Progression of Doctor-Patient Relationship Model in light of Time and Culture: a Narrative Review

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Introduction

Doctor-Patient relationship, a moving and meaningful experience, can be defined as a mutual relationship where one person i.e. the patient, knowingly seeks the help of another i.e. the doctor, who in return knowingly grants him as a patient and provides assistance (Fallon et al. 2015). Basically, doctor-patient relationship represents a kind of guardianship or trustee where the patient’s autonomy, confidentiality is respected by the physician, at the same time under the oath of Primum non nocere the physician tries to provide utmost care (Fallon et al. 2015). However, the attempt to define the doctor-patient relationship often fails to encompass the profundity of the concept of the relationship, as to attend a suffering person, a physician must possess a complete understanding of the human nature along with scientific knowledge and skill (Fallon et al. 2015; Kaba et al. 2007). A physician must acknowledge the patient not just as some symptoms, diseased organs or broken emotions, but also as a worried and helpless person seeking for answer, relief and above all trust (Hellin 2002). Patients very often share their thoughts and worries with the physicians, which they not even discuss with close friends and even family members (Fallon et al. 2015). The impact of a successful relationship between the patient and the doctor is so profound so the accuracy of the diagnosis and the effectiveness of the treatment often directly relies upon it (Kaba et al. 2007).

Based on mutual collaboration of two individuals previously unknown to each other feeling ease with variable degree of closeness, the relationship is in fact considered as interaction between two systems or persons (Kaba et al. 2007). Whether seen as a process or outcome, the purpose or the function of the relationship is observer dependent and it should be emphasized as a valuable component on the way of improving health outcomes (Ridd et al. 2009). Being an important, exclusive and difficult interpersonal relationship throughout the history of medicine, many a time this issue has been brought under microscope and debated over, linking it to the satisfaction of patient and continuity of treatment specially in Primary Health Care where knowledge of the patient is equally important to knowing the disease (Arafat 2016; Arafat 2016).

Over the decade, the course and pattern of doctor patient relationship has been evolving and several authors have argued over it keeping in concern of both the views of doctor and patient. Evidence shows that changes in society and health system have influenced...
the expectations of patients from their doctors as well as doctors’ perspective regarding the patient (Bensing et al. 2006). Radical concepts like empowerment, shared decision making have been introduced in the transformation of patient’s role from being passive dependency to active autonomy (Charles et al. 1997). Literature shows, the paternalistic model, once considered as ideal is no longer preferred as it is slowly but surely being replaced by more patient centered relationship (Bensing et al. 2006) and this process is influenced not only by the advent of science, development of communication technology (Weiner 2012) but also the mixing and ever-growing interaction between different culture and race (Verma et al. 2016).

In absence of good overview encompassing both time line and cultural influence on the change of doctor patient relationship, the author aimed to shed light over these issues in accordance with the available literature.

**Anatomy of Doctor-Patient Relationship**

The skeleton of the doctor-patient relationship is said to have several backbones namely voluntary choice of the physician and the patient, good and effective way of communication, appropriate emotions like empathy, trust, regard, continuity of the relation and no conflict of interest (Fallon et al. 2015; Stevenson 1966; Jennifer et al. 2010; Shrivastava et al. 2014). These lay the basic foundation of the doctor-patient relationship, as the patient trusts the doctors with their confidential and sensitive information as well as the doctors are confident enough to make decision based on the history provided by the patient (Fallon et al. 2015). Empathy rather than sympathy helps to build an effective rapport with the patient which in turn leads to successful treatment and healthy outcome from the doctor-patient relationship.

**Models of Doctor-Patient Relationship**

As proposed by Szasz T and Hollender M (Szasz 1956) there are three basic models of doctor-patient relationship namely a) Active-Passive model, b) Guidance- Cooperation model and c) Mutual participation model. On the contrary, Emanuel (Balint, 1957; Emanuel, 1992) gave four models of doctor-patient interaction as such, a) Paternalistic model b) Informative model c) Interpretive model and d) Deliberative model. Looking on the basics, these two different patterns can be unified to an extent with some effort. Being the oldest of the three, Active-Passive model of Szasz T and Hollender M (Szasz, 1956) can be entirely treated as the synonym of the Parental or Priestly model of Emanuel (Emanuel 1992; Raina et al. 2014). Being considered as the relation of a parent with an infant, placing the doctor in absolute control of the situation and giving a sense of superiority and feeling of gratitude and the patient is regarded helpless and unable to contribute or interact, the treatment commences regardless of the contribution and outcome (Szasz 1956). Being patient’s guardian, an obligation for the patient’s wellbeing drives the doctor to do what is in the patient’s best interest using his knowledge and skill whereas the autonomy of the patient is to approve the selected information the doctor provides and it is assumed that the patient will be grateful for the decision the doctor made whether they agreed with it or not at that time (Emanuel 1992; Raina et al. 2014). This model can be accepted in the emergency situation when waiting for consent may be futile and the consent may be waived (Fallon et al. 2015).

The Guidance-Cooperation model (Fallon et al. 2015; Kaba et al. 2007 and Szasz 1956) has some or more degree of overlapping similarities with the Informative and Interpretive model (Emanuel 1992; Raina et al. 2014). The patient is conscious and have feelings, and ready to “cooperate” as seeks help from the doctor and the doctor will provide guidance (Kaba et al. 2007; Szasz 1956), providing all the relevant information to the patient with an aim to enlighten the patient’s value and helping the patient actively or passively to make the choice best for the condition (Emanuel 1992; Raina et al. 2014). Having the impression of the relationship between a parent and an adolescent child (Szasz 1956), the responsibility of the doctor is to provide true and valid information, being competent in his or her expertise at the same time elucidating the values of the patient in a joint process of understanding in the way of making the decision by the patient himself (Emanuel 1992; Raina et al. 2014).

The most new of all the models, mutual participation guidance (Kaba et al. 2007; Szasz, 1956) or deliberative model (Raina et al. 2014) is based on the concept of positive impact of mutual participation between two persons (Kaba et al. 2007; Balint 1957). Here both parties having equal power and mutual interdependency (Fallon et al. 2015) coercion is avoided and thus the patient autonomy lies in “moral self-development”, having the power not to simply follow instincts but take the best path through involved dialogue (Emanuel 1992; Raina et al. 2014) essentially representing the relation between two adults and are very fruitful in care of chronic disease (Kaba et al. 2007).

**Evolution through time**

Throughout the course of history, the domain of doctor-patient relationship has always been changing along with social scenario comprising socio-political condition, intellectual capacity of the society and medical condition of the specific time. The ability of self-reflection of an individual along with way of communication and skill all drive the change of doctor-patient relationship (Hellin 2002). The
historical overview of the paradigm change can briefly have discussed under five time frames (Kaba et al. 2007): (a) Ancient Egyptian period; (b) Greek Civilization; (c) Medieval Europe; (d) Revolution of the French; and (e) Form 1700 onwards

**Ancient Egyptian Period**

Approximately stretching from 4000 BC to 1000 BC, the ideology reflects a parent figure who manipulates the event on behalf of the patient (Verma et al. 2016). The concept of “healers” who were doctors at the same time magicians and priest and magic was an important part of the society. So it is evident that the ancient Egyptian society had active-passive model of doctor-patient relationship and the social circumstances and state of technology of that time was in line with this model (Kaba et al. 2007).

**Greek Civilization**

Around 5th century BC, an empirico-rational approach based medicine was developed by the Greeks along with naturalistic observation, trial and error experience and abandoning of magic (Verma et al. 2016). As the first nation evolving towards democracy based social system, the doctor-patient relationship of that time was more likely to guidance-cooperation model based and a bit of mutual participation (Kaba et al. 2007). With the forthcoming of Hippocratic Oath, a higher degree of humanism in dealing the suffering was established and medical ethics rose above the self-interest of society (Kaba et al. 2007).

**Medieval Europe**

A weakening and deterioration in the doctor-patient relationship is noticed throughout the medieval period in Europe along with the demise of Roman Empire and restoration of magic and belief in supernatural power (Verma et al. 2016). Revive of magic and religious belief lead to a through back into the active-passive model of doctor-patient relationship (Kaba et al. 2007).

**Revolution of the French**

Through the Renaissance liberalism, sense of equity and dignity came into horizon and the medical attitudes and behavior was also impacted by the marked socio-political events of that time (Kaba et al. 2007). Freedom of an era which was socially underprivileged, entrapped in the dungeon lead to the emergence of guidance-cooperation based doctor-patient relationship (Shrivastava et al. 2014).

**From 1700 onwards**

During the 18th century with industrial revolution, the number of aristocrats and rich patient increased and it bring with it a patient dominant doctor-patient relationship and a competition started among the doctor to please the patients (Verma et al. 2016). Doctors were keen to attend the need arising from the symptom rather than examining the patient and this symptom based model of illness lead to a patient dominant situation throughout this time. Hospitals were place to treat the lower socio-economic class and the cornerstone of development of medical science and technology which slowly brought about the biomedical model of illness, with which the need of examining the patient increased and once again the patient became dependent on the clinical expertise of the doctor and thereby an active-passive model of doctor-patient relationship (Kaba et al. 2007).

**Modern day Patient Centered Medicine**

Patient centered medicine is the latest addition in the doctor-patient relationship as new as a 21st century idea of healthcare system (Bertakis et al. 2012). Patient centeredness is considered to be an essential element of standard healthcare system, at core of which lies the idea that the doctor will attend the need, value and preference of the patient (Saha et al. 2008, Relman 2001; Saha et al. 2008). Here the doctors with a set of skill and behavior develop a model of relationship where the patient participates as partner in making health and treatment related decision (Saha et al. 2008; Hibbard 2004). As a component of the model the physician not only attend the pathology of the patient, but also address the psycho-social and behavioral spectrum of the disease (Saha et al. 2008; Engel 1977).

**Doctor-Patient Relationship in other civilization and culture**

Like the western civilization, the doctor-patient relationship in the eastern half of the globe is also evolving. But the in a majority of areas of still the active-passive model and the paternalistic model is still preferred by far (Slaughter et al. 2007). In the south-east Asian region, due to the prominence of social hierarchy, doctors perceived a higher status in the society and there is lack of autonomy of a social group. Moreover, there is use of traditional medicine. All these contribute to a more one-way paternalistic model of doctor-patient relationship where the doctor being in a higher hierarchical level, dominate the relation and “partnership” is interpreted as a more caring attitude from the doctor but not as much as communication as would have been expected in the western countries. On top of that, educational gap, higher number of patient per doctor do not create a favorable condition for a partnership or mutual participation based model feasible (Claramita et al. 2010; Islam et al. 2014). Despite having the highest life
expectancy, in Japan there is a considerable amount of gap between the healthcare provider and the patients as the lack of explanation by the doctor and insufficient understanding of the patient is a major spectrum of medical futility (Bernat 2005; Burns et al. 2007; Kadooka et al. 2012). In summary, time restraints due to high number of patient, lack of preparedness of the patients and communication skill of both parties can be identified as the major barrier to achieving a more sophisticated model of doctor-patient relationship (Claramita et al. 2010, Lee et al. 2008; Moore 2007).

Religion: A determinant of Doctor-Patient Relationship?

The model of doctor-patient relationship may sometimes vary among religions (Kaba et al. 2007). Major eastern religions like Hinduism and Buddhism consider men to be more worthy of dealing with the art of healing, hence in these population there is a significant number of male doctors and also the model of the relationship being a paternalistic one (Kaba et al. 2007; Slaughter et al. 2007). In Islam, a virtuous physician tries to dictate his affairs according to the laws of the Quran and Sunnah and hence a Muslim physician will try to build a healthy doctor-patient relationship based on these two-primary source of Islamic law (Pasha et al. 2016; Arawi 2010). But the author 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. Future research could be done to determine the impact of different religion on doctor-patient relationship.

Doctor-Patient Relationship in Electronic Era

With the day to day advances in technology, doctor-patient relationship has entered a totally new paradigm which was unknown for even 8-10 years back (Charles et al. 1997). Exponential increase as well as easy availability of internet has rendered medical knowledge to the palm of the patients and which means the patients now a days are well informed and self-educated regarding their condition which essentially possess a challenge for the physicians to cope with the demand of the patients and build a flowing relationship (Kaba et al. 2007; Charles et al. 1997). The electronic revolution has now gone to the phase where face to face patient-doctor relationship is somewhere replaced by telemedicine which can be the future of doctor-patient relationship (Kaba et al. 2007).

Conclusion

The chronological time frame as well as cultural, religious and technological dimension of doctor-patient relationship model has been narrated. On one hand the ignorant poor sufferer to rich aristocrat and now the technologically boomed patient, on the other hand the doctor, sometime playing the role of god, healing through magic, sometimes just being the listener and often being the counselor or friend and teacher. The role of both sides has gone through significant evolution and still it is evolving. Despite the ever-changing tide, the doctor-patient relationship model is still considered one of the mankind’s most moving and meaningful mutual relationship. More works can be done to sort out more determinants or to predict any further change in the model of this relationship which will be needed to cope with the future.

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References


