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THE DOCTOR-PATIENT RELATIONSHIP: THE PHYSICIAN'S PERSPECTIVE

Lynn Karen Rudich

1979

YALE

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3/23/79
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The Doctor-Patient Relationship:
The Physician's Perspective

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Yale University School of Medicine
1979

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For Dr. Howard Spiro,
Father, Authoritarian, Teacher, Friend

Introduction

In this era of exponential growth in medical science and technology, the doctor-patient relationship continues to be central to the structure and process of medical care. Attempts have been made to describe the doctor-patient interaction as a social system based on reciprocal needs of doctor and patient[1-7] whereas other analyses have focused on the structures of patient and physician roles and the conflicts resulting from disparate interests of these structures.[8] Cultural traditions have been examined for contributions to the nature of the physician-patient interaction[9,10] as have ancient and contemporary codes of ethics.[11-13] The individual psychologies of doctor and patient [14-16] have provided additional sources for conceptions of the doctor-patient relationship and its function.

The physician's own perspective on his or her relation to patients has only infrequently been examined, however. In 1967, Ford and coworkers published a comprehensive study of how physicians viewed the doctor-patient relationship in 1964 with respect to physician effectiveness and satisfaction.[17] In the years since the Ford study, issues such as patients' rights, informed consent, and human experimentation have received much attention; medical science and technology have continued to expand. I thought it useful, therefore, to re-examine, in a selected way, how some practicing physicians currently view their interactions with patients and their medical practices.

Four basic types of physicians emerge with regard to the physician-patient interactions they portray. In this paper, I attempt to characterize the different types of relationships, as well as define some elements which seem common to all. It is likely that the traditional fatherly, authoritarian role model for the physician is challenged by recent medical, legal, sociological, and ethical developments; in response, a trend toward a less formal mode of interaction based on patient education may be occurring. Finally, I examine the implications of my awareness of these changes, as a medical student in 1978, as I am in the process of formulating my own professional identity.

Methods

I interviewed twenty-nine practicing internists in the New Haven area. Twenty-six were in solo practice or in groups of two or three; I interviewed three members of large group plans to get an idea of how their views might differ from physicians in private practice. All interviews were taped so that they could be reviewed. The physicians were informed that I was exploring the physician-patient relationship and that all sources of information would remain confidential. Characteristics of the physicians are recorded in Table I. The physicians ranged in age from 31 to 73. Only one physician was a woman, reflecting the paucity of female private internists in the New Haven area in 1978. One physician, Q, previously in private practice, had recently taken a position in hospital administration.

During the 30-45 minute interviews, I tried to get the physician to define and clarify the nature of his [18] conception of the term "my patient" in open-ended discussion; specific clarification during the remainder of the interview was encouraged with questions such as: What are your feelings about "legalizing" the doctor-patient relationship with a written contract? Would the doctor-patient relationship change in a salaried situation? How do you feel when patients ask to read their records? Why do patients comply with your therapy? Who benefits most from the doctor-patient relationship?

Table I
Physician Characteristics

Physician	Age	Practice	Specialty[1]	Classification[2]
A	31	solo	nephrology	T-A
B	32	group(2)[3]		T-A
C	32	group(2)	rheumatology	F-A
D	34	group(3)	cardiology	T-F
E	34	solo		F-A
F	39	LHP [4]		T-A
G	42	group(2)	endocrinology	F-A
H	43	solo		F-A
I	44	group(2)	endocrinology	T-A
J	47	solo	gastroenterology	F-F
K	47	solo	cardiology	F-A
L	49	group(2)	rheumatology	F-F
M	50	group(2)	cardiology	T-F
N	51	solo	gastroenterology	F-F
O	52	group(2)		T-A
P	54	group(2)	cardiology	F-A
Q	54	group[5]		T-F
R	55	solo	FP/anesth.[6]	F-F
S	56	group(2)	cardiology	F-A
T	56	solo		F-F
U	56	LHP	cardiology	T-A
V	61	group(2)	cardiology	T-A
W	64	group(2)		F-A
X	66	solo		T-F
Y	67	solo		T-F
Z	70	group(2)	cardiology	F-F
AA	71	LHP		F-F
BB	71	group(2)	GP	F-A
CC, female	73	solo		"F"-A

[1] Except for R and BB, all physicians are certified in internal medicine in addition to specialties indicated.

[2] Classification refers to the type of physician as judged by the interviewer (see Results). Abbreviations are: T-A, teacher-authoritarian; F-A, father-authoritarian; T-F, teacher-friend; F-F, father-friend.

[3] Parentheses contain the number of physicians in a group.

[4] LHP is Large Health Plan.

[5] Physician Q was previously a member of a private group but is currently in hospital administration.

[6] Family Practice/Anesthesiology, no longer practicing anesthesiology.

Results

Physicians' conceptions of their relation to patients could be characterized in two major ways, as arbitrarily judged by certain quality of response: in one way, physicians could be classified as either "father" or "teacher"; in the second, qualities suggested either "authoritarian" or "friend". "Fathers" and "teachers" differ by the nature of their positions and the responsibility they assume with respect to patients, whereas "authoritarians" and "friends" differ instead in the way they function to ensure those positions.[19] Based on these qualities, each physician could be classified in both ways. Thus, I felt that the physicians portrayed themselves relating to patients in four basic role models: "father-authoritarian", "father-friend", "teacher-authoritarian", or "teacher-friend". (See Figure 1.) The four role models represent syntheses of the components of both classifications. (See also Table II.)

	Function	
Responsibility	Authoritarian	Friend
Father	Father-Authoritarian	Father-Friend
Teacher	Teacher Authoritarian	Teacher-Friend

Figure 1
Classification of Physicians

The following quotes are selected to illustrate salient features of the various qualities of response. Because a dual classification system is used, although a quote may represent, for example, "Teacher--Nature of Interaction," the physician responsible for the statement may be expressing thoughts consistent with an "authoritarian" or "friend" orientation as well. The bracketed letters following quotes refer to corresponding physicians listed in Table I.

Father:

1. Nature of Interaction

The image of the father-figure has traditionally been assigned to the doctor and accepted by him. One physician sees his role as "accepting responsibility for trying to help in matters, way of life, as well as giving drugs, making diagnoses...this was part of my training, part of my motivation... It is not uncommon for my Catholic patients to call me 'Father'.[AA]" "My patients come to me first for any number of problems; they depend on me for advice. One patient noted that her relationship with me and her minister are about the same...(Patients) have faith in me that I'll do the right thing.[Z]" The relationship with each patient is "individual, for each person it works differently--like bringing up children.[N]" "My patients come to me for direction, like in a father-child relationship.[T]" "Most of my patients put me on a pedestal...(I have) fantastic patient loyalty.[BB]" "(Patients) have a feeling of dependence, that they

can talk honestly, the way they wouldn't be able to talk to a stranger.[W]" "(Patients) have faith, trust, confidence in me. I'm their security...They don't have to worry.[S]"

2. Responsibility

The "father" sees himself as the physician responsible for coordinating the patient's care: "If I'm the primary physician for my patients, I'm responsible for all follow-up, to see that things are right...to agree,disagree (with consultants), carry out plans...[K]" Along with this unique relationship, the father bears the great burden of responsibility: "Subspecialists have it easy... They take care of all the interesting problems but won't assume the responsibility of worrying about the patients all the time.[E]" This is also manifest in "problems with the house staff--tension about who's going to run things.[K]" "In the hospital, where other people are involved (the physician-patient relationship) is difficult; if I'm the responsible physician, I've got to know <u>everything</u> that's going on... I don't want (other physicians) to be making important decisions.[S]" The "father"assumes the patient's burden as well as his own. "To some patients I give advice about children, marriage, as well as hemorrhoids; they won't do anything without me.[J]" "It is unfair to expect the patient to assume more than a slender amount of responsibility for their care. (As a result) I expect loyalty; I am upset when I find a patient goes to a different internist.[H]"

Authoritarian:

1. Nature of Interaction

"Authoritarians" perceive decision-making as their ultimate function. "I direct decisions about therapy. I don't let (patients) tell me what to do.[U]" "I make decisions, I don't say 'What would you like to do?' Most of the time people like to have the monkey off their backs...[I]" "My patients want a doctor, at least in the context of illness, to make all the decisions. I'm perfectly willing to do it... I usually 'strongly advise'...(compliance) all depends on how you decide to present things.[C]" "If patients want another opinion I tell them whether they need it, where they can get it; if I need an opinion, I'll tell them where to get it.. but I can make the decision (about therapy) by the choice of consultant.[V]" "I offer options...but really I decide what I think is best for the patient.[F]" "With (doctors) as patients it's difficult.. they know too much, ask too many questions.[E]" "With friends as patients it's uncomfortable...there's less room to be authoritarian.[H]" "Authoritarians" are for the most part aware of their power: "A lot of people are kind of afraid of me. They're worried if they haven't lost weight, they're worried if their diabetes isn't under control, if they haven't taken their medicine.[I]"

2. Source of Authority

To the "authoritarian", patient compliance depends on the "confidence in the doctor's ability, decision-making.[S]" The "authoritarian" stresses the amount of knowledge at his disposal and the subsequent necessity to be decision-maker. "Most people have very little medical insight; we're the only ones who think we understand what we're doing.[G]" "I get very irritated when someone doesn't comply because of what a layman says.[C]" "I'm not comfortable with physicians as patients--it's easier to work with someone less informed.[H]" Patients differ, of course, in compliance, but ultimately, "the patients I do best by are patients who do what I want them to... you have to get them to relinquish their authority, and most of them do.[K]" When patients don't comply, "I'm not hostile, but also I tell them not to come back for that specific problem.[H]"

3. Demeanor

The "authoritarian" is adamant about the need to maintain distance to perform his function well. "I try to keep a distance..my patients and I are not friends.[C]" "In this profession, where emotions are always so close to the surface, it is easier to keep distance...with friends as patients, if things don't go well, it is easier to feel guilty, to second-guess yourself.[H]" "With friends as patients, it's much harder (to function well). I try to treat them as if I don't know them. I try to set a tone...

I <u>need</u> distance.[I]" With regard to non-compliance, "It doesn't bother me at all--that's one defense mechanism I have. I suppose I could get intensely emotionally involved but if (my efforts) fail, I don't let it bother me. I don't give up.[O]"

4. Information Access

To function effectively, the "authoritarian" needs to be protective of information about a patient's illness and possessive of the right to have private opinions. "The difference with physicians as patients is that they're fully aware of the significance of illnesses. You have to tell them exactly what is going on, whereas with others, if full knowledge is very upsetting, I may not tell them--I can minimize the significance... I can't think (of a reason to show a patient his reconds) unless material would compromise the situation or relationship, for example, if I made a diagnosis of schizophrenia and I didn't want to reveal that...[S]" With regard to patients asking to read their records: "That's fine, I'll fix (the records) so no one can understand them...if one's opinion is scrutinized, everything becomes bland.[K]" "Cold facts on a piece of paper, they're just not therapeutic..It's a matter of protection (for both the physician and the patient).[W]" "I would feel that my competency, concientiousness was being questioned...It's their right to do it, but I'd store it in the back of my mind...[H]" "It would be unusual (for a patient to request to see his records). I'd have

to be wary. Why? Is it trust? Don't they believe me?[P]" "I can't give the records to patients, but I offer to have them peruse; they wouldn't be able to read my scribble and I wouldn't take time to explain unless it were serious...(Patients who ask to read their records) would probably want to go to another physician anyway so there's no problem.[E]" "Records are _my_ information; comments may be misinterpreted.[C]" "I'm very rigid about records. I regard them as an 'aide memoir'. They're _my_ notes regarding how _I_ have responded to the dialogue. I'll give up any laboratory data, but these notes are _very_, _very_ personal.[U]"

5. Time Demands

To the "authoritarian", "bad" or "difficult" patients are those who are most demanding of time. "'Bad patients' unfairly utilize time for questions which have been adequately answered...calling up at all hours for me to repeat instructions given at the office...they call at _their_ convenience.[H]" "It's quite shocking when amiable patients suddenly get angry...'Hard patients' are those that can be unreasonable, taking too much time, insisting that I talk right then and there; they don't want to follow rules of hospital admission and they have all sorts of ways around it; or, after spending a large amount of time on going through a whole reasoned game plan (for therapy), they'll say...'But I just don't think I'll want to do that.'[P]"

"Patients don't seem to realize that phone calls take time.[F]" "(With friends as patients,) when things become overwhelmingly social, I just can't spend that much time...[I]"

6. Problem/Person

The "authoritarian", whether generalist or specialist, emphasizes that his function is to solve specific problems, rather than to heal persons as individuals. He sees the patient benefiting by the solution of problems, and tends to deny personal gratification in the physician-patient relationship itself. "The patient is helped most (by the relationship)...Of course I get some gratification in having the patient's condition improve but the patient definitely benefits more.[S]" "The physician doesn't benefit as much as the patient, although it's fun to take care of really sick patients' problems.[K]" Satisfaction for the "authoritarian" is in problem-solving: "The only people I take on now are those I see in urgent and emergent experience. I like people with problems...I'm trained well to treat sick people and that's what I like to do.[F]" "The physician is helped most in the management of disease, in problem-solving.[A]" "A 'good patient' is one who has an interesting problem; I can make an assessment...my response to request for medical advice is being appreciated and followed through.[U]" The "authoritarian" feels his services are not well utilized when patients come with

problems not wholly medical. "The 'bad patient' has a lot of somatic complaints, not many objective complaints...the basic underlying problem is emotional.[B]"

7. Mission

The "authoritarian"is particularly concerned with providing a service for his patients. "My main mission is that I have a service to offer by the nature of my training...[H]" In a salaried situation, "(the doctor) is not working for patients, he's working for the organization; (in my own practice) if I don't perform well, (patients) don't come back or I don't get referrals... I get rewarded for service.[K]" "(Physicians) try to look objectively at patients, but we are human... we take care of the'bad patients' because we're performing a service to the community.[A]"

Teacher:

1. Nature of Interaction

"Teachers" feel that patient education is one of their major functions. "The patients I like most are the ones I can relate to--they use me as a source of information.[D]" "When someone comes to the office, the time I spend examining them equals the time I spend talking to them: I try to educate them...they go home and read about it and then we talk some more...I try to change their attitudes so when they get sick, they're not surprised.[A]" Teaching is directed at the mechanics as well as

the content of medical care: "I teach patients how I think they can derive the best benefit; I teach them when they need to call, when they don't..[B]" "I used to get at least six inappropriate calls at home each week. Now, I <u>tell</u> people when their calls are inappropriate.[F]" "I spend most of my time giving lectures. Being a medical educator is paramount in my relationships. I teach patients what I think is good medical care, its ingredients, how it is constructed, how it may be counterfeited.[U]" For some physicians, mutual decision-making is the goal, with education as a means to patient care: "I spend most of my time giving lectures. I have to restrain myself sometimes; a lot of patients will want to be directed. I have had patients who have told me that I should be more decisive. I'm just not good at it.[O]" On the other hand, for some "teachers",education serves an alternate purpose,to facilitate compliance: "I try to educate (patients) so that they understand why I do what I want. If they understand, it's easier to treat them.[A]"

2. Responsibility

Unlike the "father", the "teacher" wants to share responsibility with the patient for health care in diagnosis and treatment. "Between the two of you, you try to figure out what's causing the problem.[B]" "Some (patients) won't follow your advice, your responsibility is to repeat it; you can't feel guilty for the rest of your life because you've failed to get the point across.[Q]"

"It doesn't bother me when a patient decides not to comply; it's just my duty to lay out the possibilities and educate.[V]" "A 'bad patient' is one who doesn't want to cope with problems... they just want Valium or Librium...you can't help them...[B]" "I get very upset with patients who say, 'Whatever you say, Doctor.' I feel that I'm caring more than the patient is... It's your body, your health. I'll give you advice but you have to do something too...[D]" "'Good patients' are the ones who really care about themselves; 'bad' ones don't. They're not honest with you... I take care of myself so why shouldn't they?" "I insist that people do their share; if they elect not to do something I inform them of the consequences but I don't scream.[M]"

Friendship:

1. Person/Problem--Nature of Interaction

"Friendship is the way I like it to be. I don't like the superior-inferior role. My patients can call me anytime... I was much more rigid when I started out-- I was into being more of an authority figure--it just wasn't working for me.[D]" The foundation of the "friendship" relationship is that the physician considers the patient as a whole person, rather than as a set of medical problems which the patient presents. Thus, "I take care of any needs-- social, health, all of them...even though I'm a specialist, I'm a general internist as well...I know (patients') families, I've been to most of their homes...[N]" "I function

as a physician, attorney, clergyman. I'm a counselor as well as a director of general medical care.[Z]" This entails a basic understanding: "Some questions (patients ask) are asinine but to that individual, they are the most important thing.[N]" Speaking of dealing with the "misbehaving" post-MI patient, one physician described the elements of mutual respect and understanding which he finds useful: "Many times, after the initial misbehavior, if you stick with them, they come around...Other physicians may perceive (misbehavior) as a threat, but I don't...you have to stick with them.[M]" "Over the years I've become more tolerant, more compassionate, more aware of the essential humanity...I don't get angry when (patients call and) they don't have disease. People continue to apologize to me for calling. Well, hell, that's what I'm here for... We're all primary physicians no matter how we've changed.[J]" "Most people do not go to a professional for their competence, most go for a psychological need.[N]" "(There's) such a difference from academic medicine--when you're at the University, responsibility is to the diagnosis; in private practice, responsibility is to the patient.[X]"

2. Reward

"Friends" reap satisfaction from the relationships themselves. "The way I wanted to spend my life was in a series of individual relationships. There were three ways I could do this... as a teacher, as a clergyman, or as a physician, caring for the

intellectual, physical, and spiritual well-being of another individual... I haven't been changed. The most rewarding thing about being a doctor is the single relationships... It's very selfish, the secondary gain that derives is enormous.[L]" "The doctor gets the most out of the relationship...It wasn't until I got into private practice that I realized this. (In academic medicine) I couldn't get close to people, and that was awful.[D]" "I have a tremendous (personal) investment...[J]"

3. Demeanor

Professional "distance" does not serve a function in the "friend" relationships. "What I want is for patients to be close... I want to be someone who cares for them...reliable, available, aware of what's going on in life... A lot of what happens with the patient is a reflection of what's going on with you...[D]" "I never need that distant 'professional' feeling... Some patients don't like this close rapport; they don't come back.[N]" "With time, I've become much more relaxed, freer to interact, less concerned with distance.[M]" Risks are taken: "The one thing about the long-term friendship relationship--it reveals the physician's defects to patients over time...we can't remain untarnished. If the physician is in any way relaxed, his personality begins to be revealed.[L]"

4. Information Access

The "friend" values accessibility of information that is facilitated by a close relationship. With regard to record reading, "It's (the patient's) body, (the patient's) life; (the patient) has the right to that information.[S]" "Patients have a right to know...it's no indication of mistrust (if they want to read their records).[T]" "Early on, I would have been much more careful (about protecting information), especially with patients who have become really sick. But now, I'm much more concerned with continuity (in the relationship), the sense of trust, telling a straight story...Patients appreciate that.[M]"

Salient features of the four types of relationships are summarized in Table II.

Table II
Characteristics of Relationships

Father	Teacher
MD[1] is responsible Interaction based on PT dependence, security, MD decision-making, direction Knowledge as source of power, control Distance MD protective of information Problem orientation Intellectual reward Service	MD and PT[2] share responsibility Interaction based on education toward compliance with MD's decisions Knowledge as source of power, control Distance MD protective of information Problem orientation Intellectual reward Service
MD is responsible Interaction based on mutual dependence, security Personal investment →mutual control Closeness Free information exchange Person orientation Personal, intellectual reward Obligation[3]	MD and PT share responsibility Interaction based on education, mutual decision-making Personal investment →mutual control Closeness Free information exchange Person orientation Personal, intellectual reward Obligation

[1]MD=physician.

[2]PT=patient.

[3]"Friends" did not explicitly describe a counterpart to the concept of "service"; it may be inferred that they feel a duty to care for others as persons. Thus, for "friends", the fulfilling of "obligation" might suffice to contrast with the provision of "service".

Although the foregoing classifications characterize individual physicians' modus operandi, there were a number of elements which seemed to underlie each physician's perception of the necessary components of the relationship:

1. Trust

Considering the possibility of requiring legal contract to define explicitly doctor-patient obligations brought out many thoughts about trust. Needless to say, no physicians were in favor of such action. "I'm not contracting to deliver six tons of stone. That's not the kind of relationship I have.[O]" "A patient may want to watch and check, but somewhere along the line, he's got to trust the doctor and go along with what he says.[K]" "(Those kinds of obligations are) implicit in what you do.[AA]" "How far do we have to take this lack of trust thing in our society? What we need is more trust, not less.[P]" Most physicians did not have experience with patients asking to read their records. Many felt that this was attributable to the trust their patients have in them. "My records are for my purposes... I would sense a mistrust if a patient wants to read them.[V]" "I think it's unwise for patients to read their records. If they don't trust you... they ought to find another physician.[M]" In complying with therapy, "Patients must trust you; they wouldn't (comply) without you.[M]" To some physicians, trust in a physician indicates expectations of honesty. Doctors as patients present a problem in trust to some

extent: "They like to manage their own cases, but it doesn't work...it takes time to develop trusting relationships...they've seen a lot...They've seen other physicians do what they shouldn't.[D] Covering for other physicians at times presents problems: "(Patients) realize you're a substitute...The trust doesn't necessarily transfer automatically.[P]"

2. Choice

To these private physicians, the freedom to choose their patients and the freedom of patients to establish relationships is most necessary for successful functioning. Some responses to the suggestion of a physician-patient contract were: "I wouldn't be a part of it. I want (the relationship) to be open and flexible.. on both sides.[Y]" "We'd do better by being kind to each other... (a contract) would spoil my life. It would infringe on what I believe to be a free commitment on my part.[L]" "It's too free a country for that... I wouldn't feel comfortable...no feeling of trying to please a patient, no freedom for the patient to leave, to go to another doctor.[V]" "It's the right of the patient to dissolve the relationship when it is of no use.[N]" The same concerns were reflected in the responses to queries about the physician-patient relationship in the context of a "salaried service." "Patients are not satisfied without choice despite equal or better care, even when it's not rational... Faculty come to me, despite belonging to the (University) Health Plan.[V]" "Unless the physician

himself feels chosen, it's not the same kind of commitment... choice is necessary, or at least the semblance of choice. When I was in the service, (the Base was) providing good care...some idiots would go into town, to inferior physicians, and pay for it![M]" "It's unreasonable to expect that I could relate therapeutically to everyone.[L]" "I tend to select my practice...(I can think) 'Well, you didn't do this or that, maybe we'd better part.'[K]" For a health plan physician, "I feel much more constrained; I'm responding to patients I wouldn't take care of in private practice... I don't have the ability to say, 'You ought to go elsewhere.'[U]"

3. Incentive

The question of "salaried service" brought out many responses which bear on the fee-for-service incentive to practice. "The biggest incentive for work is reward, and in this profession it is financial.[A]" "I sell time and advice... (A salaried service) might be fantastic--I'd be home by now... Seriously, (in a salaried position) I'd do precisely what I have to. Leave me alone and I'll perform well; nail me down and I'll do precisely what I'm supposed to...I wouldn't be working for the patient, I'd be working for the organization.[K]" "(In a salaried situation) I'd have a tendency not to work as hard. Without direct reimbursement I'd be more reluctant about doing heroic things, in terms of the time spent doing them.[H]" As far as the interaction with the patient was concerned, physicians felt, "In general, people are more apt

to do what you say if they pay for it than if it's free.[Z]" "Very few people will ill-use you as a physician as long as you're in private practice; (in a salaried service, however,) the physician is furniture.[L]"

In addition, some physicians expressed awareness of the meaning of their relationships in the context of a community: "To my patients, I have tremendous snob appeal... If I have fancy patients, I'm distinguished among my colleagues... Patients feel the same way: they come to me for my reputation. People are dying to see me...It's emotional, irrational.[J]" With referred patients, "I know by who sent them what they'll be like... I get a feeling for the mind-set of the patient, whether they want (a physician) who's fancy, ...someone with a good address, ...if they've been to a practitioner and now want a specialist. You know what they're coming for aside from the specific medical problem.[K]"

4. Compliance

Despite the various perspectives on patient education, the physicians all felt that compliance was to some degree a function of the relationship itself rather than understanding per se on the part of the patient. "(Compliance is) a matter of salesmanship... I have to win (patients) first; it has nothing to do with (patients') medical education.[V]" "I rarely have trouble convincing patients. Most have been with me for so long

that they don't question me.[BB]" "I can get them to do things, others can't.[M]" "If it's important to the doctor, the patient is more likely to comply.[AA]" "We try to explain why we suggest things but most people do it just because their physician says so--because of the relationship.[C]"

5. Self-awareness

"Authoritarian" or not, most physicians expressed doubts about their judgment at times, unexpressed to patients. "Im very insecure about the advice I give.[BB]" "I'll tell the patients what I think should be done but it's their right not to comply... sometimes you're wrong too.[X]" "You have to read things to be able to keep up with patients; they've become so well-informed sometimes it's frightening.[T]" "Sometimes your advice is going to be wrong...that can be tormenting. Sometimes the patient is wise not to follow your advice.[Q]" Sometimes their suggestions are better than mine.[B]" "There's too much presumption that (the physician) know's what (he's) doing. I don't like that.[A]"

6. Availability

Many expressed the perception that the time they personally provide for patients is greater than the time many other physicians provide. "I give much more time than the average doctor.[Z]" "'My doctor' (to my patients) means that I'm very accessible, very available. In a salaried situation, no one

would work like I do.[N]" "I'm fairly liberal about (time); for example, I return all telephone calls...[H]" "I don't charge for telephone calls like a lot of other doctors do.[B]"

7. Chronic vs. Acute Care

Regardless of status as authoritarian or friend, physicians were almost always aware of the need to assume a much more directive role in the face of acute emergencies or crisis situations. "Sick patients are dependent and want to be dependent until they're healthy. Sicker patients need more support.[I]" "With the patient who is extremely ill, I feel much more paternal, protective; with healthier patients, it's more of a peer relationship.[P]" "With sick patients in the ICU the most important thing is to get them out--I use more scientific expertise, it's much more intense; I can be more casual (about decisions) with healthy patients.[D]" "Compliance depends on how patients perceive themselves--if they feel they are sick, there's no problem in their giving you authority.[B]"

8. Teaching the "Tricks of the Trade"

When questioned about methods which would be effective in teaching medical students about the functional aspects of the physician-patient relationship, a few physicians suggested that observation in private offices would be a valuable tool. Nevertheless, "The responsibility...you've just got to do it to learn

what it's like.[E]" "There's no way to teach these things... It's a different world (from academic medicine); the set of ideas, expectations are different. The responsibility of the patient <u>outside</u> the hospital was never impressed on me as a house officer.[C]" Invariably, physicians brought out that much is dependent on the personalities involved, for various reasons. "You can't teach these things...you learn them at specific stages of life...it would be like teaching chemistry without a laboratory; they're stages in growth; many students don't have to be taught, and then there are some who have never learned...[T]" "You can't teach the relationship; everyone has their own way of getting things done.[N]"

Discussion

In the aforementioned study,[17] Ford et al. examined the attitudes of a group of surgeons, internists, pediatricians, psychiatrists and general practitioners. Their study was "based on the premise that there are uniformities to be discovered in these interpersonal relationships."[20] In their systematic search for these uniformities, Ford et al. may have overlooked some significant differentiating trends.

Although the physician population of this study is a selected one, it is evident that these doctors see a broad spectrum of physician-patient relationships by the nature of the various qualities of their responses.[21] At one end of the spectrum, the "father-authoritarian" wishes to be very much in control of the situation: He assumes responsibility for the patient's care, expecting loyalty and trust in return. His possession of much more knowledge than the patient gives him the duty to make decisions about patient care; he expects compliance by virtue of his professional authority. Necessary for physician and patient protection is "professional" distance; the "father-authoritarian" controls access to information and opinions, and divulges them at his discretion. The "father-authoritarian" is upset when time is taken "unnecessarily"; he prefers a very structured relationship, and deals with patients in terms of specific problems.

At the other end of the spectrum is the "teacher-friend". The "teacher-friend", by providing information and discussing

possibilities, wishes to share the responsibility for health with the patient. He attempts to interact with the patient, considering the whole person; he makes himself accessible for emotional and social as well as medical needs. As he sees decision-making to be a mutual process, he assures that information available to the physician is also given to the patient. Distance is not essential; in fact, the teacher-friend sees distance as hampering the interaction as well as lessening the satisfaction he gains from the relationship itself.

Between these two extremes are the "father-friend" and the "teacher-authoritarian". The "father-friend" assumes major responsibility for medical decisions, but also serves as counselor for the patient as a whole person; he prides himself in offering concern for the social and emotional; he and the patient (and the patient's family) benefit from the relationship itself. Distance would hinder the free exchange of information and support which is central to the successful function of this relationship.

The "teacher-authoritarian" perceives patient education as a primary function, but he remains in control of medical decisions. Patient education is directed toward compliance, and responsibility is shared in a mutual commitment to solving the patient's problems. The "teacher-authoritarian" serves his patient through knowledge and competence, but finds little personal reward in his formal style of interaction.

The following diagrams are an attempt to illustrate the working nature of each relationship with regard to decision-making and satisfaction. Representation of physician (MD) and patient (PT) on the same vertical level indicates shared responsibility. Represented on a higher vertical level, the physician assumes major responsibility. Sources of satisfaction are indicated. For example (Figure 4), with the physician as "teacher-friend", physician and patient share responsibility and share information as well. Both derive security and satisfaction from the relationship. The patient complies with decisions mutually made as much because he likes and trusts his doctor as because of information he has received; both physician and patient learn from the outcome. In the ideal case, relative "health" of the whole person is achieved; if not, information is gained to direct subsequent mutual decisions. The other figures may be interpreted similarly.

The current emphasis on patient self-awareness and decision-making may give form to yet another category of physician, not encountered in this sample: the "technician". Although the teacher shares information with the patient, the "technician" would view himself as <u>merely</u> the source of information, serving only the <u>patient's</u> decision-making interests. Schematically, then, the patient would be at a higher vertical level of responsibility than the physician.

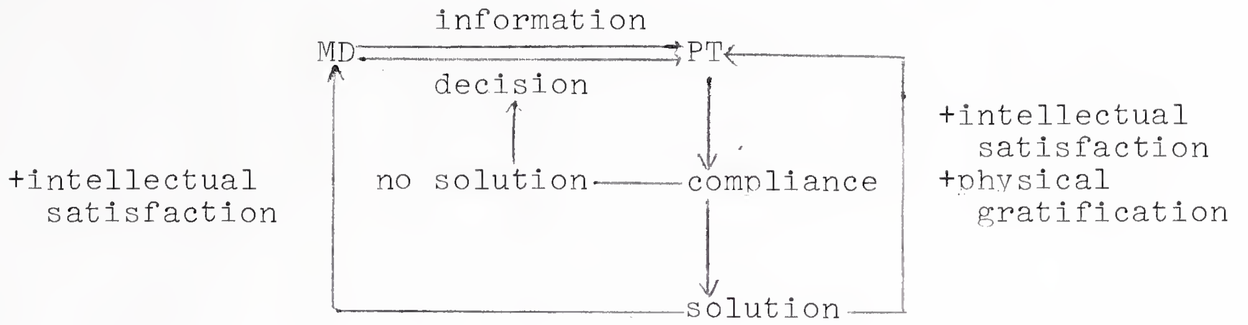

Figure 2
"Teacher-Authoritarian"

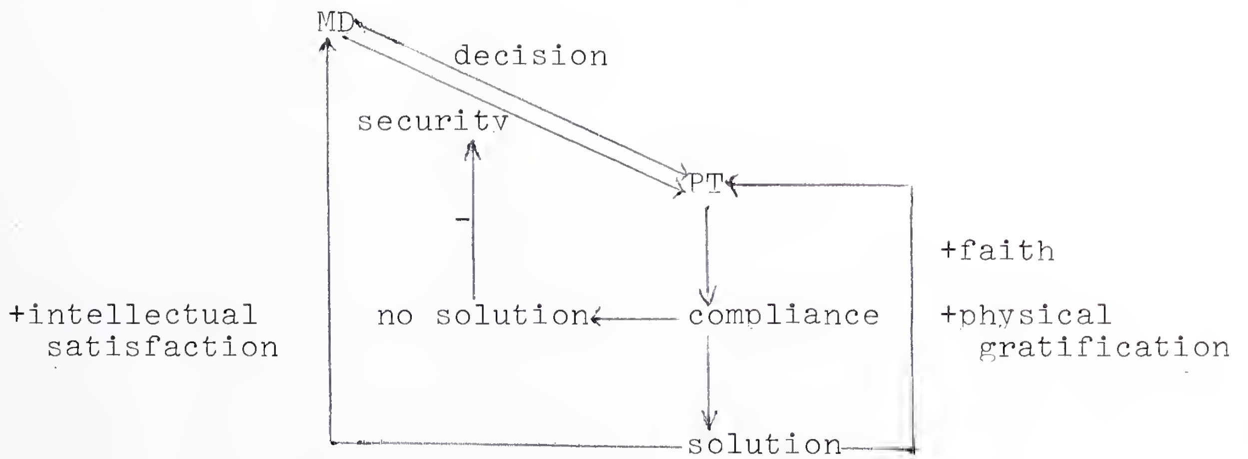

Figure 3
"Father-Authoritarian"

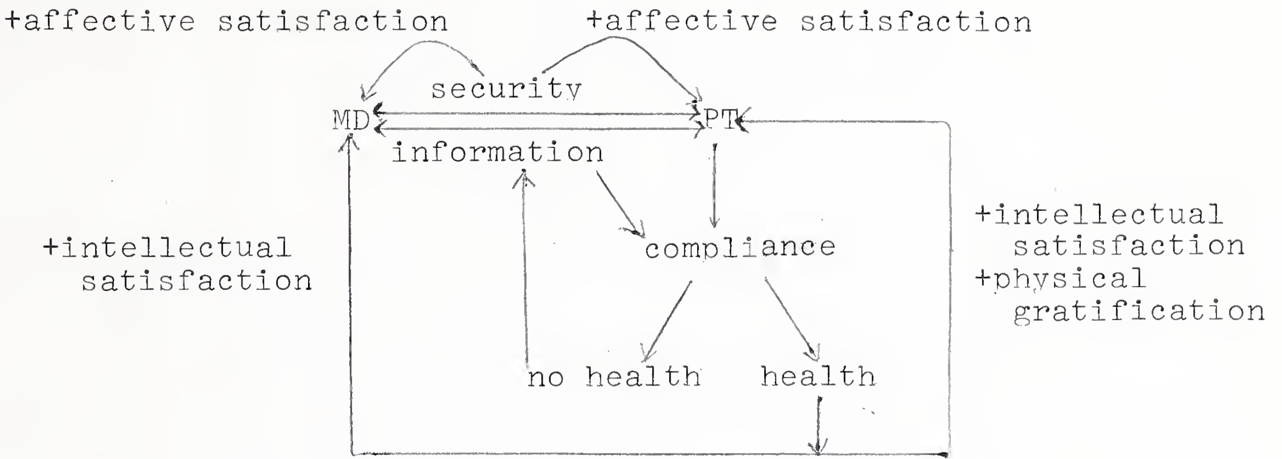

Figure 4
"Teacher-Friend"

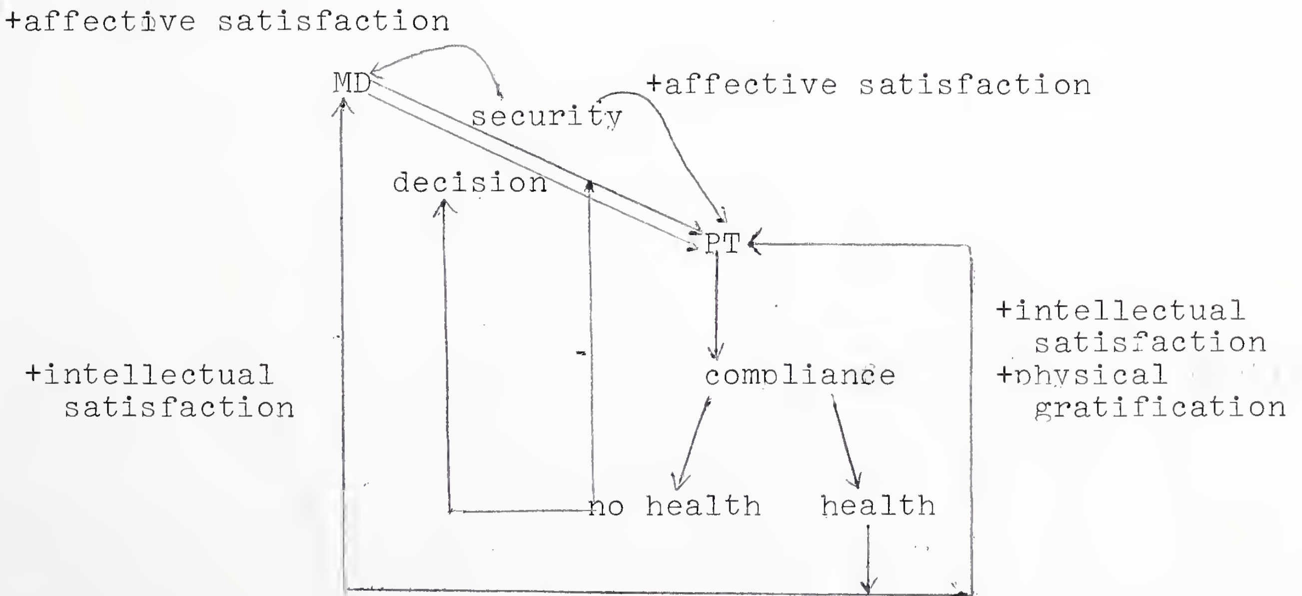

Figure 5
"Father-Friend"

Father/Teacher:

"Teachers" in general were younger than fifty, whereas "fathers" seemed to be well represented in all age groups. Are "teachers", then, a new phenomenon in medicine, or is a "teacher"-to-"father" transformation an accompaniment of longer experience?

The derivation of "doctor" from the Latin word for "teacher" has found recent emphasis, especially with regard to sharing responsibility. Donovan perceives that the physician's responsibility should be limited: the doctor "should not take away from his patient the responsibility that he, the patient, holds for his own life and health." He emphasizes that the doctor's responsibility is as a teacher in society as well, thus the doctor should "inform patients about things as the benefits of breast feeding, dangers of barbiturates... (he should) inform decision-makers of medical risks involved in plans for the patient's environment."[22] These responsibilities depend on interaction and education.

Perhaps the "teacher" has always been present if not always recognized in the medical profession. Regardless, the self-awareness of many "teachers" in the present study seems new. To some extent, the change, transient or not, may have its parallels in the rise of the legal doctrine of informed consent, developing since 1957 into its present conception. In 1975, Katz and Capron outlined six functions of informed consent in general,[23] though with specific reference to treatment modalities for chronic renal disease. These functions are: 1) to promote individual autonomy,

2) to protect the patient-subject's status as a human being, 3) to avoid fraud and duress, 4) to encourage self-scrutiny by the physician-investigator, 5) to encourage rational decision-making, and 6) to involve the public. Although they directed discussion to the research situation, they felt, "By actively including the patient-subject in the process, informed consent serves to place him on a plane with the physician-investigator and to involve him as a person in the work, and not merely as an object on which it is being performed."[24] This, in fact, seems to be the major goal of the "teacher".

More recently, however, Katz expresses the view that patient autonomy in medical decision-making has become a "fairy-tale".[25] The attempted promotion of "patients' decisional authority over their medical fate--has been severely compromised from the beginning... Anglo-American law is caught up in a conflict between its vision of human beings as autonomous persons and its deference to paternalism."[26] With reliance on medical professional standard', as opposed to legally defined regulation, Katz feels that traditional medical practice is not challenged.[27]

Goldstein also points to the inadequacy of current law in ensuring "the process of informing for decision."[28] He asserts that "the concept has been employed to emphasize the patient's or subject's actual state of mind, knowledge, or understanding (not denying) consent, rather than to emphasize and force attention on the conduct of the therapist or experimenter in the process of informing the citizen for decision."[29] The nature of these criticisms

in the legal sphere reflect contemporary concern with the patient as part of the process of medical care; ideally, the patient would assume responsibility through education in a partnership with the physician.

The nature of "responsibility" may be clarified by exploring the related issue of "paternalism" in legal, ethical, and social contexts. Formal argument dates at least to the time of J.S. Mill (Utilitarianism and On Liberty);[30] recently, however, Dworkin has considered physician-patient relationships in this function, attempting to develop guidelines for the legislative powers of society.[31] His definition of "paternalism" as "roughly the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being coerced"[32] defines the responsibility which individual physicians undertake to greater or lesser degrees.

Mills' stress on individual liberty led him to two principles: 1) self protection, that is preventing someone from harming others, is sometimes a sufficient warrant, and 2) the individual's own good is never a sufficient warrant for the exercise of compulsion either by the society as a whole or by its individual members.[33] Not disputing the first principle, Dworkin focuses on the second, attempting to describe cases in which it is legitimate to utilize paternalistic power. He suggests that paternalism may be used tolerably as a "kind of insurance policy

which we take out against making decisions which are far-reaching, potentially dangerous, and irreversible." Secondly, decisions "made under extreme psychological and sociological pressures" necessitate at least an enforced waiting period. A third class of decisions for which paternalism is legitimate involves "dangers which are not sufficiently understood or appreciated correctly by the persons involved."[34] Accordingly, Dworkin suggests the principle of the "least restrictive alternative" for the use of paternalistic power;[35] and, in a sense, he would ascribe to the government a responsibility analogous to that assumed by the "teacher" rather than the "father" on the individual level. The "teacher" attempts to limit interference with responsibility for the patient's actions, showing "concern for autonomy and freedom of the person"[36] to evaluate and choose values, treatments, whereas the "father", making judgments as to life-style, undertakes the responsibility for inculcating specific values for achieving health.[37]

While attempts are being made in the legal sphere to initiate changes in patient education and in function, a parallel awareness exists among many physicians of demands for more patient autonomy. Certainly the increase in malpractice suits has influenced the thinking, if not the practice, of many physicians. The present data, however, suggest that the distribution of decision-making and responsibility is different than traditionally perceived, at least by some physicians. Nevertheless, a permanent transformation will not necessarily ensue. As many who have examined

the physician-patient relationship have stressed, being sick makes the patient accept helplessness and dependence on others.[1-10,14-16] Similarly, the relations between physician and patient must be different in a crisis, where physicians are expected to dispense with rules of informed consent and detailed patient preparation; their technical skills take precedence over all other concerns. Yet even many "healthy" patients are culturally, emotionally prepared to relinquish their responsibilities to the physician.[14] The response, then, of physicians to patients' real and perceived "child" needs is to assume greater responsibility for making decisions. Regardless of their positions in the "father"/"teacher" spectrum, many physicians interviewed noted reluctance on the part of patients to enter into a partnership; patients preferred the comfort of child-like acceptance to the assumption of responsibility. If sharing of responsibility becomes the stated goal of the physician and patient, the "teacher's" "lesson-plan" must include the encouragement of the patient into a new role,[38] just as the patient's willingness to assume that role will necessarily influence how the physician functions.[39]

Authoritarian/Friend:

The authoritarian/friend distinction reflects current conflict about the increasing reliance on objective, technical factors in many areas of contemporary life. From the legal perspective, Burt stresses the "paradox that those who complain of impersonal, dehumanized medicine turn now for remedies to the legal system that prizes its systematic impersonality, its governance by laws, not men." He warns of the dangers of the "separation of self"--the objectivity that problem definition requires, the objectivity that is demanded by many in the contemporary milieu.[40] The "authoritarian" essentially views patients in terms of sets of problems to be solved. In recent medical literature, articles stressing humanism[41] and the necessity of reintroducing a personal conception to medical problems in understanding the <u>person</u> with disease[42] emphasize the tensions produced by expansion of scientific medical knowledge.

The underlying conflict of perspective is hardly new. It is illuminating to look at the era of twenty-five or thirty years ago, the time when many of the physicians in this study were coming of age medically. For even when Talcott Parsons was preparing his classic description of "modern medical practice,"[1] many sensed continuing change in the practice of medicine and the preparation of students for the role of physician. In 1951, Burwell saw the affiliation of medical schools with universities as indicating an ever widening application of scientific knowledge to medical

practice.[43] He noted that a "tendency toward what we may call rationalism...an understanding of the phenomena of medicine, rather than simply a remembered knowledge of them" accompanied the advent of teaching hospitals. The standard curriculum had been supplemented with "preventive medicine, public health, psychiatry, and social and environmental factors."[44] Within this context of increasing "rationalism", the editor of the New England Journal of Medicine (NEJM) asserted "that the lad who does well in the sorts of courses that enable him to take such (scientific, technical) questions in his stride will be more likely to develop into a good physician than the one who elects (undergraduate) courses in Romance philology or politican science."[45]

Notwithstanding, others were concerned "that the achievements of science have too often led us to forget that essential humanity which is indispensable to the best practice of medicine. For medicine is not all science."[46] In response, the editor of the NEJM cites these concerns as "signals of a lighthouse, they must be repeated at regular intervals if the purpose for which they are intended is to be served." However, he chose to see that "the strong trend toward scientific perfectionism with its loss of the human side of medicine has been on the credit side after all, acting as a process of purification...and now the medical profession ...sees evidence of a 'bridging of the breach' between laboratory and clinical investigation as well as between all investigation and the art with which its results are applied... There is real evidence that humanism is reasserting itself."[47]

The concept of the doctor as citizen was being emphasized as well,[48] though the traditional praise for the doctor as personal healer continued.[49] Questions of humanism did not leave physicians' self-image unscathed, however; physicians were becoming aware that the public might question their infallibility: in "Medical Malpractice" are enumerated the "three bulwarks against the unjust suit--good faith, good records, and common sense."[50] Similarly, despite attributing "dissatisfactions" of patients to "misunderstandings", a special committee of the Massachusetts Medical Society addressed the process of agreement on doctors' fees,[51] theretofore a virtually "unmentionable" subject of concern. Continuing in this vein, the editor of the NEJM produced a "reminder that for the physician, at least, all the organized public relations efforts in the world cannot replace the private relations with his patients..."[52]

Thus, it seems that conflict about value orientation existed at the time many of the physicians in this study were in medical school or beginning practice. Regardless, the "ideal" student of the 1950's was one who would take a "rational" approach to medicine and patients. Of note, however, in the present study eight of nine physicians below age forty-five were "authoritarians" whereas only nine of twenty older than forty-five were classified as such. Thus the distant decision-makers are well represented among the younger, more recently educated physicians, some in fact who were "products" of the progressive, person-oriented 1960's.

It is tempting to speculate that the concern with humanistic, person-oriented practice, the "social consciousness" of that decade did not significantly permeate the minds of future physicians. It is more likely that in the selection of medical students, "we are favoring and choosing the convergers, who are interested in physical science, given to technical and mechanical interest, and generally conventional and prone to emotional inhibition."[53] Ironically, the students described somewhat negatively by Ellard resemble the students praised in 1950! Perhaps the 1960's consciousness has again served as a reminder of the ideal "humanist" physician even though the reality continues unchanged.

Alternatively, the greater proportion of "authoritarians" among younger physicians may reflect a natural "authoritarian" to "friend" transformation with experience. The technical nature of medical training may contribute to the "chief resident syndrome" as described by Cassell. In practice for a short time, "the chief resident has not so much found out that there isn't a lot of challenging disease around (because there really is) as he has discovered that his technical skill and knowledge are not inappropriate but are only a piece of what he needs to know."[54] Is it a matter of experience, then, which leads the physician to fit together the "other pieces" of what he/she needs to know?[55] Does a physician, realizing the limitations expressed become "ultimately discontented with his role as a fellow-advisor who does not know what to advise and as a rational or mystical leader who

does not know where to lead"?[56] Is it merely a matter of time and experience until "I, as a physician, have matured enough to realize that each patient is an individual, not a stereotype, (that) I must adapt myself to each patient in a manner that allows him to be most open and free in revealing his humanness to me"?[41] Within the limits of individual personalities, this maturing process could then allow the "authoritarian" to become the "friend".[57]

In the past, numerous attempts have been made to evaluate the physician-patient relationship, sociologically as well as psychologically. In 1951, in the analysis of "modern medical practice" referred to in the foregoing, Talcott Parsons described the role of the "professional", the medical practitioner.[1] Characteristics of the physician's position are: the possession of achievement values--"competence",the use of objective criteria in decision-making--"universalism", limitation on the scope of concern--"functional specificity," "affective neutrality," and concern with patients' welfare--"collectivity orientation." The patient in the "sick role," exempt from normal social responsibility, does not have the power to get well solely by conscious decision and is under obligation to seek technically competent help. The doctor-patient relationship follows: the patient needs technical services because he can't define the problem specifically nor can he solve it, while the physician is qualified as a technical expert to help satisfy the patient's institutionally legitimized need. The "father-authoritarian" seems well-suited, then, to serve in

this capacity. It is evident, however, from this study that a number of physicians, at least from their perspective in the 1970's, do not fit neatly into the role Parsons described.

Certainly, the concept of physician in a parent role has been well promulgated, classically in Freud's[58] and others' discussions of transference and countertransference. Like Parsons, Wilson[3,4] evaluates the doctor-patient interaction as a single defined social system, fulfilling receprocal needs for both participants. Wilson sees Parsons' view of the socialization of the sick person back to health by the physician[2] as analogous to the socialization to adulthood of the child by a parent. He asserts that "although the therapeutic relationship is unique, it shares vital characteristics with a number of other intense two-person interchanges...parent-child, priest-supplicant, teacher-student." Features of the therapist's role include: 1) support of the patient, 2) permissiveness--ordinary norms of social intercourse may be suspended, 3) manipulation of reward, and 4) denial of reciprocity--the therapist withholds from the patient full interpersonal responsiveness.[59] According to Wilson, the use of these tools implies that there is a natural imbalance or asymmetry in the relationship; hence, the physician makes a significant contribution to controlling the values of his patient.[60] Despite his recognition that patient education is a function of the physician, Wilson's perception of an asymmetry of power and indoctrination of values on the part of the physician is represented by the more traditional "father-authoritarian". The "friends" in the present study, however, have no place in his analysis.

Similarly, Rueschemeyer chose to consider the physician-patient interaction as a social system, comparing the lawyer-client and the physician-patient relationships. In accordance with the tone of Parsons' thesis, he emphasized the importance of technical competence in the physician-patient relationship, with facility at interpersonal skills more characteristic of the lawyer-client relationship.[61] Again, the present study suggests that now there exists a segment of the medical profession which does not conform to these expectations. The "teacher-friend" who shares information, attending to the patient as person, needs to use interpersonal skills as much, if not more, than his technical skills.

Others have examined the physician-patient relationship to find not a single but various different modes of interaction. For example, in 1957 Szasz and Hollender proposed three basic models of the doctor-patient relationship.[62] In "activity-passivity", the physician does something to the patient, regardless of the patient's contribution, as in acute emergency (coma, delirium); in "guidance-cooperation", the patient asks for help and is ready to cooperate, as during acute infection, although the physician maintains ultimate "power" and expects full compliance; in "mutual participation," physician and patient have equal power, are mutually interdependent, and in some ways their activities satisfy both, as in the treatment of chronic disease. Parallels can be drawn to findings in our study. All physicians acknowledged that in critical situations, "activity-passivity" is the rule. The subsequent two models are reminiscent

of the "authoritarian"- and "teacher"-patient relationships. Szasz and Hollender characterize "guidance-cooperation" as being like a parent-child interaction; nevertheless, their description is closer to the "authoritarian"-patient relationship with regard to the physician's power in decision-making, which is paramount in this model. On the other hand, "mutual participation" is central to the "teacher"-patient interaction in which the "physician helps the patient help himself."[63]

Szasz and Hollender point out that by the nature of therapeutic intervention, roles ideally should be continually changing; if either the physician or patient is incapable of such accommodation, the effectiveness of the relationship is hindered.[62] Though the physicians I studied recognized that their relationships to patients changed with patients' conditions to some extent, they also were in agreement that freedom to choose, for both patients and practitioners, is necessary for effective relationships;[64] this seems to reflect the implications of Szasz and Hollender that, for the most part, physicians cannot be adequately flexible to be therapeutically valuable to the full range of patients. Rather than describing points in time in a single relationship, the models Szasz and Hollender proposed may characterize specific physicians' interactions with their patients.

Anna Freud[16] examined the physician in relation to his task from a psychological perspective as well; she defined three different sources of the wish to become a doctor, each producing

a different type of physician. Curiosity, the wish to know, is found in the researcher or scientist. Alternatively, the child's wish to hurt and maim may evolve and be submerged eventually by the wish to cure which characterizes the "helper" or healer. Finally, an interest in death and the wish for power over it motivate the "autocrat". Not unexpectedly, I did not encounter the first type of physician in the sample; he is unlikely to be found in private practice.[65] However, the "helper" and the "autocrat" parallel two types of physicians delineated in the present study: the "teacher-friend" seems to portray a "strong desire to help" by valuing his patients as individuals, giving his patients time and energy professionally as a "teacher", and personally, as a "friend". On the other hand, the "father-authoritarian" values his own decision-making, fighting disease and death with knowledge and the power he assumes.

Parsons set the stage for continuing sociological examination of the doctor-patient relationship based on a model of mutually interacting reciprocal needs for the participants.[1] Freidson challenged this concept proposing that, to understand the interaction, the separate situations of the participants should be analyzed.[6] To Freidson, the doctor-patient relationship is a function of two distinct social systems: 1) the patient acts as part of a personal network or "lay referral" system rather than as a single agent molded in a cultural pattern; this referral system ultimately serves as a source of the patient's decisions after

consultation with the physician. 2) The physician, on the other hand, functions as part of a larger professional system; this system doesn't merely legitimize the "sick role," rather it has a bias towards illness, and the profession "creates the social possibilities for being sick."[66] Freidson considers the "official social role of illness," then, to be a form of social deviance, defined by the medical profession.[10]

In "client-dependent" practice, where the physician depends on laymen for referrals, Freidson sees the process of treatment to be a matter of bargaining and compromise; in "colleague-dependent" practice, on the other hand, where fellow physicians are a source of referral and the physician has specific expertise, "the weight of professional opinion is heavier than that of the layman" and the physician initiates and controls much of the interaction with the patient.[67] Freidson finds the Szasz and Hollender models of physician-patient interaction deficient in that they represent models the physician <u>wishes</u> to be represented, rather than the reality of the situation; he sees that, instead, the physician and patient interact in a kind of negotiation as well as conflict; "...just as the doctor struggles to find ways of withholding some kinds of information, so will the patient be struggling to find ways of gaining access to, or inferring such information. Similarly, just as the doctor has no alternative but to handle cases conventionally...so the patient will be struggling to determine whether or not he is the exception to conventional rules. And

finally, professional healing being an organized practice, the therapist will be struggling to adjust or fit any single case to the convenience of practice...,while the patient will be struggling to gain a mode of management more specifically fitted to him as an individual..." Thus, professional treatment is seen "as a function of the relations between two distinct worlds, ordered by professional norms."[68] Although seen from a different perspective, Freidson's perception of the physician's struggle for power, then, is reminiscent of the "authoritarian" view of his interaction with patients.[69] The "authoritarian" may be a "teacher", as in a"client-dependent" situation, or a "father", assuming full responsibility as in a "colleague-dependent" situation. On the other hand, the "friend" does not seem to fit in Freidson's characterization of the physician-patient interaction: the "friend" approaches the patient as a whole person, part of a social system, and incorporates the patient's "personal network" into his professional judgment. Structural conflict would then not necessarily result.

The foregoing characterizations of the physician-patient relationship were constructed, essentially, from observers' view-points. In contrast, Ford et al. examined the physician's per-spective in a more systematic way.[17] From a questionnaire returned by 250 physicians in the Cleveland, Ohio area, they evaluated physicians' effectiveness and satisfaction. To the physicians, features of their practices most important for effective medical practice were: 1) competence, 2) motivation, and 3) responsibility

for the patient as an individual. Physicians deemed important patient characteristics to be: 1) adjustment, 2) self-reliance, 3) responsiveness to treatment, and 4) belief in the physician. Physicians saw their own satisfactions stemming from 1) personal responsibility, which was a mix of intellectual thoroughness, helping and caring for patients, and maintaining standards, and 2) professional position, which meant leadership in the community and relationship to colleagues and patients. Dissatisfaction of physicians, not well defined in the study, came from limitations on their independence and lack of payment. Although their backgrounds and types of practice varied widely, the physicians were generally agreed on their views of effective practice and satisfactions from their profession.

From these studies, Ford et al. saw the physicians of 1964 as responding to a "calling" or vocation based on regard for the patient, professional competence, and motivation. The responsibilities of patient care served as a source of satisfaction; these physicians were concerned with patients as individuals rather than with the general society, and did not regard themselves as scientists. Although the physicians did not express the need for control as such over patients, Ford and his coworkers asserted that, functionally, the physicians felt that control was necessary for their effectiveness; the trust and cooperation of patients was essential to effective practice.

In attempting to define a single self-characterization of their physician population, Ford and coworkers noted a "trend away from medicine as a uniform vocation with its largely Protestant ethical imperatives and toward a plurality of ever more technical and functional specialties."[70] Ford et al. were referring to potential differences in attitudes <u>between</u> specialties; the data in the present study, however, suggest that differences in attitudes do exist <u>within</u> one specialty at least, internal medicine, superimposed on sets of common components. Differences in methodology between the two studies might account for some discrepancies; Ford et al. analyzed a written multiple-choice questionnaire whereas analysis of our tapes and interviews required subjective assessment of value-laden material. Differences may stem from the size of the present sample, or from the sampling of a very selected group of private internists. We did not look for trends along subspecialty lines specifically.

Alternatively, and more likely,differences between the two studies might well be the result of social developments in the intervening decade. Increasing awareness of personal/ethnic identities, developments in consumer protection and informed consent might have moved some physicians from the "father-authoritarian" toward the "teacher-friend" pole of the spectrum. The question remains unanswered whether this is a transient phenomenon merely reflecting the contemporary social milieu.

Recently, Bloom and Wilson[5] have noted the change in the nature of disease and its potential effects on the doctor-patient relationship. Threat of death as a result of acute infection is much less apparent now than ever before. Instead, chronic diseases such as diabetes mellitus, heart disease, and cancer are in ascendance; with the technology available to prolong life, the physician necessarily functions differently than his counterparts in previous decades.[71] Is the physician, then, less able to be a "father", wholly responsible for the crisis situation, more functional as a "teacher", educating the patient toward self-responsibility and long-term care?[72]

Regardless of such considerations, a very basic social change is occurring which will undoubtedly affect the nature of the doctor-patient relationship: during the past decade, the percentage of women in medical schools has increased from 5-10% to 25-30%. One physician expressed concern that women couldn't function well in the "father" role. Will women attempt to emulate their male role models or will they add a set of "mother" "attributes" to the established clusters? Will they function best as teachers, a role in which patients are accustomed to female presence? Will they be sought only by certain types of patients? Or will women, like men, distribute across the spectrum? On another level, is the presence of women physicians one of the instigating factors in the reexamination of roles that is occurring?

Other aspects of the 1960's culture and developments in the public health sphere do not seem to have influenced some basic aspects of these private physician's perspectives. In 1967, Ford et al. concluded that "...concern for the individual patient (is) so preeminent that only a minority of physicians show an active interest in the broad humanitarian goals of medicine." They felt it likely "that doctors will turn increasingly to patterns of work organization which produce better results for more patients." They asserted, however, that "the danger in the trend toward increased social organization, that sick people may become lost in an impersonal bureaucratic system, will be strongly resisted by the physician's dedication to the welfare of the particular human being he thinks of as <u>his</u> patient."[70] When asked about a "salaried system," the physicians in this study, most of whom have chosen, by definition, not to participate in such organizations, across the spectrum, expressed their concerns: loss of autonomy in selection of patients and in function, loss of monetary incentive, increased bureaucratic demands. Accordingly, resistance to the organizational change remains strong, at least in our sample. On the other hand, some physicians praised specific nurses who, in the private setting, functioned as part of a "team". How will these physicians react to various new health care personnel--physician assistants, nurse-practitioners--in terms of organization? Will modifications be necessary, will there be a "redistribution of the "wealth" of trust, responsibility, and loyalty to the "team-patient" relationship by all,

or will only certain physicians, (e.g."teachers") be amenable to such change?[73] Is the appearance of these new personnel merely a response to the change in the nature of disease alluded to in the foregoing[5]? This may reflect the fact that the physician-patient "dyad" is necessarily in the process of being diffused and that it may only be a matter of time before such private relationships in fact will be obsolete.

What of the motives expressed by today's private internists? What happened to the ideal of the altruistic, self-sacrificing physician making "home calls" at all hours of the day or night? How have physicians become "reluctant to do heroic things" without a monetary incentive? Has the nature of medical practice so changed that an emergency room is the only realistic answer to care after office hours? Have medical schools successfully weeded out the altruistic candidates from those more protective of their time and energies? Or, is it merely that the new self-consciousness of the nineteen-seventies has made physicians more aware of, and more willing to express, their motivations than in the past? Have the technicalities of medical practice intimidated physicians into believing that their roles as "healers" are jeopardized--that they must now insure their income as well as their reputations?

Thus, there are many questions which are raised by this exploration of what the contemporary private specialist in internal medicine means when he uses the term "my patient." Although

there was universal agreement by the physicians in the study that one cannot "teach" how to relate effectively to patients, the discussion and organization of the issues herein has profoundly affected the process of becoming a physician for the author, a fourth-year medical student. To an extent, the last year of medical school offers the student the opportunity to assume direct responsibility for patient care (albeit different from that in the private setting), and management concerns are finally the domain of the future physician.

When the student assumes the role of subintern, patients do not choose their student doctor, nor does the student define his practice; as pointed out in the foregoing, this limitation of freedom is a potential source of strain. In this position, I have been aware of a skepticism on the part of patients, not necessarily with respect to my competence as a clinician, rather with respect to my position as an individual "assigned" to care for them. Without the benefit of having established responsibility by agreement, they have been wary of my ability to provide the personal support they require. Recognizing these concerns, I have attempted to establish mutual trust before using my newly acquired technical skills, and I think my functioning with my patients has been facilitated.

My unfamiliarity with my role as a physician is evident as I struggle with understanding my patients' and my own needs for distance and friendship. As patients become "my patients," I am

granted very privileged access to occasionally very private information--about life-styles, families, reactions to stress. For this investment of knowledge, many patients demand and receive intense support at critical times. In the past, I have been accustomed to sharing such intimate experiences and information only with friends; I find myself tempted to expect much personally from my patients in return. I am satisfied when a patient leaves the hospital in good health, yet I also find that I want to share the good--the experience outside--as well as the bad. In reaction, then, I lapse into "authoritarianism", to protect myself with distance. Unlike the physicians in this study, I have yet to define the functional medium and manner which will best benefit my patients and myself; my discussions with these physicians have provided me with a framework, however, with which to evaluate future experiences.

In this transition from student to doctor, "authoritarianism" has been useful in another sense for me. With few women as professional role models, interaction with women physicians is unfamiliar to patients; as a result, my patients and myself are at times uncomfortable. The pressure to prove competence is conducive to a very directive "authoritarian" mode. Such manner has worked well for women physicians in the past; perhaps by "natural selection" only the most aggressive women found their ways to medical school and beyond. With the increasing number of women admitted to medical schools, however, I belong to a different generation of women

physicians. We have not necessarily been selected for our aggressiveness and many of us are searching for the most personally congruous and concomitantly functional manners. I dread the sly remarks of the VA Hospital patient "regulars", yet understand their discomfort on calling me, a small woman, "Doc". For now, "authoritarianism" serves two purposes: on one hand, I can provide some reassurance of at least a familiar "tough" stereotype of a woman doctor. On the other hand, it also prevents me from offering too much of so-called "motherliness" or a nurturing manner which would prevent effective "professional" functioning. Recognition of my humanity and femininity leads me to continue to search however, for more comfortable means of interaction for the future.

As medical school education for the most part is limited by time and tradition to the University or teaching hospital, the private physicians in the study certainly add another dimension to my awareness of the physician-patient interaction. Unless one person (physician) takes on the responsibility for the whole person, tertiary-type, fragmented care is what primary problems of ward patients receive. I now understand that to function successfully as a subintern or house officer, for those hospitalized patients who have private physicians, I have to understand the mode of a particular physician-patient interaction and respect the patient's expectations of the hospital "stand-in" physician. The private physician feels responsible for following developments, continuing decision-making relationships with patients, maintaining trust;

he senses a loss of autonomy when his patient is in the hospital; understanding these concepts makes the personal politics of care more satisfactory for the student/house officer as well as the private physician involved.

In the hospital, when matters are usually acute or semi-acute, often the patient is left out of or intimidated by the consensus of physicians when important decisions are to be made. In this respect, education, then, is often directed at compliance, not decision-making. Because information is so new to me, discussions with patients or their families is very much a sharing process. But when the occasional decisions are to be made <u>with</u> the patient and I'm asked, "Well, what do <u>you</u> think, Doctor?", I'm uncomfortable with the ultimate power we as physicians are so often given; it makes me want to retreat, continue "teaching". Perhaps this study supplies me with some preventive medicine, however; perhaps I'll suffer the "chief resident syndrome" with only minor symptomatology. Someday I'll have learned more of the art of medicine, and I'll be advising as well.

And in the brief outpatient clinic experience I've had, "my patient" is one who comes to the desk at a time mutually agreed upon and asks for me by name. I've become very protective, I want the responsibility of knowing what's been happening. Though at this stage many may know of my patient's problems and progress because of the advice I seek, I'm the one who is ultimately available to communicate with the patient; the familiarity between us facilitates the best possible care. I thought that concept was fairly

FOOTNOTES

1. Parsons, T.: "Social structure and dynamic process: the case of modern medical practice," The Social System. New York, The Free Press, 1964, pp. 428-479.

2. Parsons, T., Fox.: "Illness, therapy and the modern urban family." J. Social Issues 8: 31-44, 1952.

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4. Wilson, R.N.: "Patient-practitioner relations," The Sociology of Health: An Introduction. New York, Random House, 1970,pp.13-32. Hereinafter cited as "Wilson, The Sociology of Health."

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7. Reader, F.G., Pratt, L., Mudd, M.C.: "What patients expect from their doctors." Modern Hospital 89: 88-94, 1957.

8. Bloom and Wilson, Handbook (1972), p. 328.

9. Zborowski, M.: People in Pain. San Francisco, Jossey-Bass, 1969.

10. Freidson, E.C.: Profession of Medicine: A Study of the Sociology of Applied Knowledge.New York, Dodd, Mead & Co., 1970. Hereinafter cited as "Freidson, The Profession of Medicine."

11. Campbell, A.V.: Moral Dilemmas in Medicine. Edinburgh, London, New York, Churchill Livingstone, 1975. Hereinafter cited as "Campbell."

12. Fletcher, J.: *Morals and Medicine.* Princeton, Princeton University Press, 1954. Hereinafter cited as "Fletcher."

13. Bok, S.: *Lying: Moral Choice in Public and Private Life*. New York, Pantheon Books, 1978. Hereinafter cited as "Bok."

14. Schilder, P.: "The relation between the physician and the patient," *Psychotherapy*. Revised by Bender, L. New York, W.W. Norton and Co., 1951, pp.158-182. Hereinafter cited as "Schilder."

15. Freud, S.: *The Complete Introductory Lectures on Psychoanalysis*. Translated and edited by Strachey,J. New York, W.W. Norton and Co., Inc., 1966, pp.431-447. Hereinafter cited as "Freud, *Lectures*."

16. Freud, A.: "The doctor-patient relationship." Lecture to Western Reserve University Medical School students and faculty, Cleveland, Oct. 30, 1964.

17. Ford, A.B., Liske, R.E., Ort, R.S., Denton, J.C.: *The Doctor's Perspective: Physicians View their Patients and Practice*. Cleveland, The Press of Case Western Reserve University, 1967. Hereinafter cited as "Ford et al."

18. For lack of adequate substitute, the male third person pronoun should be understood herein as referring to both male and female subjects.

19. In their study cited in Footnote 17, Ford et al. originally proposed that physicians would see their "attributes" and "functions" differently. Although their study did not prove this hypothesis, perhaps the distinctions I see (father/teacher and authoritarian/friend) are based on qualities analagous to "attributes" and "functions", respectively.

20. Ford et al., p. 112.

21. Together, these qualities reflect the varying ethical perspectives from which the physicians function. They concern questions of respect for persons (see Campbell, "Respect for persons," pp.107-140), truthtelling (see Fletcher, "Medical diagnosis: our right to know the truth," pp.34-64), the common good (see Campbell, "The common good," pp.45-76), and "do no harm" (see Bok, Lying: "Lies to the sick and dying," pp.220-241).

22. Donovan, C.F.: "A doctor's responsibility to his patients." Proc. Roy. Soc. Med. 70(1): 21-23, 1977.

23. Katz, J., Capron, A.M.: "The authority and capacity of patient-subjects," Catastrophic Diseases: Who Decides What?. New York, Russell Sage Foundation, 1975, pp.79-115, hereinafter cited as "Katz and Capron, Catastrophic Diseases."

24. Katz and Capron, Catastrophic Diseases, p.88.

25. Katz, J.: "Informed consent--a fairy tale? Law's vision." U. Pittsburg Law Rev. 39 (2): 137-174, 1977.

26. Ibid., p. 139.

27. Elsewhere, Katz (Katz, J.: "News from the psycholegal centers: who's afraid of informed consent?" J. Psychiatry and Law, Summer, 1976: 315-326.) has pointed out what he sees to be the differences between the traditional model of physician-patient decision-making and the legal model of informed consent: the medical model "encourages regression to the earliest level of parent-child relationship" whereas "the legal model (is an appeal to) more adult levels of functioning." Thus conflict arises in the implementation of informed consent. Katz feels that co-decision-making in the therapeutic process would represent a major break with tradition and if accomplished, would also create attendant problems. Nevertheless, the present data suggest that the "teacher-friend", co-decision-maker, may well be appearing in medical practice.

28. Goldstein, J.: "For Harold Lasswell: some reflections on human dignity, entrapment, informed consent, and the plea bargain." Yale Law J. 84(1): 683-703, 1975.

29. *Ibid.*, pp. 690-692.

30. As cited by Dworkin (see footnote 31). Mill, J.S.: *Utilitarianism and On Liberty*. Edited by Warnock, M. London, Fontana Library Edition, 1962.

31. Dworkin, G.: "Paternalism." *Monist 56(1): 64-84*, 1972.

32. *Ibid.*, p. 65.

33. *Ibid.*, p. 64.

34. *Ibid.*, pp. 80-82.

35. *Ibid.*, p. 84.

36. *Ibid.*, p. 83.

37. Katz and Capron, *Catastrophic Diseases*, see informed consent ideally as a means for the patient to evaluate his physician's values; however: "(Patients) can also become guarantors of their own rights to autonomy and dignity, by exercising a check over the judgments of physicians who all too often may be biased by their strong desire to 'conquer disease.'" (p.89). Thus, "paternalism" has no place in the ideal informed consent model.

38. Egbert et al. (Egbert, L.D., Batitt, G.E., Welch, C.R., Bartlett, M.K.: "Reduction of postoperative pain by encouragement and instruction of patients." *NEJM 270(16)*: 825-827, 1964.) showed that patients, warned preoperatively of the kind of pain that they would experience, and its sources after elective abdominal operations, needed half as many narcotics for pain relief than did other, less-informed patients. Although the perception and expression of pain is complex, it may be inferred that dispelling fear of enexpected events might enable a patient to take on more responsibility than he would have, if left to his own devices. This certainly is perceived as important by the "teacher-authoritarian" (see Teacher, Nature of Interaction, Physician A.).

39. It may be, however, that the younger "teacher" is operating under the influence of his recent training in an academic center in this respect as well; his role models have been "physician-investigators", constrained by recent legal developments to consider aspects of informed consent in many of their patient-as-subject encounters. The question arises whether, in private practice for a while without public scrutiny, the "teacher" will be less able to resist his patients' desires to relinquish their responsibility, and will function in the more "fatherly" traditional role.

40. Burt, R.A.: "The limits of the law in regulating health care decisions." Hastings Center Report December, 1977: 29-32.

41. Crawshaw, R.: "Humanism in medicine--the rudimentary process." NEJM 293(25): 1320-1322, 1975.

42. Zee, H.: "Subjectivity in science." Ann. Int. Med. 82(2): 417-418, 1975.

43. Burwell, S.: "Medicine as a social instrument: medical education in the twentieth century." NEJM 244(18): 673-681, 1951.

44. Ibid., pp. 676-677.

45. Editorial: "Medical aptitude." NEJM 244(20): 771-772, 1951.

46. Cohen, Sir H.: "Medicine, science and humanism." Br. Med. J. 2: 179-184, 1950.

47. Editorial: "Medicine, science and humanism." NEJM 243(18): 716-717, 1950.

48. For example, in "correspondence" to the NEJM: Goethals, T.R.: "Americans first." NEJM 243(22): 896-897, 1950; and Editorial: "Doctor draft." NEJM 243(22): 893, 1950.

49. Appel, B.: "A testimonial." NEJM 232(26): 1146-1147, 1955. Also, the doctor was praised in: Fuess, C.M.: "As others see you!" NEJM 243(12): 435-440, 1950.

50. Ford, R.: "Medical malpractice." NEJM 243(11): 408, 1950.

51. Editorial: "The doctor's fee." NEJM 243(5): 203, 1950.

52. Editorial: "Relations, public and private." NEJM 244(9): 342, 1951.

53. Ellard, J.: "The disease of being a doctor." Med. J. Australia 2: 318-322, 1974.

54. Cassell, E.J.: The Healers Art. Philadelphia and New York, J.B. Lippincott Co., 1976, p.22.

55. The young "authoritarian", impressed with his technical prowess yet still uncomfortable with his impact on people's lives, may perceive that the power over information is another of his tools; this tool, however, may be used to protect and distance himself personally. Sissela Bok, (Lying: "Paternalistic lies," pp. 203-219) has recently cautioned against relying on "implied consent," a term meaning "that some day....those who are rightly deceived will be grateful for the restraints imposed upon them for their own good. And those who are wrongly deceived will not." (p. 214.) She encourages the elimination of "paternalistic lies" if at all possible, to reduce the risks of loss of credibility, risks to the relationship in which deception takes place and risks of exploitation of the deceived. The "authoritarian" may feel compelled to take these risks until he has learned that patients' spirits, if not their bodies, are often stronger than expected; he is then at risk of being encumbered with patients' personal burdens. "Paternalistic lies" and prevention of free exchange of information may then no longer be necessary or functional.

56. Schilder, pp. 6-7.

57. Perhaps this supports the contention of Spiro and Mandell (Spiro, H.S., Mandell, H.N.: "Visceral Viewpoints: the leaders and the swan--who should do family practice?" NEJM 295(2): 90-92, 1976) that older physicians are better suited to provide primary care, and that younger physicians, instead of choosing or being chosen for "family practice" experiences should indeed make full use of their newly-acquired technical skills and expertise. Indeed, from a sociological perspective (Moore, W.E.: "The formation of a professional," The Professions: Roles and Rules. New York, Russel Sage Foundation, 1970, pp. 66-83), a major feature of professional socialization is the learning of a technical language. It might well be that using technical skills re-inforces the physician's image of himself as a member of the collectivity of doctors, and only later, com-fortable in his role, he is able to take on a less structured conception of his profession.

58. Freud, Lectures: "Transference," pp. 431-447.

59. Wilson, Handbook (1963), pp. 286-287.

60. Wilson, The Sociology of Health, pp. 15-22.

61. Rueschemeyer, D.: "Doctors and lawyers: a comment on the theory of the professions," Medical Men and Their Work. Edited by Freidson, E. and Lorber, J. Chicago, Aldine Atherton, Inc., 1972, pp. 5-19.

62. Szasz, T.S., Hollender, M.H.: "A contribution to the philosophy of medicine: the basic models of a doctor-patient relationship." A.M.A. Arch. Int. Med. 97: 585-592, 1976.

63. Ibid., p. 587.

64. The expressed view of the importance of patients to be able to choose their physician is in some conflict with the sociological conception that "any transfer, by professional views, should come from a professional referral, not from a client's dissatisfaction or eager-ness for a bargain." (Moore: The Professions, cited in Footnote 57, "The professional and his clients," pp. 87-108) A number of physicians in the present study seemed pleased with patients referred by other physicians, yet did not seem particularly dissatisfied with lay referrals; rather, the latter referrals seemed to provide satisfaction in affirming the physician's status.

65. Although the "wish to know" guides the researcher or scientist, recent developments in informed consent, outlined in the foregoing and in Katz and Capron, Catastrophic Diseases, makes the model human researcher a patient "helper" and teacher as well.

66. Freidson, The Profession of Medicine, p. 206.

67. Ibid., p. 308.

68. Ibid., p. 322.

69. Although both Freidson and the "authoritarian" emphasize that "service" is the physician's major function, service is directed more to the patient as a biological, rather than a social being; hence, the conflict which marks the doctor-patient relationship is not paradoxical.

70. Ford et al., p. 150.

71. In acute infection, the most beneficial outcome is obvious to all; however, in chronic renal disease at least, Katz and Capron, Catastrophic Diseases, point out that "there is no objective, medical way to determine the proper treatment for the individual since disease itself is not an objective concept but depends upon the degree of dysfunction experienced... by each individual...Who, other than the patient-subjects, can determine whether the benefits of a procedure, conventional or experimental, outweigh the burdens that will be imposed on them?" (p. 89).

72. It is interesting that, although studies have been done in the past two decades about patient compliance with therapy, Hulka et al. (Hulka, B.S., Cassel, J.C., Kupper, L.L., Burdett, J.A.: "Communication, compliance, concordance between physicians and patients with prescribed medications." Am. J. Public Health 66(9): 847-852, 1976) point out that many cases of "non-compliance" with proposed medication schedules (in patients with adult onset diabetes mellitus and/or congestive heart failure) are due to discrepancy between what the doctor thinks he has advised the patient to do and what the patient understands to be the prescribed regimen. In fact, patient errors in self-medication were minimal when both doctor and patient had the same understanding as to regimen. When patients were unaware of the purpose of medications, they were more likely to take them unnecessarily or at the wrong time than if they could describe the purpose of the drugs involved. Thus, this seems to point to the importance of continuing patient education in the management of chronic disease. The question of which member of the medical "team" will be responsible for this function, however, may be raised.

73. Bok (Lying: "Lies to the sick and dying," pp. 220-241), notes the change that may necessarily result from the fact that doctors no longer work alone with patients: "truthtelling", rather than being an arbitrary decision of a single physician, will necessitate more concensus of caretakers; or at least, if not more important, discussion of the issue which has heretofore been avoided should ensue.

74. It is tempting to speculate that the nature of certain specialties might attract or produce a predominance of certain types of physicians. For example, the "surgeon" brings to mind the "father-authoritarian" whereas the "pediatrician"may serve as a "teacher-friend" for patients' families, and so on. Alternatively, different types of relationships altogether might be functional in other specialties.

75. The study by Hulka et al., cited in Footnote 72, is an example of one research method which will be useful: both patient and doctor were asked to describe the medication regimen that the doctor had purportedly prescribed; the con- or discordance between sets of answers was evaluated and sheds light on the interaction.

76. Eisenberg, J.M., Rossoff, A.J.: "Physician responsibility for the cost of unnecessary medical services." NEJM 299(2): 76-80, 1978.

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