain aspects as interactions for example with broader health policies or secondary and tertiary care structures may be missed.

Certain comparision aspects were not possible to be included fully, as data findings and

interpretations are presented in more detail, than presented by particular research in Netherlands. However, contextual factor analyses was implemented have an integrated picture

Addressing these limitations requires careful consideration of study design for the future research, robust data collection methods, and acknowledgment of the contextual factors influencing healthcare delivery and outcomes in each country.

Conclusion

As a conclusion, patients in Georgia percieve challenges in the primary care accessibility, symptom management, physicians‘ willingness to help and communication. These challenges may compromise physician patient relationship, patient trust, loyalty and respect to the primary care system in Georgia. The Dutch system on the other hand, shows advanced levels in development of these parameters. How the Dutch system achieved this level of development is crucial to understand for the Georgian health community, in order to further develop the primary care in Georgia.

Implications for the primary care practice are important to understand. The Netherlands has a more developed patient-centered care, communication, accessibility, and systematic health monitoring. These strengths contribute to high levels of patient trust, satisfaction, and effective disease management. Overall, the Dutch system showcases a well-developed model with a strong emphasis on quality and patient engagement. Healthcare providers first priority is building rapport and sustainable trust with patients through their communication skills, empathy and loyalty.

In contrast, the Georgian primary care system, which has evolved from a centrally planned Semashko model, faces several challenges, including outdated infrastructure, limited roles for nurses, and less emphasis on patient-centered care. Regional disparities and limited follow-up care further exacerbates these issues. The governance, political will and resources devoted to the primary care in the Netherlands make contextual factors, that compose the environment and mindset for the primary care professionals. In this atmosphere, training and profesisonal development is more effective and sustainable. Hence, physician patient repationship concepts as trust, knowledge, respecct and loyalty become improved and also positively affect each other as interconnected factors. Georgian system highlights the difficulties of transitioning from a Soviet-era model and the ongoing need for improvement in primary care delivery. Infrustructural improvement, accessibility and accents on trust building with patients can be first line priorities for further improvement.

Results on the point of accesibility presented in Georgian results indicate difficult

accesibility, but in the Netherlands healthcare system usually ensures relatively good access to primary care services. While there can be variations, particularly in rural areas or during peak times, many patients can secure timely appointments. The system often provides options for urgent care and uses electronic health records to streamline appointment scheduling. The Netherlands has a well-developed healthcare infrastructure that supports accessibility. Primary care physicians, known as gatekeepers , are generally accessible, and there are measures in place to address both routine and urgent healthcare needs effectively (Van der Feltz-Cornelis. M.C et. al 2003).

Based on the comparison of the Dutch and Georgian primary care systems, several policy implications can be suggested for Georgia to improve its healthcare delivery:

Infrastructural Investments, or allocation of resources to update the primary healthcare infrastructure, especially in rural and poorly developed areas. This can improve access to primary care facilities. Also, raising more awareness in regards to the primary care.

Promotion of the Patient-Centered Care across the country. Implementation of policies, that prioritize patient-centered care practices, in addition investing in training healthcare professionals in communication skills. All these activities will foster and promote the trust-building relationships with patients.

Healthcare financing reforms are also an important component for the improvement. Development of stable financing mechanisms to ensure equitable access to healthcare services should be a priority.It might be possible also to implement changes through reforms that enhance financial incentives for primary care providers.

Professional Development for multidisciplinary teams in primary care is one of the pillars to develop. Investment in continuous professional development programs for healthcare providers, physicians, nurses and other specialists in primary care. That will help to expand their roles in primary care delivery and improve overall service quality.

Telehealth and Technology Integration as a ways for future development are also very important. Integrated technologies and electronic health records that will enhance

accessibility and make healthcare delivery possible especially in remote areas is significant and resource intence.

Strengthening of governance structures and policy coordination to provide effective implementation of primary care reforms and better allignment with national health priorities is one of the directions to work more.

Quality Assurance and Monitoring is not on a very high level. Mechanisms that will help to establish the quality assurance and monitoring of primary care services will need to be developed. That might includ regular monitoring and feedback to health care providers, in order to improve service delivery and patient outcomes.

These recommendations might help Georgia to improve current situation and better address the challenges in its primary care system. Ultimately improving healthcare access, quality, and patient satisfaction across the country.

Summary

The study was conducted to explore physician patient relationship in primary care in Georgia and compare it to the Netherlands model. The intention was to explore the aspects of the successful Netherland's model and reveal aspects, that may be helpful for Georgian context. The Primary care setting was selected as the primary care is the sector for future development. Findings showed that challenges with communication barriers, accessibility, doctor's willingness to help and symptom management are factors that affect patient's trust, respect and loyalty to the primary care. Further development in physician patient relationship aspect in Georgia will help to improve those aspects. It will be beneficial to explore more the Netherland's example in future research.

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List of Appendices

Appendix: Questionnaire for Interview

Age Gender

1. **My Family care doctor understands me**

   Agree Strongly Agree Disagree Strongly Disagree

2. **I trust my family care doctor**

   Agree Strongly Agree Disagree Strongly Disagree

3. **My Family doctor is dedicated to help me**

   Agree Strongly Agree Disagree Strongly Disagree

4. **My Family doctor has enough time for me**

   Agree Strongly Agree Disagree Strongly Disagree

5. **I find my Family doctor easily accessible**

   Agree Strongly Agree Disagree Strongly Disagree

6. **I benefit from the treatment of my Family doctor**

   Agree Strongly Agree Disagree Strongly Disagree

7. **Thanks to my Family doctor I feel better**

   Agree Strongly Agree Disagree Strongly Disagree

8. **I became aware of different services available for me with help of my doctor**

   Agree Strongly Agree Disagree Strongly Disagree

9. **Do you have any Chronic Disease**

   Yes No Please indicate disease: