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NAVIGATING THE COMPLEXITIES OF ABORTION: AN EXPLORATION OF THE RIGHTS OF INTERESTED PARTIES, DOCTOR-PATIENT DYNAMICS, AND THE LEGAL LANDSCAPE IN A DEVELOPING COUNTRY CONTEXT

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ABSTRACT

Doctor – Patient relationship is not a new concept in medical practice and ethics -it is the foundation of medical practice. The concept governs the interaction between doctors and patients. This relationship is integral in the practice of healthcare delivery, in the diagnosis and treatment of diseases. This research discussed the evolution of this relationship, rights and duties of doctors and patients and existing challenges in achieving a smooth relationship. The research methodology adopted was the doctrinal legal research methodology. Findings showed that there were factors that inhibited the realization of doctor-patient relationship; some were doctor related, while others were patient related and others were factors outside the doctors and patients. Recommendations were made on how to improve on this relationship. These include training and retraining of doctors, introduction of simplified patient health education and establishment of a comprehensive health insurance policy, among others

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INTRODUCTION

The Doctor – Patient relationship is a crucial element of healthcare. '...the importance of an intimate relationship between Patient and Physician can never be overstated because in most cases an accurate diagnosis, as well as an effective treatment relies directly on the quality of this relationship' (Kaba, 2007). Hippocrates, (Heritage and Maynard, 2006) observed that 'some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician. Michael Balint also suggested that the doctor himself was actually a therapeutic 'drug' (James, 2007).

Given therefore that this relationship is important and the crux of medical practice, it's realization in any worthwhile medical system is paramount. This research therefore aims at identifying those factors that inhibit and/or are clogs in the realization of this relationship with a view to suggesting measures and practical ways for strengthening and enhancing the relationship.

The research intends to achieve this by laying a foundation to the proper understanding of Doctor – Patient relationship basically by way of definition, its nature, relevant laws, cases and other incidental matters.

Apart from practices that are common to the field of medicine generally and references that would be made where necessary to other jurisdictions, the scope of this work will be limited to Nigeria.

DOCTOR - PATIENT RELATIONSHIP DEFINED

Doctor - Patient relationship refers to the normal interaction and relation between a doctor and a patient in medical and healthcare practice (Oparaji, 2006).

It is that interface where patient's data are gathered, diagnoses and plans are made, compliance is accomplished and healing, patient activation and support are provided (Abiola, 2014).

Emmanuel Ezekiel conceives of an ideal Patient - Doctor relationship in terms of six fundamental components (the 6 C's) namely:-

1. **Choice.** For patients, this means choice of practice type and setting, choice of primary care physician, choice of specialist or facility for emergencies and special conditions, and choice among treatment alternatives.
2. **Competence.** Physicians should stay up to date, have good technical and diagnostic skills, exhibit good clinical judgment and be cognizant of their own limitations.
3. **Communication.** First, physicians should listen and understand symptoms, values, family, jobs and other health-related patient concerns. Second, physicians should be able to explain the disease, the diagnosis, treatment alternatives and how these affect patient values, guiding

patients through issues raised by their illness, while respecting patients' preferences for how much they want to know.

4. **Compassion.** This is about empathy and helping patients feel supported.

5. **Continuity.** This presupposes that the "ideal physician-patient relationship requires a significant investment of time," and that frequent changes of physicians undermines such relationship. It also acknowledges that "relationships that endure over time may be more efficient" both by helping doctors treat the patient in more appropriate manner and by fostering patient trust and confidence.

6. **(Non) Conflict of interest.** Personal and financial interests are emphasized, but the expectation seems to be that "a physician's primary concern will be his or her patient's well-being, even though physicians may have obligations that conflict."

HISTORYIEVOLUTUON OF DOCTOR - PATIENT – RELATIONSHIP

The study of Doctor-Patient relationship was first initiated by Talcott Parsons in the 1950s. He identified four major functional elements in the sick role': (i) the individual is not responsible for his illness; (ii) exemption of the sick individual from normal obligations until he is well; (iii) that illness is undesirable; and (iv) the sick individual should seek professional help. Parsons described the sick role as a temporary, medically sanctioned form of deviant behavior (Loh, and Sivalingam, 2008). The Patient - Doctor relationship in Nigeria is as old as the traditional medical system; the system of health care that existed prior to the coming of western/orthodox medical system.

[The relationship] has undergone a transition throughout the ages. Prior to the last two decades, the relationship was predominantly between a patient seeking help and a doctor whose decisions were silently complied with by the patient (Kaba, 2007). A redefinition however allows both the physician and the patient to take an active role in treatment decisions. Four models for the Physician - Patient relationship have been proposed (Ezekiel and Emanuel, 1992).

1. **The Paternalistic Model:** - sometimes referred to as the parental or priestly model. In this model, the Physician - Patient interaction ensures that patients receive the interventions that best promote their health and well-being. To this end, physicians use their skills to determine the patient's medical condition and his or her stage in the disease process and to identify the medical tests and treatments most likely to restore the patient's health or ameliorate pain. Then the physician presents the patient with selected information that will encourage the patient to consent to the intervention the physician considers best. At the extreme, the physician authoritatively informs the patient when the intervention

will be initiated. The paternalistic model assumes that there are shared objective criteria for determining what is best. Hence, the physician can discern what is in the patient's best interest with limited patient participation. Ultimately, it is assumed that the patient will be thankful for decisions made by the physician even if he or she would not agree to them at the time. In the tension between the patient's autonomy and well-being between choice and health, the paternalistic physician's main emphasis is toward the latter. In the paternalistic model, the physician acts as the patient's guardian, articulating and implementing what is best for the patient. As such, the physician has obligations, including that of placing the patient's interest above his or her own and soliciting the views of others when lacking adequate knowledge. The conception of patient autonomy is patient assent, either at the time or later to the physician's determinations of what is best.

2. **The Informative Model:** sometimes called the scientific engineering or consumer model. The objective of this model is for the physician to provide the patient with all relevant information for the patient to select the medical interventions he or she wants, and for the physician to execute the selected interventions. The physician informs the patient of his or her disease state, the nature of possible diagnostic and therapeutic interventions and any uncertainties of knowledge. At the extreme, patients could come to know all medical information relevant to their disease and available interventions and select the interventions that best realize their values. The informative model assumes a fairly clear distinction between facts and values. The patient's values are well defined and known, what the patient lacks is facts. It is the physician's obligation to provide all available facts, and the patient's values then determine what treatments are to be given. There is no role for the physician's values, or his or her judgment of the worth of the patient's values. The physician is a purveyor of technical expertise providing the patient with the means to exercise control. As technical experts, physicians have important obligations to provide truthful information to maintain competencies in their area of expertise, and to consult others when their knowledge or skills are lacking. The conception of patient autonomy is patient control over medical decision making.

3. **The Interpretive Model:** the aim of the interaction is to elucidate the patient's values and what he or she wants, and to help the patient select the available medical interventions that realize these values. The interpretive physician provides the patient with information on the nature of the condition and the risks and benefits of possible interventions. The interpretive physician assists the patient in elucidating and articulating his or her values and in determining what medical interventions best realize the specified values, thus helping to interpret the patient's values for the patient. According to the interpretive model, the patient's values are not necessarily fixed and known to the patient. They are often inchoate and the patient may only partially understand them; they may conflict when applied

to specific situations. The physician working with the patient must elucidate and make coherent these values. To do this the physician works with the patient to reconstruct the patient's goals and aspirations, commitments and character. At the extreme, the physician must conceive the patient's life as a narrative whole and from this specify the patient's values and their priority. Then the physician determines which tests and treatments best realize these values. Importantly, the physician does not dictate to the patient; it is the patient who ultimately decides which values and course of action best fit who he or she is. Neither is the physician judging the patient's values; he or she helps the patient to understand and use them in the medical situation. In this model, the physician is a counselor, supplying relevant information, helping to elucidate values and suggesting what medical interventions realize these values. The physician's obligations include those enumerated in the informative model but also require engaging the patient in a joint process of understanding. Accordingly, the conception of patient autonomy is self-understanding; the patient comes to know more clearly who he or she is and how the various medical options bear on his or her identity.

4. **The Deliberative Model:** the aim here is to help the patient determine and choose the best health - related values that can be realized in the clinical situation. To this end, the physician must delineate information on the patient's clinical situation and then elucidate the types of values embodied in the available options. The physician's objectives include suggesting why certain health related values are more worthy and should be aspired to. At the extreme, the physician and the patient engage in deliberation about what kind of health-related values the patient could and ultimately should pursue. The physician discusses only values that affect or are affected by the patient's disease and treatments.

In this model, the physician acts as a teacher or friend, engaging the patient in dialogue on what course of action would be best. Not only does the physician indicate what the patient could do, but knowing the patient and wishing what is best, the physician indicates what the patient should do, what decision regarding medical therapy would be admirable. The conception of patient autonomy is moral self-development; the patient is empowered not simply to follow unexamined preferences or examined values, but to consider through dialogue, alternative health related values, their worthiness and their implications for treatment.

[Generally], a shift towards the informative model has occurred; patients are more involved in choosing their treatment (Ezekiel and Emanuel, 1992). These models have weaknesses but the deliberative model may be the best for the Physician - Patient relationship. It allows the physician to guide patients in a caring manner, but does not limit patient independence (Ezekiel and Emanuel, 1992). Nigeria is still largely paternalistic.

THE NATURE OFDOCTOR – PATIENT RELATIONSHIP

An important element upon which Patient - Doctor relationship is built, is trust. The relationship is therefore fiduciary and recognized at common law. Physicians have a fiduciary duty to their patients because the balance of knowledge and information favors the physician; patients are reliant on their physicians and may be vulnerable. The patient must always be confident that the physician has put the needs of the patient first. The significance of trust to the Physician - Patient relationship and in turn to its characterization of that relationship as fiduciary was emphasized thus:

"…the doctor - patient relationship shares the peculiar hallmark of the fiduciary relationship - trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only his or her good and in his or her best interests. Recognizing the fiduciary nature of the Doctor - Patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires.*

Apart from the fiduciary nature of Patient - Doctor relationship, it may also be conceptualized in a variety of ways. "It may be viewed as a creature of contract with the physician's failure to fulfill his or her obligations giving rise to an action for breach of contract. It undoubtedly gives rise to a duty of care, the breach of which constitutes the tort of negligence...."

ESTABLISHMENT OF PATIENT - DOCTOR RELATIONSHIP

A Patient - Physician relationship is generally formed when a doctor affirmatively acts in a Patient's case by examining, diagnosing, treating or agreeing to do so (Blake, 2012).

In Mead V Adler,an on call neurosurgeon was consulted by an emergency room doctor who suspected a severe neurological disease was causing a patient's low back pain. The neurosurgeon examined the patient and recommended that she be admitted but said that surgery was not needed. Four days later, it was determined that the patient did require the surgery, following which she was permanently impaired. The patient sued the neurosurgeon who was originally consulted for damages but he defended that he owed her no duty because a patient physician relationship had not been established. The court held that in the absence of an express agreement by the physician to treat a patient, a physician's assent to a physician - patient relationship can be inferred when the physician takes an affirmative action with regard to the care of the patient. A patient - physician relationship was formed because the physician took an affirmative action in rendering an opinion on the course of the patient's care.

The existence of this relationship gives rise to certain rights and obligations on the part of the doctor and patient respectively.

LEGAL AND REGULATORY FRAMEWORK FOR PATIENT – DOCTOR RELATIONSHIP IN NIGERIA

The Principal Statute that regulates medical practice in Nigeria is the Medical and Dental Practitioners Act. Others are codes of medical ethics and declarations and they include:

1. Hippocratic Oath
2. Declaration of Geneva (1948)
3. Declaration of Helsinki (1964)
4. International Code of Medical Ethics (Declaration ofVenice,1983)
5. Code of Medical Ethics in Nigeria

The Medical and Dental Council of Nigeria administer the Act.

Important aspects of Patient - Doctor relationship are elucidated in the rights they have and the duties/responsibilities they owe to themselves.

While both take active roles in the healing process, it does not imply that both partners have identical responsibilities or equal power. [Broadly], while physicians have the responsibility to provide health care services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program (American Medical Association, 2012).

DUTIES OF DOCTOR TO PATIENT

Duty of Care:- once a doctor undertakes to care for the patient, a contract and/or relationship comes into existence and remains in force until the end of the treatment or formal termination by either party (Ogungbo, 2017). The duty of care exists even if not formally written down or confirmed verbally (Ogungbo, 2017).It exists between an unconscious patient and the doctor. The duty includes an obligation to diagnose and treat. Patients must be treated attentively and conscientiously.

Doctors must recognize their own limits: in case of doubt, they must get information from other people or refer patients to specialists.

The duty to treat patients includes the duty to

- Prescribe the right medication,
- Tell patients about the advantages, disadvantages, risks and alternatives regarding a proposed treatment or operation, and
- Provide adequate follow-up to the patient within a reasonable amount of time.

2. **Duty to Demonstrate Professional Competence:-** this presupposes that physicians should be skilled clinicians committed to the values of the profession. Physicians should be responsible for maintaining the medical knowledge and clinical skills necessary to provide the highest possible quality care to the patients. At all times physicians should:

   - Be aware of deficiencies in knowledge or ability,
   - Obtain help when needed
   - Ensure that their practice matches their level of competence.

3. **Maintaining Confidentiality:** An important component of trust is the honest and compassionate communication of information in complete confidence. Receiving and giving sensitive patient information is essential to the physician's ability to provide quality care to the patient. Patients give information to physicians in a unique context where they have the utmost faith that the physician will maintain patient privacy and confidentiality. Occasionally however, their responsibility to the public outweighs their responsibility to an individual patient, necessitating reporting to another party.

4. **Collaborating with patients and others:** - Collaboration with an individual patient is essential to providing good medical care. The physician must work with the patient in order to understand the patient's health care needs, to formulate treatment plans that are optimal for the patient, to ensure that the patient remains informed about his or her care and to address patient questions and concerns. Collaboration also involves recognizing and accepting the unique roles and contributions of other health professionals. The best interests of patients are served when physicians utilize the skills of others, whether they are physicians or other health professionals. Good quality healthcare is often delivered by a team of professionals and individuals who contribute expertise in a variety of ways.

5. **Managing Conflicts of Interests:** - A physician must always act in the patient's best interests. A physician’s conflict of interest must be properly managed so as not to compromise the patient’s best interest or be avoided.

6. **Duty to Provide Information:-**Doctors must give their patients all the information they need to make free and informed decisions. For example, doctors must tell their patients about the following:

   - Diagnosis
   - Nature, goal and seriousness of the treatment

- Risks of the treatment (including the chances of success and the risk of failure of the suggested treatment).

The doctor's duty to provide information also involves answering questions.

On the other hand, a doctor is not only laden with duties owed to his patients, he has no obligation as a general rule to treat a patient unless he chooses to. Exceptions are however made when emergency care is needed and when refusal to treat is based on discrimination.

DUTIES/RESPONSIBILITIES OF PATIENT.

Patients' responsibilities are derived from the principle of autonomy. The principle of patient autonomy holds that an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options. Autonomous, competent patients assert some control over the decisions which direct their health care. With that exercise of self-governance and free choice comes a number of responsibilities.

1. Good communication is essential to a successful patient-physician relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their physicians.
2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.
3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
4. Once patients and physicians agree upon the goals of therapy and a treatment plan, patients have a responsibility to cooperate with that treatment plan and to keep their agreed-upon appointments. Compliance with physician instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
5. Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited resource like health care and try to use medical resources judiciously.

6. Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients should take personal responsibility when they are able to avert the development of disease.

7. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.

RIGHTS OF THE PATIENT

The Doctor - Patient relationship is a collaborative effort between the physician and the patient towards the health and well-being of the patient. Patients share with physicians the responsibility for their own health care. Just like they have responsibilities in the relationship, they also have rights.

The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or

summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

1. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

2. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

3. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

4. The patient has the right to continuity of health care, that is, the patient has the right not to be abandoned. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

5. The patient has a basic right to have available adequate health care. Fulfillment of this right is dependent on [the government] providing resources so that no patient is deprived of necessary care because of the inability to pay for the care.

IMPEDIMENTS TO THE REALISATION OF PATIENT – DOCTOR RELATIONSHIP

Doctor related, factors affecting Patient - Doctor Relationship

Poor Clinical Skills: Basic clinical skills are essential to the practice of medicine. Some of these skills needed when working with individual patients include learning how to conduct a medical interview, perform a physical examination and organise the data to reach a diagnosis. Good clinical skills will help develop professionalism that is expected of all physicians. A lack of it therefore is fatal to any patient - doctor relationship as it ultimately will affect diagnosis, investigations, management of cases and other procedural skills.

Rising health care costs due to advances in science and technology and specialization:- Over the years, science and technology has advanced, so also has the practice of modem medicine. The practice of modem medicine is therefore inclined towards the use of state of the art equipment. The cost of obtaining such equipment especially for developing countries like Nigeria is a challenge. The effect is high cost of treatments involving the use of such equipment thereby making it inaccessible. Fertility treatment (in vitro fertilization) is an example.

Work Overload:- this usually is the case where there is no balance in the doctor - patient ratio. Consequently, the doctor is overworked and "fatigued both mentally and physically. A hectic schedule associated with long hours is tiring for physicians. Tired people are less patient, more error prone and the willingness of even the most altruistic individual to spend the time needed to communicate effectively is reduced."

Poor communication skills:- Comprehension of the patient may be affected by the physician's sociolinguistic structure. The physician is most times bound by his duty to see patients whether literate or not. His choice of words can determine whether or not there is a communication gap. In the face of a poor or incomplete understanding, a patient will often not ask for clarification or simplification as he/she may want to avoid appearing ignorant. This is especially true of patients with low literacy. The implications of this in terms of treatment compliance and outcome and therefore patient satisfaction are obvious.

Patient related factors affecting Patient - Doctor Relationship.

Religious beliefs: - certain religious practices put patient - doctor relationship at risk. For example, refusal of blood transfusion and blood products by Jehovah's witnesses. When such people are in need of

healthcare, their faith and belief is an obstacle for their proper treatment and poses legal, ethical and medical challenges for attending health care provider (Chand, *et al.,* 2017).

Medical and Dental Practitioners Disciplinary Tribunal V. Okonkwo is a case in point. The patient and her husband, Jehovah's witnesses persistently refused to give their consent for the patient to be transfused with blood as recommended by the doctor. She was discharged and admitted in another hospital where she died, hence the institution of this case.

Cultural and Ethnic factors: - Many cultures operate with a belief that anything told to them in an informed consent process actually increases the likelihood of the event occurring. In other words, informing a patient that death is a potential outcome of a procedure even if a remote possibility, in the patient's mind, makes this outcome more likely if not probable. Such beliefs can create problems when a physician must obtain an informed consent. While informed consent is considered a standard practice in western medicine, it can clearly affect outcomes if used without regard to important cultural beliefs.

Literacy factor:- The assumption is that health care is accessible once the patient walks through the examining room door. Yet access to care requires more than the patient's presence; it also requires that the patient engage in the process of care. Low literacy, limits access by preventing patients from engaging fully in the process of care. Baker and colleaguesdescribe how important outcomes of care such as health status and hospitalization are linked to literacy (Roter *et al.,* 1998). They found that patients with low literacy skills had poorer health, higher rates of hospitalization, and incurred higher health care costs than patients with adequate literacy.

The Functional Health Literacy Assessment Test (TOFHLA), which is based on a patient's ability to perform health-related tasks that require reading and computational skills, was used to measure literacy. These tasks include taking medication, keeping appointments, preparing for tests and procedures, and giving informed consent. The result revealed that some patients were functionally illiterate while others were only marginally literate.

With low literacy skills so prevalent among the general population in Nigeria, physicians are likely to encounter patients with this limitation. The circumstances underlying low literacy are varied. Limited education accounts for much of poor literacy in Nigeria. Commonly held expectations for reading ability and social approbation for illiteracy inhibit disclosure, silence patients, and discourage patients' efforts to seek information and request assistance. Poor literacy may also account for communication difficulties faced by patients. Levine and colleagues provided some insight into the mechanisms in several studies conducted in developing countries. These investigators found a relation between literacy level and speech comprehension. They suggested that literacy builds a cognitive process that facilitates the comprehension of spoken

language, including health messages. Even further, Dexter and colleagues demonstrated that poor literacy skill was linked with inadequate health-related descriptions. Therefore, low literacy not only interferes with patient education, but also may complicate history taking. While some patients may be intimidated and won't ask questions in the face of uncertainty, others mistakenly think they understand when infact they may not understand and simply not realize it. This takes its toll on Patient - Doctor Relationship.

Poverty: - closely related to the literacy factor, is poverty because poverty creates illiteracy, leaving people poorly informed about health risks. Poverty affects the perception that people have of healthcare and the value that people place on health. Poverty affects treatment plans and ultimately treatment goals. A Patient - Doctor Relationship is frustrated where treatment goals are not met.

IMPROVING PATIENT - DOCTOR RELATIONSHIP

The Doctor - Patient relationship can be improved by constructive patient interviews. There are several techniques that can help physicians facilitate this. Patients who are involved in their treatment plan are more likely to feel better and to manage their symptoms. Some techniques that can be employed include the following (Douglas, *et al.,* 2017):

1. **Active Listening:** Encourage the patient to tell his/her story of the illness, through the restatement of information in the patient's own words, and the development of open- ended questions during the medical interview.
2. **Nonverbal Communication:** Effective use of nonverbal communication can help develop an environment of support, comfort, trust, and security. Frequent eye contact and periods of well-timed silence are examples of methods that can enhance the interview.
3. **Agendas:** Patients and physicians may approach the appointment with somewhat different agendas. The physician's agenda may be to help patients accept the diagnosis of a functional disorder and to consider symptom management. The patient, on the other hand, might come to the appointment seeking a specific diagnosis, a cure, or the reassurance that they do not have cancer [for example]. Therefore, it is important for both physician and patient to communicate their agendas at the onset of the appointment. To facilitate this, physicians can ask several questions such as: "What do you think is going on, what are your concerns and fears, and how can I be of most help to you at this time?"
4. **Empathize:** The physician should acknowledge the difficulty patients experience in trying to manage their pain as they struggle to perform jobs, maintain their roles within the family, and validate their disorders to themselves and others. Patients who have experienced major

psychosocial loss or trauma (e.g., abuse history) might find it embarrassing to discuss these issues. For this reason, it is important for the physician to validate the patient's feelings without making a personal judgment or offering a quick solution. Furthermore, mentioning how studies have shown a link between traumatic events and GI disorders can increase patient's understanding of the issue. Empathy means demonstrating an understanding of the patient's pain and distress while maintaining an objective and observant stance.

5. **Educating Patients:** Education plays a crucial part in a good doctor-patient relationship. Education involves a dialogue where the physician elicits the patient's thoughts, feelings and beliefs, and then provides new information consistent with the patient's needs and interests. Providing written materials can be particularly helpful in supplementing and enhancing the information obtained from the physician during the appointment.

6. **Reassurance:** Identifying and legitimizing a patient's concerns and worries without offering false reassurances can help comfort the patient. It puts them at ease by knowing that the physician has a commitment to them and recognizes their emotions as important and their disorder as real and not "in their head."

7. **Agreeing On A Treatment Plan:** After the medical interview and physical exam are completed, it is important for the patient and physician to agree upon a treatment plan. The physician should take into account the patient's personal experiences and life style, and provide choices that are consistent with these factors.

8. **Taking Responsibility:** It is important to have the patient acknowledge their role in managing their pain, symptoms and treatment. The physician should ask the question "how are you managing your symptoms," rather than "how is your pain." This shifts the responsibility for pain and symptoms management from the doctor to the patient and helps patients acknowledge their role in their care.

9. **Avoid Overreacting:** Some patients may appear demanding, dependent or even adversarial. It is the physician's responsibility not to overreact in these situations. This can be achieved by establishing limitations (boundaries) on what can be provided and suggesting appropriate ways for the patient to contact the physician. Feelings and emotions should be addressed honestly, thereby facilitating communications between the doctor and patient on a positive level and helping to avoid conflict.

10. **Establishing Boundaries:** Frequent phone calls, unscheduled visits, and unrealistic expectations are ways in which some patients lose perspective on the shared responsibility for

their care. Doctors need to establish boundaries for patients in a way that does not belittle them. Scheduling brief return appointments can meet the needs of patients, while helping the physician set boundaries as to when and how often he/she will be accessible for out of the office contact.

CONCLUSION

There is no doubt that impediments exist to the realization of the Doctor - Patient relationship in Nigeria. This research established that some of these factors are doctor related; some are patient related while others exist independently of the doctor or patient. Peculiar factors for Nigeria on the part of the doctor are poor clinical skills and work overload. For the patient however, illiteracy and poverty pose threat to the actualization of this relationship among others. The researcher suggests techniques that could be adopted by the stakeholders to attain a good patient relationship.

RECOMMENDATIONS

The researcher recommends as follows:

1. More doctors should be trained to solve the problem of work overload and its attendant consequences.
2. Medical facilities should be well equipped and skilled manpower made available to operate equipment.
3. Viable and comprehensive health insurance schemes/policies should be put in place to address the problem of high cost of health care. Nigeria already has the National Health Insurance Scheme in place but the scheme still leaves a lot to be desired as it is not very comprehensive. Only the most elementary cases are covered. The scheme should be extended to the non-formal sector and expanded to cover treatment of terminal illnesses like cancers.
4. Introduction of patient health education which should be conducted in simplified language.
5. Medical ethics should be introduced as part of course curriculum for medical students in our universities.
6. Where there is a conflict between the law, ethics and cultural or religious beliefs, the law should be explicit on how to resolve the problem.

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