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Doctor-patient relationship:
History, current models and flaws

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# Doctor-patient relationship

## Abstract

The doctor-patient relationship has been adapted and altered throughout history. Global societal changes over millennia have seen a shift in medical practice from magic to logic and religion to egalitarianism. Physicians have a role in guiding patients in a caring manner by exploring values and promoting independence. There currently lies various models for how a doctor-patient relationship can come across, ranging from a paternalistic, or ‘priest-like’ approach to a deliberative model which encourages conversation. Flaws of the doctor-patient relationship vary based on the model, however, poor education and training to doctors remains a problem and is a cause of medical malpractice suits throughout the USA.

## Introduction

*“Why do doctors so often make mistakes? Because they are not sufficiently individual in their diagnoses or their treatment. They class a sick man under some given department of their nosology, whereas every invalid is’really a special case, an unique example.”*

This quote (Amiel, 1889), taken from Henri-Frédéric Amiel’s journal (a 19th Century Swiss philosopher), epitomises the crisis physicians face in a society impacted by globalisation and a target-orientated business one could call medicine. The doctor-patient relationship forms a fundamental component of the practice of medicine. It establishes the foundation for a physician to utilise his or her knowledge to make a diagnosis and treatment plan. Throughout medical school and beyond, epidemiology is taught with a generalisation of a given population to understand incidence, distribution and control of diseases. However, this fails to address the individual and how a disease can manifest itself in many diverse ways, affecting the patient physiologically and psychologically.

Society was perceived by Talcott Parsons as a living organism, with sociological ideologies such as functionalism and social constructionism paving the way to restore order to the art of medicine and medical practice. Parsons was one of the first sociologists to describe the doctor-patient relationship, and his work formed the foundation for many others to determine the ideal doctor (Hughes, 1994).

To ensure that physicians uphold outstanding moral and ethical standards, medical ethics and the Hippocratic Oath have been designed and is taught to students alongside basic communication skills. The Hippocratic Oath, originally formed over 2000 years ago by Hippocrates, was one of the first documented medical texts, designed to ensure that physicians upheld specific standards. Despite its age, it is one of the most well-known oaths to have been written and was revised in 1948 during the Geneva Convention, as shown in figure 1 (Association, 2017). Medical ethics are put into place both clinically and in medical research to apply moral principles and values. Respect for autonomy, non-maleficence, beneficence, and justice form the common framework used in medical ethics.

*AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:*

*I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;
I WILL GIVE to my teachers the respect and gratitude that is their due;
I WILL PRACTISE my profession with conscience and dignity;
THE HEALTH OF MY PATIENT will be my first consideration;
I WILL RESPECT the secrets that are confided in me, even after the patient has died;
I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;
MY COLLEAGUES will be my sisters and brothers;
I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I WILL MAINTAIN the utmost respect for human life;
I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;
I MAKE THESE PROMISES solemnly, freely and upon my honour.*

Figure 1 A modern version of the Hippocratic oath, drawn up by the World Medical association at the 1948 Geneva convention (Association, 2017)

The doctor-patient relationship has changed throughout time, and is currently being redefined so that both the doctor and patient have a role in treatment decisions. However, individual perspectives and cultural differences across the world mean that the doctor-patient relationships can alter. There are 4 main models of the doctor-patient relationship; the paternalistic model, the informative model, the interpretive model, and the deliberative model (Emanuel and Emanuel, 1992). As well as the various models, different aspects of the doctor-patient relationship have been identified which includes but is not limited to; confidentiality and informed consent, shared decision making, physician superiority/conversational dominance, conflict of interest, transitional care, and finally, other involved individuals. The General Medical Council (GMC) has published advice to doctors in order to ensure that doctors are aware of the standards expected of them (GMC, 2013). The British Medical association (BMA) also provides career advice and support to any physician regarding key issues (BMA, 2017).

Each model of the doctor-patient relationship and the various aspects of it have come under continuous scrutiny, as various incidents have questioned the ethical limits. The doctor-patient relationship has changed throughout history, dating back from the more mythical approach of the Ancient Egyptians to the technological approach a doctor faces now.

## History of the doctor patients relationship

The doctor-patient relationship has experienced an evolution throughout human existence. The ideal doctor within a society has ranged from strict paternalism all the way to a magical healer. In the current day, physicians and other healthcare assistants approach patients with a more patient-centred approach, with symptoms being diagnostic. This patient centred approach can be described as a mutual participation, where two people who do not know each other, are able to feel more at ease through a certain level of intimacy. This sort of interaction requires both the patient and the doctor to accept that they have equal power, mutual independence and equal satisfaction (Kaba and Sooriakumaran, 2007).

Kaba and Sooriakumaran described ancient human kind as, *‘[Attempting] to master nature through his fears of helplessness, sickness and death, by means of magic and mysticism, theology and rationality’.* In Ancient Egypt, disease was supposedly sent to people as punishment from the gods or from evil spirits, as a result, there were many rituals, spells and charms. The first doctors were priests of the Goddess Sekhmet and they were trained in both practical medicine and magic (Hickson, 1971). Although this would now be considered unsophisticated, at the time, this was the best known way to treat both the physiological and psychological side of disease. As it was often priests who were at the forefront of medicine, there was an activity-passivity type of relationship, where the priests treated patients the same was a parent treats a child.

The Greek Enlightenment saw great advances in society and medicine, modestly boasting wealth and a democratic environment, with more social organisation. Medicine had more of a naturalistic approach, which was further enhanced and improved through trial and error. The Hippocratic Oath designed a code of ethics for doctors to follow, therefore providing a greater degree of humanism and a shift away from the activity-passivity of the Ancient Egyptians. However, the end of the Roman and Greek Empires led to a rise in religious and supernatural beliefs, including the strong belief that if one had unique abilities, they were a witch. The increasing popularity of the old and new testaments added to the magical and religious beliefs, therefore, doctors possessed magical powers and the patients were helpless, meaning that they had to follow the orders of doctors.

The French revolution and the emergence of the Renaissance period saw a decrease in strict Catholicism and an increase in Protestantism. Society altered, becoming more liberal and people were treated with more dignity. Strong political and societal protests throughout the Renaissance altered medical attitudes and actions. The previous centuries of incarceration of the mentally ill had come to an end and the doctor-patient relationship become more humanised and shifted towards the patient-centred approach. However, even into the 18th century, there was still an inequality between the rich and poor. Only the rich could afford the few doctors that existed, therefore, majority of the patients were upper class. This meant that doctors rarely examined patients and focused more on being attentive to the rich patients’ needs and doing what they requested. The short supply of doctors and the aristocrat patients meant that this period of time saw patient dominance.

It wasn’t until the late 18th century that hospitals built for the underprivileged emerged. Advances made in microbiology and surgery saw more accurate diagnosis and improved treatments. There was a shift from treating symptoms to using symptoms as diagnostic tools, known as the biomedical model. Doctors now examined patients and used expert anatomical and clinical knowledge to form a diagnosis, as a result, patients became completely reliant on doctors. The previous patient dominant healthcare environment went back to a paternalistic approach.

Sigmund Freud, an Austrian neurologist, was the founding father of psychoanalysis in the late 19th century. His psychoanalytical theories placed great importance to listening to patients and taking more of an interest in them. He believed that the patient has an active role in their tre atment, paving the way to the modern day doctor-patient relationship (Kaba and Sooriakumaran, 2007). Michael Balint, a physician who trained in both medicine and psychoanalysis, acknowledged the fact that an individual would not seek their GP solely for objective reasons; psychological and social influences played a factor. He therefore emphasised that doctors need to look past the physical signs and symptoms and focus on the unique social and psychological context in which the patient finds themselves in, and therefore the real reason for the consultation. Balint described a doctor as a drug, which altered the doctor-patient relationship (Lakasing, 2005). To ensure that the drug is successful, dosage, addictive properties and side effects needed to be monitored. The dosage of a ‘doctor drug’ is the frequency of visits needed, the addictive properties is how reliant the patient is on the doctor and the side effects are the harm a doctor can do. It was from Balints’ research and theories that he described mutual investment, where a series of consultations would improve time management and the efficacy of the consultation. It also allows the patient to develop insight into what the doctor wants and needs.

## Medical ethics and the Doctor-patient relationship models

Medical ethics is a branch of philosophy dealing with values concerning human conduct in regards to the rightness and wrongness of actions and motives (Farlex, 2017). Medical ethics has designed guidelines which oversee medical decisions, therefore, indirectly affecting the doctor-patient relationship through the ethical standards expected from physicians. In 1985, Tom Beauchamp and James Childress published the Principle of biomedical ethics. This book has been widely distributed and entails the framework for medical ethics in clinical and non-clinical settings. It encompasses four main principles, autonomy, non-maleficence, beneficence and justice. The first, a respect for autonomy, allows those with decision making capacities to make reasoned informed choices at their own will. Beneficence considers balancing the benefit of a treatment with the risks and costs, yet emphasises that the healthcare professional should act in a way that benefits the patient. Non-maleficence pertains that a doctor should do no harm. In the case that harm needs to be done, it must be for the greater good and not be disproportionate to the benefits of the treatment. Finally, the principle of justice encompasses society as a whole rather than a specific individual. Benefits of treatments should be distributed equally, therefore, everyone should be treated in a similar manner (UKCEN, 2017). Without these principles, doctors would be able to favourably treat certain individuals or even harm those who do not deserve to be treated as such. Despite these being guidelines, ethical standards are implemented across all of medicine and prevent medicine reverting back to paternalistic inhumane ways where the patient had no control over their medical decisions.

In 1992, Ezekiel Emanuel and his ex-spouse, Linda Emanuel, formulated four models of the doctor-patient relationship, the paternalistic model, the informative model, the interpretive model, and the deliberative model (See figure 2). The paternalistic model limits patient participation. In one extreme, the physician commandingly informs the patient of when the intervention will begin. However, the paternalistic model is more commonly seen as a doctor presenting a patient with specific information that will encourage the patient to consent. It is warranted during emergencies where time taken to obtain consent can do more harm. The informative model, is where the doctor informs the patient of all the relevant information and allows the patient to select which intervention he or she wants. The doctor is also required to inform patients of their disease state and therefore, the diagnostic and therapeutic interventions, the nature of these and the risks and benefits. The purpose of this model is that the patient is known to know their own values, however, they lack the facts and the doctor is able to provide these so that the patient can exercise control. The interpretive model takes the informative models slightly further by eliciting the patients’ values and helping the patient select the available interventions. This model is akin to a counsellor’s role, where information is provided, values are exposed and medical interventions are selected. These three models fail to address one’s own health related values that are specific to the clinical situation. Therefore, the deliberative model, which is analogous to a teacher or friend, allows the physician to engage in a dialogue on what course of action would be best (Emanuel and Emanuel, 1992).

Figure 2 (Reach, 2017)The four models as described by Ezekiel Emanuel and Lina Emanuel

A fifth model, the instrumental model, is where the patient’s values are completely disregarded for the greater good of society. Although this is rarely seen, an example would be the Tuskegee syphilis experiment, which ran from 1932 to 1972. It involved almost 400 African-American men with latent syphilis. The purpose of the experiment was to see if syphilis affected black men in a different way to white men. Despite the discovery of penicillin and it being known as a simple cure for syphilis, it was never offered. This experiment altered societies opinion on unethical and racist experiments, and it is this reason why the instrumental model is rarely seen today (CDC, 2017).

Other models do exist but encompass similar concepts to the four above. Szasz and Hollender created their own three models; the model of activity-passivity, the model of guidance co-operation and the model of mutual participation. (Szasz and Hollender, 1956). The first is comparable to the relationship between a parent and their child, almost identical to the paternalistic model. Guidance co-operation is when the patient is conscious of their own objectives, however, during a time of heightened anxiety, are willing to place the doctor in a position of authority and superiority. The final model, mutual participation, is based firmly around the idea that the interaction between a doctor and patient relies on them having equal power, mutual independence and equal satisfaction. The benefit of this final model is that the patient is able to take care of themselves.

Despite the shift towards a more patient centres approach, when life-saving medicine is needed, or the patient does not have capacity, other models should be applied.

## Current flaws

The doctor-patient relationship, despite having various models and different approaches, still has many difficulties. Medical practice still varies across the world and approaches by doctors often clashes with patient expectations. Healthcare in general hopes to improve health outcomes, yet it has come to question how much of a role a doctor plays in a technological environment. The term e-patient is being thrown around more and more, as patients seek information and help through easily accessible online forums and websites.

The paternalistic approach would now be considered unethical in most situations. The informative model lacks a caring approach despite all necessary information being conveyed as it fails to address the patients’ values. It also fails to utilise the physicians expertise based on prior experiences of similar situations. The interpretive model, despite being designed to elicit the patients’ values, may sometimes be unconsciously altered by the physicians imposing their own values. This is often the case as individuals are rarely sure of what their own values are and often need assistance in becoming aware of these values. Despite the deliberative model being most appropriate in the worlds current environment, it can occasionally lean towards a paternalistic approach as doctors unconsciously steer the conversation away from what the patient wants. All these models also require the full competence of the physician and the physicians’ ability to elicit patients’ values and needs, which itself is a difficult skill set.

Power is an inexorable aspect of all social relationships. Doctors use their expertise and technical abilities to exert their powers and bring to fruition their professional responsibilities. However, patients also require a sense of power in order to convey their tenets and fulfil their responsibilities. Empowering both the patient and the doctor to form an ‘adult-adult’ relationship allows humility, autonomy and responsibility, however, an adult-child relationship can lead to a dangerously dominant relationship where autonomy can be lost and justice reduced. However, even an adult-adult relationship can lead to conflicts if opinions and expectations clash. Empowering both the doctors and patients may be unrealistic and not always possible, however, it offers acknowledgement of power issues (Goodyear-Smith and Buetow, 2001).

In the US, managed care plans, a type of health insurance, has had many deleterious impacts on the doctor-patient relationship. A managed care organisation provides a population with limited resources in an integrated system of care (Goold and Lipkin, 1999). The trident of patients, doctors and plans can create a conflict of interest, as plans align financial incentives in a competitive market. Paying physicians through several means can create a discord as doctors practice more for financial incentives. This creates an environment in which patients wonder whether the doctors genuinely care for them or their own jobs. This is equally problematic in a fee-for-service care. This will detrimentally effect trust and hinder patient-centred care. Managed care plans also heavily rely on primary care to co-ordinate referrals. This can create an environment where general practitioners are overly cautious to prevent over-spending. Medical malpractice cases has become one of the most testing issues in healthcare in the US, with annual medical malpractice premiums totalling more than $5 billion (Hiatt, 1992). Although most medical malpractice cases are not successful, the effect on the medical staff can be detrimental and even career ending. The result of this is that physicians have more difficulty in building rapport with patients. However, positive communication increases a patients perception of a physicians’ competence and decreases the chance of a medical malpractice suit (Moore et al., 2000).

## Conclusion

Societies, institutes and individuals are completely reliant on doctors to survive and have a functioning civilisation. History has seen medicine being based on religion, culture, magic and superstitions. Magic and religion has slowly replaced by logic, intuition, education and psychology. The future of the doctor-patient relationship is difficult to predict, yet technological advances, increased utilisation of social media and an increase in the use of artificial intelligence could have a huge impact. Patients could become more independent and not need doctors, or rely on doctors to get some human interaction during anxious times, which machines cannot supply. Doctors see thousands of patients in their lifetime and are taught how diseases affect millions, it is as a result of this that it is easy for doctors to forget that each patient is their own individual with their own values, expectations and rights.

## Bibliography

Amiel, H. F. d. r. (1889) *Amiel's journal : the journal intime of Henri-Frederic Amiel.* 2nd ed. edn. London: Macmillan.

Association, W. M. (2017) *WMA - The World Medical Association-WMA Declaration of Geneva*. Available at: https://[www.wma.net/policies-post/wma-declaration-of-geneva/](http://www.wma.net/policies-post/wma-declaration-of-geneva/) (Accessed: 23.06.2017.

BMA (2017) *Confidentiality and health records tool kit*: @theBMA. Available at: https://[www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/confidentiality-and-health-records-tool-kit](http://www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/confidentiality-and-health-records-tool-kit) (Accessed: 19.07.2017.

CDC (2017) *Tuskegee Study - Timeline - CDC - NCHHSTP*. Available at: https://[www.cdc.gov/tuskegee/timeline.htm](http://www.cdc.gov/tuskegee/timeline.htm) (Accessed: 20.07.2017.

Emanuel, E. J. and Emanuel, L. L. (1992) 'Four Models of the Physician-Patient Relationship', *JAMA,* 267(16), pp. 2221-2226.

Farlex (2017) *Medical ethics*. Available at: [http://medical-dictionary.thefreedictionary.com/medical+ethics](http://medical-dictionary.thefreedictionary.com/medical%2Bethics) (Accessed: 20.07.2017.

GMC (2013) *Good medical practice*: General Medical Council, Regent’s Place, 350 Euston Road, London NW1 3JN. Available at: <http://www.gmc-uk.org/guidance/index.asp> (Accessed: 19.07.2017.

Goodyear-Smith, F. and Buetow, S. (2001) 'Power issues in the doctor-patient relationship', *Health Care Anal,* 9(4), pp. 449-62.

Goold, S. D. and Lipkin, M. (1999) 'The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies', *J Gen Intern Med,* 14(Suppl 1), pp. S26-33.

Hiatt, H. (1992) 'Medical malpractice', *Bull N Y Acad Med,* 68(2), pp. 254-60; discussion 261-4.

Hickson, J. F. (1971) 'Medicine in ancient Egypt and its relevance today', *J R Coll Gen Pract,* 21(110), pp. 511-6.

Hughes, J. J. (1994) *The Doctor-Patient Relationship: A Review*. Available at: <http://www.changesurfer.com/Hlth/DPReview.html> (Accessed: 23.06.2017.

Kaba, R. and Sooriakumaran, P. (2007) 'The evolution of the doctor-patient relationship', *Int J Surg,* 5(1), pp. 57-65.

Lakasing, E. (2005) 'Michael Balint — an outstanding medical life', *Br J Gen Pract,* 55(518), pp. 724-5.

Moore, P. J., Adler, N. E. and Robertson, P. A. (2000) 'Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions', *West J Med: Vol. 4*, pp. 244-50.

Reach, G. (2017) 'Patient autonomy in chronic care: solving a paradox', *Patient Preference and Adherence,* 8, pp. 15-24.

Szasz, T. S. and Hollender, M. H. (1956) 'A contribution to the philosophy of medicine; the basic models of the doctor-patient relationship', *AMA Arch Intern Med,* 97(5), pp. 585-92.

UKCEN (2017) *UKCEN: Ethical Issues - Ethical Frameworks*. Available at: <http://www.ukcen.net/ethical_issues/ethical_frameworks/the_four_principles_of_biomedical_ethics> (Accessed: 20.07.2017.