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The evolution of the doctor-patient relationship

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KEYWORDS
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Abstract The doctor-patient 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. In this paternalistic model of the doctor-patient relationship, the doctor utilises his skills to choose the necessary interventions and treatments most likely to restore the patient's health or ameliorate his pain. Any information given to the patient is selected to encourage them to consent to the doctor's decisions. This description of the asymmetrical or imbalanced interaction between doctor and patient [Parsons T. The social system. Free Press, New York, 1951.][1] has been challenged during the last 20 years. Critics have proposed a more active, autonomous and thus patient-centred role for the patient who advocates greater patient control, reduced physician dominance, and more mutual participation. This patient-centred approach has been described as one where *''the physician tries to enter the patient's world, to see the illness through the patient's eyes''* [McWhinney I. The need for a transformed clinical method. In: Stewart M, Roter D, Communicating with medical patients. London: Sage, 1989.][2], and has become the predominant model in clinical practice today.

Introduction

''To attend those who suffer, a physician must possess not only the scientific knowledge and technical abilities, but also an understanding of human nature. The patient is not just a group of symptoms, damaged organs and altered emotions. The patient is a human being, at the same time worried and hopeful, who is searching for relief, help and trust. 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''.[3]

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On considering a relationship that is based on mutual participation of two individuals, the term ''relationship'' refers to neither structure nor function but rather an abstraction encompassing the activities of two interacting systems or persons.[4] The apparent, intrinsic quality of this unique doctor-patient relationship allows two people, previously unknown to each other, to feel at ease with variable degree of intimacy. This relationship, in time, may develop to allow the patient to convey highly personal and private matters in a safe and constructive environment.

History of the doctor-patient relationship

The doctor-patient relationship in a historical setting is dependent on the medical situation and the social scene. The doctor's and patient's ability for self-reflection and communication as well as any technical skills are embodied within this 'medical situation'. The 'social scene' refers to the socio-political and intellectual-scientific climate at the time.

The work performed by Szasz and Hollender (1956)[5] demarcated three basic models of the doctor-patient relationship. These are (a) activity-passivity, (b) guidance-co-operation and (c) mutual participation. The activity-passivity and guidance-co-operation models are entirely paternalistic and thus predominantly doctor-centred. The latter, mutual participation has a greater emphasis on patient centred medicine. By employing these conceptual models one can present an historical overview of the certain changes that occurred between the doctor and patient which led to the development and creation of a patient-centred focus that is currently practised today. The social conditions and medical practice models of the following periods will be briefly discussed:

(a) Ancient Egypt (approximately 4000 to 1000 B.C)
(b) Greek enlightenment (approximately 600 to 100 B.C)
(c) Medieval Europe and the inquisition (approximately 1200 to 1600 A.D)
(d) The French revolution (late 18th century)
(e) Doctor-patient relationship 1700-to present day

Ancient Egypt

Edelstein et al. (1937)[6] proposed that the doctor-patient relationship evolved from the priest-supplicant relationship, thus retaining the ideology of a parent-figure to manipulate events on behalf of the patient. Man has attempted to master nature, through his fears of helplessness, sickness and death, by means of magic and mysticism, theology and rationality. Healers were as much magicians and priests as they were doctors and magic was an integral part of care. Treatment was largely limited to external and visible disorders such as fractures. Psychiatric disorders which were regarded as internal, presented certain observational difficulties in the face of a naïve, culturally unsophisticated approach to medicine. It therefore seems likely that in ancient Egyptian medicine the activity-passivity type relationship existed and that this relationship was unaltered. Neither the social circumstances nor the technical advances were such as to require a change within this relationship.

Greek enlightenment (5th Century B.C.)

The Greeks developed a system of medicine based on an empirico-rational approach, such that they relied ever more on naturalistic observation, enhanced by practical trial and error experience, abandoning magical and religious justifications of human bodily dysfunction. They were also among the first nations to evolve towards a democratic form of social organization, and consequently established equality among the electorate. Thus guidance-co-operation and to a lesser degree mutual-participation were the distinguishing patterns of the doctor-patient relationship.

The Hippocratic Oath established a code of ethics for the doctor, whilst also providing a 'Bill of Rights' for the patient. The rules codifying the doctor's prescribed attitude towards his patient[7]: ''*The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for wrong…Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any seduction, of male or female, of bond free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart there from, which ought not be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.*''

This oath provides a higher degree of humanism in dealing with the needs, well-being, and interests of people when compared to previous codes of conduct. In this, the Hippocratic Oath raised medical ethics above the self-interests of class and status.

Medieval Europe and the inquisition

The restoration of religious and supernatural world beliefs, following the demise of the Roman Empire,

and concluding in the Crusades and witch-hunts throughout the middle-ages, led to the deterioration, weakening and regression of the doctor-patient relationship throughout medieval Europe. The, magico-religious beliefs personified in the Old and New Testaments were revived and became widely accepted. The doctor, filled with magical powers, was in a glorious, high ranking position in society and his patients were regarded as helpless infants, analogous to the activity-passivity model.

The French revolution

Through the initiation of the Renaissance encouraged by the emerging Protestantism, Man's search for liberalism, equality, dignity and empirical science began once again. There are marked illustrations of the effects of the dominant socio-political events (e.g. the successful Protestant protests against the unimpeded might of the Roman Catholic Church, the removal of English dominance from America, and the momentous social struggle of the French revolution) on medical attitudes, actions and thus behaviours during this time. The events that led to the French Revolution brought an end to an era in which the mentally ill and socially underprivileged were incarcerated in dungeons.[5] This exemplifies the change in the doctor-patient relationship from an activity-passivity approach to a guidance-co-operation model.

Doctor-patient relationship from 1700 to present day

''The relationship between the doctor and patient has a very pronounced association with the model of illness that dominates at any given time''.[8] During the 18th Century the symptom was the illness. Doctors were few in number and their patients mainly upper class and aristocratic. This status disparity ensured the supremacy or dominance of the patient and doctors had to compete with each other in order to please the patient. The model of illness that developed was one based on the interpretation of the patients' individual symptoms. The doctor found that it was less necessary to examine the patient but rather more important to be attentive to their needs and experiences manifest in the form of their symptoms. This symptom-based model of illness ensured the preservation of patient dominance throughout this period.

During the late 18th Century hospitals emerged as places to treat patients who were underprivileged. Doctors now found themselves providing medical treatment for those who were traditionally regarded as more passive. The hospital became the cornerstone of medical care and along with the rapid growth in microbiological knowledge and surgical skills during this time, a new Medicine developed that focused not on the symptom, but rather on the accurate diagnosis of a pathological lesion inside the body — the biomedical model of illness. This new theory suggested that the symptom was no longer the illness, but instead acted as a unique indicator for the presence of absence of a particular pathology. This new model required the examination of the patient's body and the expert clinical and anatomical knowledge possessed by the doctor to formulate a diagnosis, and thus the patient became dependent as a result. The relationship was between a dominant doctor and a passive patient, i.e. an activity-passivity (paternalistic) model.

The development of paternalism

The Hippocratic doctors considered it an ethical requirement to follow the *'criterion of beneficence'* as well as the principle *'primun non nocere' ('not to hurt')* which has become a core principle of medical ethics within the doctor-patient relationship. Hellin (2002)[3] regards paternalism as hard-line beneficence, analogous to the parent-infant relationship[5] in which the infant is wholly dependent on the parent for decision-making. Thus the doctor's role involved acting in the patient's best medical interests,[1] with doctors regarding a 'good patient' as one who submissively accepted the passive role of the infant.[3]

The emergence of psychology

The psychoanalytical and psychosocial theories proposed by Breuer and Freud (1955)[9] in the late 19th Century began to further constitute the patient as a person. This therapeutic model meant that, in terms of the doctor-patient relationship, it was of great importance to listen to the patient at great length. Their interest in the patient allowed them to develop a genuine communicative relationship and reintroduced the patient into the medical consultation as an active participant. This early therapeutic intervention paved the way towards the broad implementation of mutual participation between the doctor and patient[5,10] which ultimately led to the creation of patient-centred medicine.

The doctor had become conscious or aware of the patients' personality: *''the patient was not simply an object but a person, needing enlightenment and reassurance''*.[11] The report of the Planning Committee of the Royal College of Physicians on Medical Education regarded as essential that

''from the beginning of his clinical career, the student should be encouraged to study his patient's personality… just as he studies his patient's physical signs and the data on the temperature chart''.[12]

The theories of Balint (1964)[10]

Michael Balint trained in both medicine and psychoanalysis, and attempted to combine these sciences. He acknowledged that an individual's tendency to seek the attention of a GP could not be described in solely objective terms; social and psychological influences were equally important. He argued that illness was as much a psychosocial phenomenon as a biological one. He encouraged doctors to look past the physical signs and symptoms reported and to focus on the patient's unique psychological and social context, thereby allowing them to understand the 'real' reason for the consultation. He also proposed that the unique emotional relationship that develops between the doctor and patient over many encounters is itself a critical constituent of both therapeutic and diagnostic processes.

Balint's concept of the *''doctor as drug''* emphasised the dynamic nature of the doctor-patient relationship. He adamantly maintained that *''the most powerful therapeutic tool the doctor possessed was himself or herself''*. However, Balint acknowledged that very little was known about the 'pharmacological' aspects of this drug, such as the correct 'dosages' (frequency of visits), any addictive properties (whereby the patient becomes increasingly reliant on the doctor), and side effects (i.e. what harm the doctor could do). Another concept of the doctor-patient relationship that *Balint* described was what he coined *''mutual investment''*. He believed that the individual consultation was one in a series of consultations, as opposed to a single episode, such that each consultation followed on from the next. With time the doctor obtained the patient's trust and or confidence, such that he began to know more and more about his patient's personalities, social and physical environments, their biography and their relationships. This allowed the doctor to improve his time management skills, so that each new consultation was more effective, which ultimately provided a better insight into the patients' needs. The ideology behind mutual investment also incorporates the opportunity for the patient to develop insight into the doctors own needs. This implied that the doctor-patient relationship was a mutual investment which over time would benefit both parties.

The three basic models proposed by Szasz and Hollender (1956)[5]

Szasz and Hollender (1956)[5] proposed three models of the doctor-patient relationship (also see Table 1):

(a) The model of *activity-passivity* is entirely paternalistic in nature; this is analogous to the parent-infant relationship described previously. They argued that this model is not an interaction, as the person being acted upon is unable to actively contribute. The patient is regarded as helpless requiring the expert knowledge of the doctor, and treatment is commenced *''irrespective of the patient's contribution and regardless of the outcome''*. This is entirely justified in the medical emergency setting because the time required to get informed consent or involve the patient in decision making would clearly jeopardize the patient's health. This type of relationship places the doctor in total control of the situation *and ''in this way it gratifies needs for mastery and contributes to feelings of superiority''*.[13]

(b) The model of *guidance-co-operation* is employed in situations which are less acute. They argued that despite the fact that the patient is ill, they are conscious and thus have feelings and aspirations of their own. During this time the patient may suffer from anxiety and pain and in light of this he may seek help. The patient is, therefore, ready and willing to *''cooperate''* and in doing so he places the doctor in a position of power. Therefore the doctor will speak of guidance and thus expect the patient to cooperate and obey without question. They described this model as a prototype in the relationship between a parent and a child (adolescent).

(c) The model of mutual participation (also advocated by Balint (1964)[10]) is based on the belief that equality amongst human beings is mutually advantageous. In this model the doctor does not confess to know exactly what is best for the patient. They argued that equality amongst human beings is critical to the social structure of egalitarianism and democracy. In order for the concept of mutual participation between the doctor and patient to exist, it is important that the interaction between them is based on having equal power, mutual independence, and equal satisfaction. This ultimately allows the patients to take care of themselves. The management of chronic disease provides a good example. This model therefore provides the patient with a greater degree of

Table 1 Three basic models of the doctor-patient relationship (adapted from Szasz and Hollender 1956).[5] Reprinted from Arch. Intern. Med. 1956, 97; 585—92. Copyright © 2006 American Medical Association. All rights reserved.

Model	Physician's role	Patient's role	Clinical application of model	Prototype model
Activity-passivity	Does something to the patient	Recipient (unable to respond to inert)	Anaesthesia, acute trauma, coma, delirium, etc.	Parent-infant
Guidance-co-operation	Tells patient what to do	Co-operator (obeys)	Acute infectious processes, etc.	Parent-child (adolescent)
Mutual participation	Helps patient to help himself	Participant in ''*partnership*'' (uses expert help)	Most chronic illness, psychoanalysis	Adult-adult

responsibility and is characterised by a high degree of empathy and has elements often associated with friendship and partnership, as well as the imparting of expert medical advice. Therefore, the doctor's satisfaction cannot be derived from power nor can it stem from the control over someone else, but rather from the unique service he provides to humanity.[3]

Patient-centred medicine

''…one of the essential qualities of the clinicians is interest in humanity, for the secret of the care of patients is in caring for the patient''.[3]

Over the last 20 years an extensive body of literature has emerged that advocated the patient-centred approach to medical care. The concept of patient centred medicine can be described and illustrated through the following five key dimensions, as proposed by Mead and Bower (2000).[14]

Biopsychosocial perspective

Stewart et al. (1995)[15] assert that the patient-centred approach requires a ''willingness to become involved in the full range of difficulties patients bring to their doctors, not just their biomedical problems.'' Also, these authors regarded health promotion as an essential component of patient-centred medicine. Lipkin et al. (1984)[16] highlighted the importance of being open to the patient's ''hidden agenda'', reflecting the psychoanalytical influence of the earlier work by Balint (1964).[10] Grol et al. (1990)[17] proposed that the patient-centred doctor ''feels responsible for non-medical aspects of problems.''

The 'patient-as-person'

A biopsychosocial perspective alone is not sufficient for a full understanding of the patient's experience of illness, which depends on his or her particular ''*biography*''.[18] For example, a compound leg fracture will not be experienced in the same way by two different people. They also suggested that the medical treatment (even cure) of disease does not necessarily alleviate suffering for all patients. Thus, in order to understand illness and ease the patient's suffering doctors must first understand the personal meaning of illness for the patient. Mead and Bower (2000)[14] suggested that this can have many dimensions; for example, financial insecurity may make a patient reluctant to interpret symptoms as illness for fear of being labelled unfit to work. Thus, patient-centred medicine regards the patient as an experiencing individual rather than the object of some disease or entity.[19] Attending to ''*the patient's story of illness*''[20] involves exploring both the presenting symptoms and the broader life setting in which they occur,[15] by eliciting each patient's expectations, feelings and fears about the illness.[21] The goal, according to Balint (1964),[10] is to ''*understand the complaints offered by the patient, and the symptoms and signs found by the doctor, not only in terms of illnesses, but also as expressions of the patient's unique individuality, his conflicts and problems.*'' Therefore to develop a full understanding of the patient's presentation and provide effective management the doctor should strive to understand the patient as a distinctive personality within his or her unique context.

Shared power and responsibility

Mead and Bower (2000)[14] advocated the use of a democratic, equal doctor-patient relationship differing fundamentally from the paternalistic focus envisaged by Parsons (1951).[1] Society advocated a shift in the doctor-patient relationship from the 'guidance-co-operation' model to 'mutual participation',[5] whereby power and responsibility are shared with the patient. Byrne and

Long (1976)[22] suggested that patient-centred consultations reflect recognition of patients' needs and preferences, characterized by behaviours such as encouraging the patient to voice ideas, listening, reflecting, and offering collaboration. In this way, patient-centred medicine encourages much greater patient involvement in care than is generally associated with the biomedical model.

The therapeutic alliance

Patient-centred medicine ensures a far greater priority to the personal relationship between the doctor and patient, based on psychotherapeutic developments around the concept of the therapeutic alliance. This notion was supported by Rogers (1967),[23] who projected that the core therapist attitudes of empathy, congruence and unconditional positive regard are both necessary and sufficient for effecting therapeutic change in clients. More recently, Roth and Fonagy (1996),[24] emphasized the importance of aspects of the doctor-patient relationship, including (a) the patient's perception of the relevance and potency of interventions offered, (b) agreement over the goals of treatment, and (c) cognitive and affective components, such as the personal bond between doctor and patient and perception of the doctor as caring, sensitive and sympathetic.[25] Thus, a friendly and sympathetic manner may increase the likelihood of patient adherence to treatment. Conversely negative emotional responses by either party (e.g. anger, resentment) may serve to complicate medical judgment (causing diagnostic error) or cause patients to default their treatment. A common understanding of the goals and requirements of treatment is crucial to any therapy, whether physical or psychological (Mead and Bower, 2000).[14]

The 'doctor-as-person'

Balint et al. (1993)[26] described the biomedical model as ''*one person medicine*'' in that a satisfactory clinical description does not require consideration of the doctor. By contrast, patient-centred medicine is ''*two-person medicine*'', whereby the doctor is an integral aspect of any such description: ''*the doctor and patient are influencing each other all the time and cannot be considered separately*''.[26] Sensitivity and insight into the reactions of both parties can be used for therapeutic purposes.[14] Balint et al. (1993)[26] describes how emotions provoked in the doctor by particular patient presentations may be used as an aid to further management (''*counter-transference*''). Winefield et al. (1996)[27] described the dimensions of patient-centeredness as attention by the doctor to cues of the affective relationship as it develops between the parties, including self-awareness of emotional responses.

The factors influencing patient-centeredness (see also Fig. 1)

Mead and Bower (2000)[14] suggested that a large number of variables can potentially influences of a doctor's propensity to be patient-centred, both within the context of individual consultations and over the course of the professional career. The diagram below indicates some of their hypothesized influences. At the centre of the model, is the doctor-patient relationship expressed in the form of a behavioural interaction between two parties. As previously discussed, these behaviours may be interpreted as more or less patient-centred across the five dimensions described above.

The most distant level, the ''*shapers*'' (such as cultural norms or clinical experience), may impact on more specific determinants (like gender or attitudes). For example, norms relating to gender mean that it is more socially acceptable for females to discuss feelings and emotions than males.

The specific context of medical practice may also impact on doctors' patient-centeredness.[28] For example, the introduction of videotaped consultation assessments into the membership examination for the Royal College of General Practitioners may encourage more systematic attention to interpersonal aspects of care by GPs.[28] However recent policy initiatives to promote greater team work and role substitution among primary care professionals[29] may reduce possibilities for sustained personal contact with individual patients, which may prove detrimental to the patient centred approach within the doctor-patient relationship.

Finally, Mead and Bower (2000)[14] point out that the consultation-level influences have the most immediate impact on the propensity of doctors to be patient centred. For example, ethnic differences may create barriers to effective communication. Time or workload pressures may limit possibilities for full negotiation and resolution of conflict between the doctor and patient 'agendas'. Alternatively, such pressures may increase the value placed by a doctor on such aspects of clinical work, encouraging adoption of specific mechanisms (e.g. offering longer appointment slots) to facilitate patient-centred care.

Fig. 1 explicitly recognizes that the propensity of a doctor to be patient-centred will vary over time, and that some dimensions (i.e. the patient-as-person

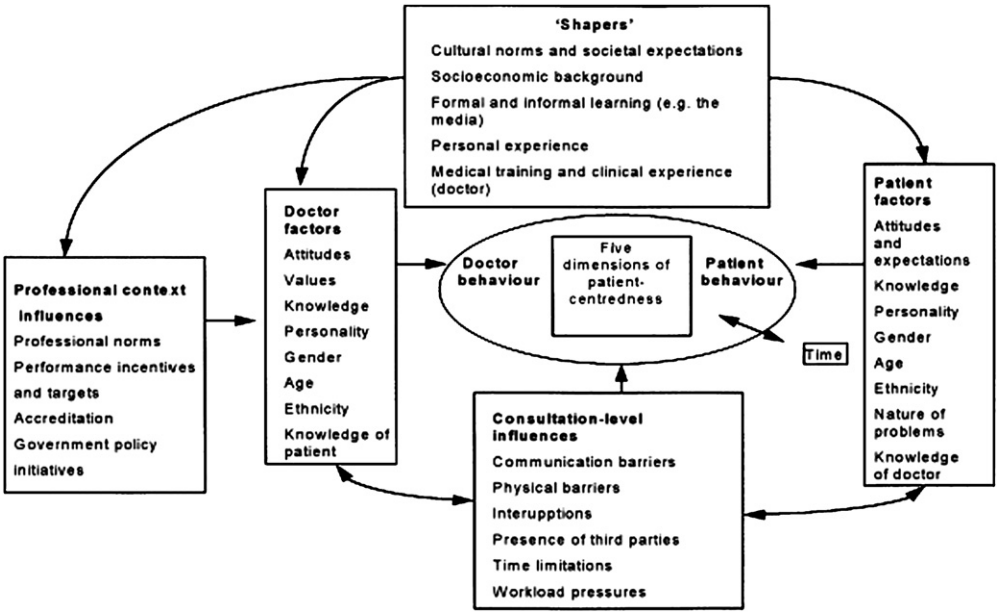

Figure 1 The patient-centred model (adapted from Mead and Bower (2000)[14]). Reprinted from *Soc Sci Med*, 51, Mead N and Bower P, Patient-centredness: a conceptual framework and review of the empirical literature, pp 1087—110, 2000, with permission from Elsevier.

and the doctor-as-person) require significant time to develop between the doctor and patient. Fig. 2 charts the evolution of the doctor-patient relationship over time.

Contemporary issues

We have so far considered the evolution of the doctor-patient relationship in Western civilization. A full discussion of its evolution in other civilizations is beyond the scope of this paper; however, it is worth noting that the doctor-patient relationship in the two oldest civilizations, those of India and China, has remained far more constant than in Western societies. A paternalistic approach still dominates, and doctors have a high status in society.[30] The teachings of the major Eastern religions, most notably Hinduism, Buddhism, and Taoism, deems the art of healing as work most worthy of men, which may partially account for such a high regard in these populations.[30] The focus of these civilizations on the different roles of men and women in society may also be a contributory reason as to why there is a predominance of men in the medical profession, and many patients, even female, prefer to see male doctors.[30] Of course, exceptions such as Moslem women preferring to be treated by female Moslem doctors are notable.[30] We would stress though that these statements express generalizations and that the complexities of the doctor-patient relationship in these different contexts is beyond the scope of this paper.

Another difference between Eastern and Western societies is that litigation rates of doctors are far lower in the former civilizations compared to the continually escalating negligence claims in the UK, Australia, and particularly, the USA. The elevated status of doctors in Eastern civilizations as mentioned above is undoubtedly a factor in this. In the West, medical negligence claims have been revolutionized by the Bolam test[31] and Bolitho qualification[32] (that state that the acceptable standard of care must be that which 'no reasonable doctor in similar position' fall below,[31] and that courts would reserve the right to make this judgment[32]). Claims in the UK have risen 15-fold in the UK since April 1995.[33] The effect of this has been to erode the doctor-patient relationship with higher levels of mutual distrust, the seeking of second opinions by patients, and often the development of adversarial relationships. The UK Department of Health's consultation document, 'Making Amends',[34] aims to reform the negligence claims process to make it less adversarial, recognising the benefit this will have in restoring public confidence in the medical profession.

Another contemporary effect on the doctor-patient relationship has been the exponential increase in the use of the Internet by patients. This has meant that patients are generally better informed, especially in the more affluent countries of the West, and this has facilitated the patient-centred approach to health care that predominates today. While better patient education has obvious advantages for the doctor-patient relationship,

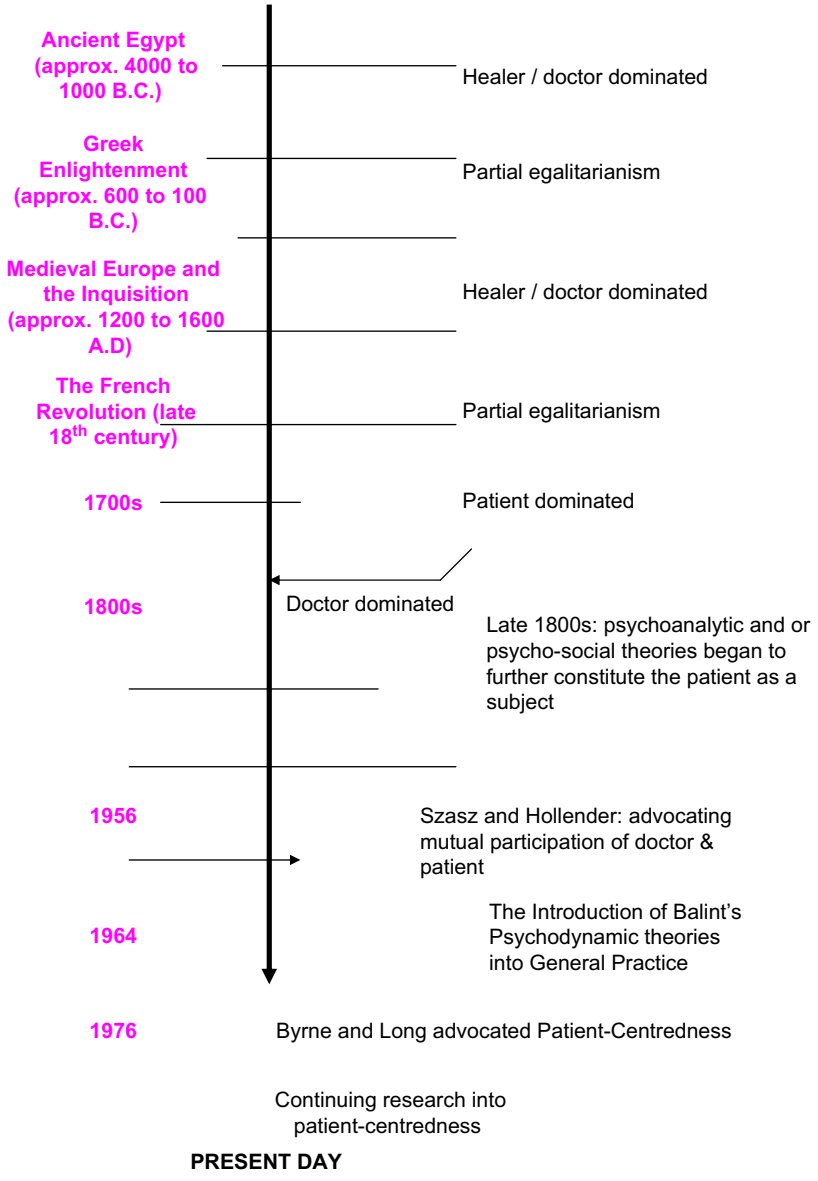

Figure 2 A time line indicating the evolution of the doctor-patient relationship.

there are concerns that information on the Internet might not always be accurate and reliable.[35] This poses a new challenge for the medical professional — that of revising any misinformation the patient has found him- or her-self.

Conclusion

The chronological evolution of the doctor-patient relationship has been described. Previously, patients were most often considered to be too ignorant to make decisions on their own behalf. Thus, informing patients about the uncertainties and limitations of medical interventions served only to undermine the faith that was so essential to the therapeutic success. Doctors felt comfortable in making decisions on behalf of their patients. Later on, doctors soon became separated from their patients politically, economically, and socially. The distance between the doctor and patient widened. Little social mingling remained, and the doctor-patient relationship became impersonal and remote, based upon negotiation and financial transaction. While this was the case for all specialties within Medicine, the extent of this impersonality has generally varied, with physicians being more aloof in earlier times, and surgeons more so in the 1800s, as a direct result of the status placed on them by patients.

Today however there is a new alliance between the doctor and patient, based on co-operation

rather than confrontation, in which the doctor must ''*understand the patient as a unique human being*''.[36] Thus patient-cantered care has replaced a one-sided, doctor-dominated relationship in which the exercise of power distorts the decision-making process for both parties. Such an alliance must take into account not only the application of technical knowledge, but also communication of information calculated to assist the patient to understand, control, and cope with overpowering emotions and anxiety. Doctors must accept responsibility for both a technical expert and a supportive interpersonal role. Mutual participation, respect, and shared decision-making must replace passivity. Thus, by dispensing information in a manner that maximizes understanding is a prerequisite for more equal participation. Balint (1969)[36] argued that the patient not the illness should be the primary focus of medicine such that the primary objective of the doctor is to listen to the patient in order to identify what the 'real' problem actually is, instead of simply eliciting symptoms and signs. Shared decision making between the doctor and patient will determine the most appropriate and best course of action for an individual patient. The doctor in this patient-centred model is ideally placed to bridge the gap between the world of medicine and the personal experiences and needs of his patients.

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