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Relationship Between Doctor and Patient: A Psychological Study

Binil Raj S

Abstract: ***The doctor–patient relationship is a psychologically important component of healthcare because patients evaluate care not only through clinical competence but also through communication, interpersonal behaviour, accessibility, time, and financial experience. The present quantitative study examined patient satisfaction in the context of the doctor–patient relationship from the patient's perspective. A total of 108 adult respondents participated and completed a socio-demographic data sheet and the RAND Patient Satisfaction Questionnaire (PSQ-18). Descriptive statistics were used to summarize patient satisfaction across seven PSQ-18 domains, while Mann–Whitney U, Kruskal–Wallis H, and Spearman's rank correlation were used to examine differences and associations with selected socio-demographic characteristics. The overall PSQ-18 mean was 65.45 (SD = 8.14), corresponding to an average item score of approximately 3.64 on a five-point scale. Interpersonal manner was the strongest domain (M = 4.20, SD = 0.85), followed by accessibility/convenience (M = 3.94, SD = 0.76) and communication (M = 3.85, SD = 0.60). Time spent with the doctor was the weakest domain (M = 2.86, SD = 0.77), followed by financial aspects (M = 2.94, SD = 0.72). Using descriptive categories developed for this study, 55.6% of respondents had high satisfaction and 44.4% had moderate satisfaction. Satisfaction differed significantly by gender, education, occupation, income, marital status, and healthcare facility, whereas age was not significantly associated with satisfaction. The findings suggest that a generally favourable healthcare experience can coexist with specific psychological and practical areas requiring improvement, particularly adequate consultation time and financial accessibility.***

Keywords: doctor–patient relationship, patient satisfaction, PSQ-18, communication, interpersonal manner, healthcare, patient-centred care

1. Introduction

The doctor–patient relationship is a central element of healthcare delivery and has implications for diagnosis, treatment adherence, patient satisfaction, and health outcomes. From a psychological perspective, the relationship involves trust, confidence, communication, empathy, mutual respect, emotional security, and the patient's interpretation of the healthcare encounter. Patients are not passive recipients of treatment; their perceptions, beliefs, expectations, previous experiences, and social circumstances influence how they understand medical information and respond to professional advice.

The movement toward patient-centred care has increased attention to shared understanding, participation, dignity, and respect. Effective communication can reduce uncertainty and facilitate disclosure of concerns, while empathic and courteous behaviour can strengthen patients' sense of being understood. Conversely, rushed consultations, inadequate explanations, financial strain, and limited access can create dissatisfaction even when patients perceive doctors as technically competent.

The Indian context makes these issues particularly relevant because healthcare experiences occur across differences in education, income, language, culture, family involvement, and type of healthcare facility. The present study therefore examines patient satisfaction as a multidimensional psychological and practical outcome of healthcare interaction. The study specifically considers general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with the doctor, and accessibility/convenience.

2. Objectives

- To examine the role of patient trust and confidence in shaping the doctor–patient relationship.
- To study how patients' perceptions, beliefs, and expectations influence their interactions with doctors.
- To analyze the impact of doctors' communication style, empathy, and behaviour on patient satisfaction and emotional well-being.
- To evaluate the influence of social, cultural, and economic background on patients' understanding of and response to medical advice.
- To suggest measures for strengthening the doctor–patient relationship from the patient's psychological perspective.

3. Review of Literature

The literature reviewed in the dissertation identifies trust, communication, empathy, patient-centred care, satisfaction, and social context as interconnected components of healthcare relationships. Balint (1957) emphasized the therapeutic influence of the physician, while Engel's (1977) biopsychosocial model established that health and illness should be understood through interacting biological, psychological, and social factors. Patient-centred approaches subsequently emphasized participation, respect, autonomy, and attention to patients' values.

Research on communication indicates that patients who feel heard and respected are more likely to develop confidence and cooperate with care. The literature also suggests that communication can influence understanding, emotional responses, and behavioural outcomes. Patient-centred care has been associated with satisfaction and trust, while empathy and respectful interpersonal behaviour contribute to emotional security and dignity.

The dissertation's empirical review includes work examining physician–patient relationships, communication among older patients, telemedicine, patient-centred care, and communication pathways to health outcomes. Collectively, these studies support the view that healthcare quality is not adequately represented by technical treatment alone. The present study addresses an identified need for patient-focused evidence, particularly within an Indian context, and examines the pattern of satisfaction across multiple dimensions rather than treating satisfaction as a single undifferentiated construct.

4. Method

Design and Participants

A quantitative descriptive, cross-sectional survey design was used. The final dataset included 108 adult respondents. Participants represented different age groups, genders, educational backgrounds, occupations, income categories, marital-status groups, and healthcare settings. Purposive sampling was used to identify participants with relevant healthcare consultation experience.

Measures

A socio-demographic data sheet recorded age, gender, education, occupation, monthly family income, marital status, and type of healthcare facility visited. Patient satisfaction was measured using the RAND Patient Satisfaction Questionnaire (PSQ-18), an 18-item standardized measure covering General Satisfaction, Technical Quality, Interpersonal Manner, Communication, Financial Aspects, Time Spent with Doctor, and Accessibility/Convenience. Negatively worded items were reverse scored so that higher values represented greater satisfaction.

Procedure and Analysis

Participants were informed about the purpose and voluntary nature of the study and responses were treated confidentially. Completed questionnaires were coded and analyzed descriptively and inferentially. Frequencies and percentages described categorical variables; means and standard deviations summarized PSQ-18 scores. Mann–Whitney U tests were used for two-category comparisons, Kruskal–Wallis H tests for variables with more than two categories, and Spearman's rank correlation for age and overall satisfaction. Statistical significance was evaluated at $\alpha = .05$.

Three respondents selected two response options simultaneously for Item 1; midpoint coding was used for these ambiguous responses. The study reports available-item descriptive summaries for 108 respondents and a complete-case overall mean based on 105 respondents. The descriptive low/moderate/high categories used in the study were developed for this sample and are not universally validated PSQ-18 diagnostic cut-offs.

5. Results

PSQ-18 Domain	Items	M	SD
General Satisfaction	2	3.76	0.59
Technical Quality	4	3.61	0.45
Interpersonal Manner	2	4.20	0.85
Communication	2	3.85	0.60
Financial Aspects	2	2.94	0.72
Time Spent with Doctor	2	2.86	0.77
Accessibility/Convenience	4	3.94	0.76

The overall PSQ-18 score was 65.45 (SD = 8.14), with an average item score of approximately 3.64. Interpersonal manner was the strongest domain, indicating particularly favourable perceptions of friendliness, courtesy, and interpersonal treatment. Accessibility/convenience and communication were also positively evaluated. The lowest domain was time spent with the doctor, followed by financial aspects. At the item level, the highest mean was for doctors treating patients in a friendly and courteous manner (M = 4.38, SD = 0.78), while the lowest was for doctors spending plenty of time with patients (M = 2.33, SD = 0.77).

Of the 108 respondents, 60 (55.6%) were classified as having high satisfaction and 48 (44.4%) as having moderate satisfaction; none were classified as low according to the study-specific descriptive categories. Inferential analysis showed significant differences in satisfaction by gender ($U = 2203.50$, $p < .001$), education ($H = 41.922$, $p < .001$), occupation ($H = 6.626$, $p = .036$), monthly family income ($H = 25.160$, $p < .001$), marital status ($H = 14.936$, $p < .001$), and healthcare facility ($U = 2059.50$, $p < .001$). Age was not significantly associated with satisfaction, $\rho = -.161$, $p = .096$.

Female respondents reported a higher mean total PSQ-18 score (M = 68.44) than male respondents (M = 61.56). Respondents attending specialist clinics also reported a higher mean satisfaction score (M = 67.95) than those attending primary healthcare facilities (M = 62.55). These findings represent associations within the sample and should not be interpreted as causal effects.

6. Discussion

The overall pattern indicates that respondents generally experienced healthcare positively, but satisfaction was multidimensional. The particularly high interpersonal-manner score is consistent with literature emphasizing respect, courtesy, empathy, and supportive communication as psychologically meaningful aspects of healthcare. Patients who perceive providers as friendly and respectful may feel safer expressing concerns and may develop greater confidence in care.

Communication was also rated favourably. The high score for explaining the reasons for medical tests suggests that information provision may reduce uncertainty and reinforce transparency. This is consistent with the broader literature reviewed in the dissertation, which describes communication as a pathway linking healthcare interactions with understanding, emotional responses, cooperation, and satisfaction.

The comparatively low time-spent domain is an important finding. Although patients viewed interpersonal behaviour positively, they may nevertheless perceive consultations as too brief. Limited consultation time can restrict opportunities for patients to describe symptoms, ask questions, discuss fears, and clarify treatment instructions. Thus, the psychological quality of a consultation depends not only on what providers communicate but also on whether sufficient interaction time is available.

Financial aspects were another comparatively weak area. This suggests that satisfaction with interpersonal care can coexist with concern about affordability. Financial insecurity may influence psychological comfort and willingness to continue treatment. The significant associations between satisfaction and income, education, occupation, marital status, gender, and healthcare facility further support the view that patient satisfaction is shaped by the social and service environment. However, the income finding requires caution because 37% of respondents selected 'prefer not to say,' and the 'other' marital-status category contained only one respondent.

Age was not significantly related to satisfaction. Although the correlation was weak and negative, the evidence was insufficient at the .05 level to conclude that satisfaction systematically changes with age in this sample. Overall, the findings support a patient-centred understanding in which interpersonal qualities and contextual conditions operate together.

7. Conclusion

The study demonstrates that patient satisfaction within the doctor–patient relationship was generally favourable among the 108 respondents. Interpersonal manner, accessibility/convenience, and communication emerged as relative strengths, while time spent with the doctor and financial aspects represented important areas for improvement. Satisfaction also varied significantly across several socio-demographic and healthcare-context variables, whereas age showed no significant association. The findings suggest that strengthening the doctor–patient relationship requires attention to both psychological and practical dimensions of care. Respectful communication, perceived competence, adequate consultation time, clear explanations, and sensitivity to patients' financial and social circumstances can contribute to a healthcare environment in which patients feel heard, informed, respected, and confident.

8. Implications and Recommendations

- Healthcare professionals should combine clinical competence with respectful, courteous, and empathic interaction.
- Doctors should provide clear explanations about investigations, diagnoses, treatment plans, and follow-up requirements and allow patients opportunities to ask questions.
- Consultation systems should minimize unnecessarily rushed interactions and support adequate time for listening and clarification.
- Healthcare organizations should strengthen appointment, staffing, continuity, and patient-feedback systems.
- Patients should receive clearer information about expected costs and available alternatives where appropriate.
- Patient feedback should be reviewed by individual PSQ-18 domains rather than relying only on an overall satisfaction score.
- Future research should include larger and more diverse samples and directly measure trust, empathy, anxiety, health literacy, communication quality, and treatment adherence using validated instruments.

9. Limitations

The study used a relatively small sample of 108 respondents and purposive sampling, limiting generalizability. Several socio-demographic categories were unevenly distributed, including a very small 'other' marital-status group and a substantial income non-disclosure group. The study relied on self-reported satisfaction, which may be influenced by expectations, mood, recent experiences, recall, and social desirability. Its cross-sectional design permits identification of associations but not causal relationships. The study-specific satisfaction categories are descriptive rather than validated diagnostic cut-offs. In addition, the study did not directly assess several psychological constructs, including trust, empathy, anxiety, health literacy, communication quality, and adherence, with separate validated scales.

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