

From Pedestal to Partnership: Healing the Patient-Doctor Relationship

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Introduction

Importance of the Relationship

The relationship between a patient and a doctor lies at the heart of medicine. Understanding of the nature and importance of this relationship has steadily grown in the last fifty years; for example, approximately 600 articles per year were published on the topic of the patient-doctor relationship from 1981 to 1991. This complex relationship at the heart of clinical medicine—the interaction of an individual patient with an individual physician, includes widely differing expectations, those of the patient, the patient's family, society, and the doctor. Persons' experiences of illness unfold within a matrix of interpersonal relationships in both informal and formal contexts¹. A patient's social class, social supports, ethnicity and interpersonal abilities all illuminate their illness and health behaviours. Geographical location such as urban or rural setting also affects their health care relationships.

The patient-doctor relationship is a form of social support and may therefore mediate and reduce the harmful effects of stressors. It is a unique relationship, especially if the patient is seriously ill; there is need for trust in the doctor's judgment and need at times to give up more autonomy than one ever would to a lawyer or other professional. Medicine is special; it is a moral enterprise between an ill person and a healer providing precious service.

In our current high-tech atmosphere, where the human components of the physician's tasks can be easily eclipsed by the technical aspects (of health care)², Peabody's words are even more important today than when he lectured to Harvard medical students in the 1920's:

...the secret of the care of the patient is caring for the patient. ...The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it, and the failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients.³

Many others have confirmed this view:

...the doctor himself is still probably the most important part of the treatment, as Balint emphasised so many years ago. He administers himself through his relationship with his patients, and the effects may have a very long half-life indeed.⁴

At the core of medical practice is the need to create and nurture a healing dyadic relationship between physician and patient. Other elements of medical professionalism reflect broader responsibilities that the physician has to society and the profession, to family and self.⁵

The foundation of good medical care is a comfortable and evolving relationship between the patient and the physician. Since the dawn of medicine with Hippocrates and later Plato, this relationship was regarded as the foundation of the art of medicine. This bidirectional relationship has evolved over time from a benign physician paternalism to one of patient autonomy.⁶

A social contract, unwritten and constantly changing also exists between physician and society. As writes Duffin:

Doctors can be doctors only when someone else agrees. A contract has always existed between physician and patient, although usually it was not recorded in writing. This contract assumes doctors have expert *knowledge* that will fill patient *expectations*. When these expectations are met, patients grant doctors the privileges of *authority* and professional *control*...Privileges continue as long as the contract is filled to the satisfaction of both parties.⁷

Although there currently exists more medical knowledge and better medical care than ever before, there is more mistrust in the therapeutic encounter. "The patient's good is the end of medicine, that which shapes the particular virtues required for its attainment." "...the virtuous physician is one so habitually disposed to act in the patient's good, to place that good in ordinary instances above his own, that he can reliably be expected to do so."⁸ However, as Pellegrino points out, "A person who is a virtuous person can cultivate the technical skills of medicine for reasons other than the good of the patient—his own pride, profit, prestige, power⁹. He goes on to describe the obvious split in the profession between those who see and feel the altruistic imperatives in medicine, and those who do not¹⁰. "Today, we must be more forthright about the differences in value commitment among physicians."¹¹

This two-part paper discusses the importance of healing the patient-doctor relationship, including an exploration of the nature, models, and history of the relationship in part 1, and a discussion of the relevant current social pressures in part 2. An understanding of the historical development of the patient-doctor relationship helps shed light on the current crisis. An underlying question for consideration is: how do the relationships between the physician and society, and between the patient and society impact on the relationship between the physician and the patient?

Heartburn in the Relationship

There is increasing evidence that all is not well between physicians and patients. The following metaphors describe the current state of the doctor-patient relationship: it is unravelling, disintegrating, and shattering; it is under fire from patients and from third parties such as insurance companies. There is heartburn between patients and doctors. They are at loggerheads, embattled, involved in a tug-of-war. Doctors are being pushed from their pedestals

(by patients, government, licensing bodies and citizen groups)¹². Physicians are frustrated and embattled because of increasing limits placed by the larger social system; at the same time, doctors' behaviour is one of the wedges driving them apart from their patients.

Numerous clinical studies and public opinion surveys have revealed dissatisfaction with physicians' communication skills. Results of a 1995 *Maclean's/Medical Post*/ Angus Reid survey of 1503 Canadian public's and 1710 physicians' views on health care and doctor-patient relations were published in a feature *Maclean's* article, called *Feverish Relations: The traditional doctor-patient relationship is breaking down as a result of government cutbacks and patients demanding to be treated as customers*. It reported that while the majority of Canadians were satisfied with their physicians (68%), over one-third were not. Thirty-one percent reported that their physician behaved arrogantly or insensitively. Nearly four out of ten Canadians (38%) had been irritated enough to change physicians. Women tended to experience more problems with their doctors than did men; more than a third (37%) of women cited incidents of arrogance or insensitivity, compared with twenty-five percent of men. Six percent of women reported being sexually harassed by their physician¹³.

A 1995 U.S. survey on doctor-patient relationships reported similar findings. Published by *Consumer Reports*, the responses from 70,000 subscribers revealed that most patients were satisfied with their care, and that generally, physicians were perceived as competent and concerned. However, respondents were very critical of doctors' communication skills, including a lack of interest in their patients' opinions, unwillingness to discuss patients' questions, failure to give lifestyle advice, and inadequate discussion of the side effects of prescription drugs¹⁴.

News coverage on problems with patient-doctor communication has increased in the last decade. Examples include:

- A February 1997 Canadian Press wire story, *Doctors told to treat patients as people, not diseases*,
- A 1996 *Edmonton Journal* story, *Rude MDs urged to mend bedside manner: cutbacks, changes blamed for growing patient complaints about frenzied physicians*,
- A 1994 *Montreal Gazette* story, *Communication breakdown: many women feel rushed and ignored by their doctors*,
- A 1994 *Globe and Mail* story, *Cancer MDs fail to communicate, and*
- A 1995 *Calgary Herald* story, *A Physician and friend: people are no longer going to doctors only for treatment: they want old fashioned support and advice*.

The relationship between doctors and their patients is also currently receiving a great deal of attention in the arts: plays, films, and books are seen depicting physicians as emotionally distant, abrupt, pompous, insensitive and even incompetent. The movie, *The Doctor*, was released in 1991, based on a book entitled, *A Taste of My Own Medicine* by Dr. Ed Rosenbaum. The film chronicles an insensitive, arrogant cardiothoracic surgeon's transformation into a kind and caring doctor as a result of his personal experience with cancer. He moves from pedestal to partnership in his relationships with patients, as well as in his other significant relationships. Other examples are: *Wit* by Margaret Elson, *Operating in the Dark* by Lisa Priest, and *Patch Adams*¹⁵. The notion that something is seriously lacking in the doctor-patient-relationship seems to have become thoroughly embedded in contemporary Western culture¹⁶.

... a good doctor listens to you and then addresses what you're feeling¹⁷. Patients want doctors to respond favourably to their questioning and show sensitivity to their well-being. Patients today generally expect a more active role in the relationship than in the past when treatment was not negotiable and their role was to be passive. There are many studies showing both that good communication skills are effective in improving health care outcomes and patient satisfaction, and that communication skills are not innate and can be learned¹⁸. However, despite adequate research on medical communication, much of this information has not been used in either medical practice or medical education¹⁹.

Communication difficulties are among the leading causes of complaints to provincial medical colleges²⁰. A review of the literature confirms the magnitude of communication problems: 54% of patient complaints are not elicited by physicians; 45% of patients' concerns about their problems are not elicited by physicians; 50% of psychosocial and psychiatric problems are missed by physicians; physicians interrupt patients after an average of 18 to 21 seconds into the patient's story; and, in 50% of visits, the patient and doctor do not agree on the nature of the main problem²¹. Physicians most often attribute communication problems to the patient rather than to their own limitations. The results of patient dissatisfaction include higher rates of non-adherence to treatment, doctor-shopping and malpractice litigation. When patients understand their illness, understand what needs to be done to preserve their health, trust their physicians, and are full participants in their care, non-compliance will be a non-issue²².

Still, one must ask why communication has become such a growing concern in medical care. It can be argued that a well-educated, well-informed, and sophisticated public wants to have a say in both the diagnostic and medical decision-making process, while at the same time, physicians are frustrated by shrinking resources and budgets. Discrepancies exist between physicians' and patients' definitions of quality of care. Many patients now see themselves as consumers, have expectations of having their needs met, and no longer have an unquestioning deference to physicians. These high expectations have put some clinicians on the defensive. Lack of appreciation by patients and budget-slashing governments, and pressure for increased performance from doctors who already feel overworked and under-compensated have caused professional morale to weaken²³.

Nature of the Therapeutic Relationship

Relationships between physicians and patients constitute the most intimate core of medical practice²⁴.

The patient-doctor relationship is one type of therapeutic or healing relationship; other types occur between patients and nurses or other health professionals. The therapeutic qualities of a good healing relationship are: interest, empathy, respect, genuineness, honesty, unconditional positive regard, a non-judgmental attitude, and warmth. The healer needs to learn to be objective and at the same time warm and empathic. A relationship like this is inherently healing, and provides the experience of a healthy relationship for those patients who may have no other role models. The expression of empathy consists of eliciting feelings, paraphrasing and reflecting, using silence, listening attentively to what the patient is saying, and also to what she or he is unable to say, encouragements, and non-verbal behaviours²⁵.

A healthy doctor-patient relationship is the foundation of humanistic care, defined as viewing patients as autonomous, unique, and irreplaceable persons, who should be treated with empathy and warmth, and should share in decisions with health care providers in a reciprocal and egalitarian relationship²⁶. When the physician shows concern and a

caring manner, and allows patients to tell their stories at their own pace, the consultation is transformative; taking a history can be therapeutic. The doctor also provides company and a thorough consideration of a patient's problem. Patients are often reassured when a doctor is not alarmed by their story; the doctor's questions clarify, summarize, and add a new perspective of understanding and insight which can be helpful²⁷. Similarly, the beneficial effects of physical examination, a blood test or an X-ray are widely recognised as part of the medical relationship.

Many factors come into play in patient-doctor encounters, including individual attitudes, values and beliefs concerning culture, race, gender, class and age, affecting both the physician and the patient. I think doctors are actually chameleon-like. I find myself a very different person with different patients. So I've got to know what you bring to the table, what your culture and beliefs are, what values you hold, and who you are, particularly if a big thing is going on. I don't think that's so true if you have a sore throat²⁸. Stereotyping and labelling of patients in different social classes is often perpetrated by doctors, as with patients with disabilities or sexual orientations different from the physician's.

We learn more from people when we see them in context. We don't make home visits much anymore, although the best place to learn about people is in their homes²⁹. The locus of medical attention through most of the nineteenth century was the home. The doctor was seen as a confidential friend, with deep personal knowledge of the patient and the family. An internal medicine residency at Mount Sinai School of Medicine in New York City includes house calls in order to remind residents that their patients are people, not biochemical analyses. The program, called Visiting Doctors, was founded by three former residents who worried that the grueling demands of residency training were creating a breed of callous, angry physicians³⁰.

What needs to be done when a doctor meets a patient? The physician needs to make a diagnosis or define diagnostic possibilities and develop and negotiate a plan, communicate the plans to the patient, and develop a relationship with the patient. The disease-centred approach, the traditional clinical method, in general use since the early 1900's, focuses on the patient's chief complaint. The method then proceeds with the history of present illness, past medical history, social history, family history, review of systems or functional inquiry, physical examination, differential diagnosis, plan of evaluation and management. In this method, there is little teaching on how to actually conduct a medical interview; instead while physicians are taught how to make written and oral presentation of their findings in clinical encounters.

Many physicians are criticized for being uncaring because they fail to compensate for problems with this traditional clinical method. A new transformed clinical method, with the patient at the centre, was introduced in 1986 by a family physician, Dr. Ian McWhinney. In patient-centred interviews, the physician seeks the patient's point of view and encourages him or her to speak openly and ask questions. The patient-centred clinical method results in increased patient and doctor satisfaction. With modifications, it is also effective in emergency and specialist consultation settings^{31,32}.

Doctors want to be close to their patients. Doctors are very angry about the walls that have come up between their patients and them. They need ways of coming closer. And I think one of the ways that we can come closer to our patients is to treat them as individuals and to talk about ourselves as individuals³³. At the same time of course, there need to be healthy boundaries in the patient-doctor relationship as well; it is not appropriate for doctors to share their very personal matters nor to have sexual relationships with patients. The professional regulating bodies have clear guidelines on the latter.

What does a patient want from the clinical encounter? Most patients want an explanation of the cause of their

illness along with a treatment and cure. They want to be kept informed and may want decision-making power. The latter is a dynamic process depending on the patient's state of health; many reclaim their power as their health is restored after serious or acute illness. The balance of decision-making power is an ongoing interpretive process needing frequent re-assessment.

Language is an important issue affecting communication in the patient-doctor relationship. Explanations must be understandable not just for etiquette, but for informed consent as required by law. Access to medical language is a tool of empowerment; the uninitiated are often alienated by the language. This special language contributes to a sense of closeness and professional spirit among people who are under a great deal of stress³⁴. Doctors may have difficulty translating complex information into understandable language for patients with different levels of education and language skills, according to physicians in a focus group at the Communication in Breast Cancer Conference held in Calgary in 1996.

One more dimension of the patient-doctor relationship to consider is power: 'Power comes easily to doctors, slipping into their lives as readily as they acquire the special language in medical school, as rapidly as they learn the proper placement of a stethoscope round their necks, as effortlessly as they don a white costume. During my twenty-nine years as a practicing surgeon I never yielded any of my power. I never shared my language or listened to the patient's language or asked a proper question: What does it feel like to have heart disease and to await surgery and suffer? I allowed no negotiation and no true communication. To do so would be to get involved, to drop my surgical mask, to feel the patient's pain, to yield power³⁵.'

The surgeon who wrote the quote above goes on to say how he cheated himself and his patients of understanding, participation and comfort by giving only his expertise in the operating room. Patients do better when they share power. Power is the impulse to exert and impose one's will on others, and the physician is empowered by virtue of knowledge, while the patient is often submissive because of need. Power may be exercised, but it has to be done with tact and respect³⁶. Two examples of documented abuses of medical power are the actions of the Nazi doctors and the Tuskegee study of untreated syphilis in black men in the U.S.³⁷

Interestingly, many but not all systems of complementary and alternative medicine (CAM) place emphasis on the uniqueness of the individual patient; homeopathy, for example, involves treatment of different patients with a problem such as urinary tract infection with different remedies depending on the patient's particular symptoms and characteristics. One element in the resurgence of CAM in modern society may be the patients' interest in individualized therapy.

Models of the therapeutic relationship

The three most common models of a therapeutic relationship, based on the doctor-patient relationship are: paternalistic, shared decision-making and consumerist. However, it is important to keep in mind that while models provide a mental framework, this relationship is an extremely complex one, and in reality, beyond models. Possible aspects of the relationship to consider include conflict, collaboration, confrontation, collusion, harmony, and others.

1) The Paternalistic model (or medical professional dominance)

In this model, the relationship is seen as an interplay between two social roles, each with duties and responsibilities. The role of the "sick" exempts the patient from normal life, yet comes with the responsibility to comply with treatment and strive to recover. The patient can refuse treatment, but does not choose between treatment options. The physician chooses and presents the treatment to the patient³⁸. This

model corresponds to the traditional, physician-centred clinical method.

In a later revision of this model, the relationship is still paternalistic; however, the patient may participate in decision-making in the context of a chronic illness³⁹. The physician can override the patient's choices when he/she judges that it is for the patient's own good. The authority of the physician is based on expert technical knowledge and expertise which is not available to the patient. The patient's knowledge of the situation is considered irrelevant. As a result, the patient may not reveal important diagnostic information⁴⁰. Gender, age, educational and ethnic differences usually serve to exacerbate this imbalance of power^{41,42}. Interaction in this model is limited. There is a reluctance to give information to the patient about his or her condition, and a tendency to use medical jargon, and evade direct questions about diagnosis or treatment⁴³.

A variation of this model is the activity-passivity model which is appropriate in serious illness or an emergency situation, with a relatively helpless patient requiring full decision-making power of the physician. Another variation is called the guidance-cooperation model, which applies in acute illness; the physician makes the decisions and the patient acts as instructed

This model, most commonly used in the past, has been found over the last twenty years to be inadequate in communication effectiveness. It is often associated with patient dissatisfaction with the lack of attention given to their ideas on their condition⁴⁴. A consultation often ends with symbolical tearing of a piece of paper without explanation, only a set of instructions⁴⁵.

2) The shared decision-making model

This model is also known as the model of mutual participation⁴⁶. The physician has expertise in clinical knowledge, while the patient has expertise based on knowledge of the facts about his or her own personal situation. The physician helps the patient make the treatment choice that is most appropriate through an understanding of how medical information relates to that patient's unique situation. This model is especially suitable when dealing with chronic diseases. It corresponds to the patient-centred clinical method, including finding common ground, negotiation and consensus seeking⁴⁷.

The patient's own experience provides clues to treatment and the patient accepts responsibility for lifestyle changes recommended as part of the therapy. For this model to work, ongoing dialogue is required between physician and patient⁴⁸. The patient asks questions, seeks explanation, and makes choices as an informed consumer. Patients are encouraged to express their reasons for visiting the physician, including symptoms, thoughts, feelings, and expectations. The doctor answers questions and gathers further medical information if needed. Each person in this relationship accepts the other as a relative equal. In this collaborative approach, information is widely shared, and consultation precedes decision-making. If not satisfied, the patient chooses another physician. The physician may also end the relationship if another physician is available to take over patient care. The shared decision-making model developed as a reaction to the paternalistic model and was encouraged by social movements such as the growing emphasis on individual rights, the civil rights movement of the 1960's, the feminist movement, and the general rise of consumerism⁴⁹⁻⁵¹.

Although this model is preferred by many patients⁵²⁻⁵⁴, it is not free of concerns. The first is modern societal pressures of time and money: However, the current economic pressures on industrialized countries have made it difficult for physicians to give patients the amount of time and attention required to deliver care in this way⁵⁵.

The second concern, although this model seems to be in

demand by the public, it is not always easy for physicians to share decision-making and power⁵⁶. This lack of congruence between patient expectations of the therapeutic relationship and what doctors are actually able to provide often leads to frustration on the part of physicians and dissatisfaction among patients⁵⁷. Third, this model is not appropriate for patients who are immature, poorly educated or mentally deficient. Patients from a lower social class background most commonly have problems communicating with physicians. Patients who are poorly educated are often treated impersonally and with less respect than the upper and middle classes; their questions are often ignored. Persons with lower socioeconomic status tend to ask fewer questions of doctors. The social background of both the doctor and the patient are important in the giving and receiving of information⁵⁸. Ethnic minority members, especially those who do not speak English, in Canada often experience serious communication problems.

3) The consumerist model

This model contrasts with the first model, paternalism, and is an extension of the second model, shared decision-making. In this case, decision-making rests in the hands of the patient/consumer⁵⁹. The patient chooses an intervention after the doctor outlines the relevant clinical information to the patient; the doctor then executes the chosen option. A business-oriented consumer model has been evolving in the United States, with the growth of managed care.

This model is difficult to apply since it assumes that patients and doctors have equal power, that patients are well-educated, assertive, able to challenge the doctor and able to speak as an equal. It fails to take into account the uneducated, those of lower socioeconomic class or minority groups, namely those who often most need help, and have most difficulty using medical services^{60,61}. This model also fails to acknowledge that patients are often in pain, suffering, in distress, fearful and anxious, unable to think clearly, and hence, unable to fully consider the risks and benefits of treatment. Thus, while the consumerist model has value in that it emphasizes the patient's right to self determination, it does not adequately capture the situation for a majority of patients⁶².

Which model of the therapeutic relationship best characterizes the needs and desires of providers and patients in today's society? Perhaps, the ideal medical encounter integrates the patient-centred and physician-centred approaches: the patient leads in areas where he or she is the expert, and the physician leads in her or his domain of disease and treatment⁶³. Levenstein et al. call this approach 'reconciling the two agendas'⁶⁴; similarly, Roter and Hall call it 'mutuality'⁶⁵. The model of mutuality in the medical encounter consists of a high degree of both physician control and patient empowerment. It is the meeting of two different experts in an atmosphere of mutual respect resulting in benefit for both physician and patient; both the patient's care and the physician's work are facilitated.

Historical Development of the Patient-Doctor Relationship

Some of the most potent images of physicians focus on their role in the research laboratory. Soberly clad in the uniform of science—the white laboratory coat—doctors tell us news of the latest research findings for curing disease. At the same time, however, television programs, newspaper articles, books and even professional medical journals wistfully detail the life and times of the old-time general practitioner. Almost always portrayed as a selfless caretaker of the community, this historical physician is lauded for dedication to his patients, a hero who made house calls even in the most extreme circumstances⁶⁶.

Medicine is both an art and a science; the doctor is both a scientist and a healer. Doctors have struggled with these conflicting images since the ancient Greeks, especially as they relate to interactions with patients. Traditional histories of medicine have usually maintained that scientific discoveries led the way in changing the art of medicine. More recently, however, scholars have suggested that the doctor-patient relationship has had an equally important role to play in shaping medical science as well. An overview of the history of the patient-doctor relationship will shed light on the current crisis.

In these histories, the patients become more than inert, inarticulate lumps, and their needs care instead seen as integral in molding physician practices⁶⁷. Nevertheless, the habitual neglect of the patient persists⁶⁸. With only a few exceptions, there is very little known about the actual interaction between doctors and patients in the past. In literature, however, the patient is as prominent as the physician; as such, the study of literature may help restore the patient missing from history⁶⁹.

The history of the patient-doctor relationship has evolved along with the history of science in medicine. The profession has passed through periods of ascendancy and decline⁷⁰. Historically, doctors were not always high in social standing or power; before the mid-eighteenth century in England, barber-surgeons were skilled tradesmen, not learned professionals. Traditional doctors (1750 -1850) had little authority over patients and patients refused to believe that doctors had any specialized knowledge. Public opinion was as good as medical opinion, and patients challenged doctors' diagnosis or treatment plan and often disregarded what the doctor said. The rise to present-day authority originated in the scientific advances of the nineteenth century, such as germ theory, asepsis, and effective remedies. Medicine's increasing capacity to cure, mitigate, and prevent the ravages of many diseases led to the elevation of physicians to a commanding position (in society)⁷¹. Overall, in the history of the patient-doctor relationship, there has been a relatively brief existence of the caring physician and the trusting patient⁷².

Until the end of the nineteenth century, doctors saw each patient in a holistic way; each patient and his or her symptoms were unique. This world view began with the ancient Greeks as early as 500 B.C. from Pythagoras to Hippocrates, when medicine was based on humoral physiology and pathology. Health depended on the equilibrium and blending of the humours, while illness resulted from an improper mixing of the humours, or from an accumulation of a fluid in one part of the body. Therapeutics emphasized the individual patient, as the physician aimed to restore the body's humoral balance which was influenced by the surrounding environment. This system relied heavily on the physician's relationship to and knowledge of the individual patient. It was considered an art to interpret symptoms and give advice on how to treat the sick patient⁷³.

In the second and third centuries B.C., physicians were divided into two sects who debated about whether to use logic to search for hidden causes (the Dogmatists) or bedside experience (the Empiricists) to shape scientific ideas. The work of the Graeco-Roman physician, Galen, (who died in 199 A.D.) had tremendous long-term impact on medicine by ending the sectarian division. His work, based on logic, astrology, and anatomy was the only medical science to survive the ancient period. He was an Empiricist, who believed that physicians must rely on their own senses; however, he agreed with the need to seek the nature of hidden causes of disease. He advocated the use of reason, not as a pure mental construct, but as related to clinical experience.

Galen described clinical examination as being most effective when the physician knew the patient in a state of

health. He then used his senses, especially sight and touch, to assess both the patient and the patient's surroundings. Treatment varied according to the particular patient and the condition of the disease. Galen elevated medicine to a learned discipline; the physician had become literate and educated, equal to his upper-class patients.

The acceptance of Christianity in western Europe by the early Middle Ages introduced the idea that disease was punishment for sinfulness and that pain in the body was to be welcomed as a test of one's faith. Medicine achieved a high public profile because doctors had become church leaders and in some cases, even saints. The priest-physicians helped to develop hospitals, making secular as well as spiritual care available to the poor and the old. Christianity also helped promote medical care by having doctors help dying patients, whereas prior to this time, physicians had withdrawn their care when they could no longer improve a patient's health.

As medicine became integrated into the medieval university curriculum, practitioners learned both theoretical and practical aspects of healing, including that of the therapeutic patient-doctor relationship. A profession of medicine established Galenic medical theory within the scholastic tradition. Medicine also became separate from surgery in order to gain acceptance within the university as a cerebral discipline disassociated from manual labour.

The Renaissance with its anatomical and other scientific discoveries, challenged Galenic medicine, but did not replace ancient medical practice based on a holistic understanding of the uniqueness of each patient. For example, William Harvey's discovery of the circulation of the blood was fitted into an understanding of the humoral theory. Though after Harvey a practitioner might now know more about what happened when he opened a vein for bloodletting, the reason for performing bloodletting was a faith in ancient therapeutic ideals⁷⁴.

Paracelsus (1493-1541) challenged the excessive emphasis of ancient Galenic science on reason over the Hippocratic ideal of experience. With his chemical philosophy, Paracelsus challenged humoral pathology. Since he thought that disease was caused by a specific agent foreign to the body, he developed therapeutic agents including both chemical and herbal remedies aimed at the disease agents. He rejected book learning, and his philosophy was spiritual and magical. Over the long-term he allowed for the increased use of chemically-derived drugs and a movement toward greater innovation in finding more effective remedies⁷⁵.

During the seventeenth and eighteenth centuries, biological discoveries had little impact on humoral medicine and its focus on direct observation of the patient. Medical school curricula at the University of Leyden and the University of Paris continued to reflect Galenic beliefs although they did not totally rely on Galen⁷⁶. The usefulness of pure medical science was questioned in part due to the difficulty of observing and measuring multiple phenomena. The famous British physician, Sydenham (1624-89) believed that doctors should spend their time in sickrooms rather than in laboratories⁷⁷. Bedside practice during the many outbreaks of epidemic disease reinforced the intellectual skepticism; patient needs demanded that remedies be found quickly.

In the first half of the nineteenth century, the French doctors of the Paris school with their radical empiricism posed the first real challenge to medieval Galenic medicine. They emphasized careful observation of phenomena and avoidance of speculation. Eventually bedside observations were correlated with subsequent pathological anatomy from autopsies. Skepticism developed with regard to traditional Galenic therapeutics.

Physical examination and laboratory tests gave the modern doctor his power and influence. The development of tools such as the stethoscope allowed physicians to examine and

even measure their patients instead of merely observing them. In 1819, the stethoscope was introduced by Laennec (and by the mid-1800's widely used) and gradually adopted as an indispensable tool for physical examination. The effect of the use of this instrument on the healing relationship was to distance the doctor, who had previously put his ear directly onto the chest of patients. The stethoscope became a symbol of medical power.

Before the 1920's in the US and later in Britain, doctors saw most patients in house calls, called visits; the doctor was constantly on the road, and spent a lot of time, sometimes days at each house. He saw few patients and his practice was not lucrative. City doctors saw more patients, up to thirty to forty per day, and some were seen up to three to four times per day, to document changes in fever, for example. Doctors in both the countryside and the city knew their patients intimately. American physicians who flocked to France had their ideas about the practice of medicine seriously challenged. They were practical and felt that the medical science of understanding and observing disease was subordinate to intervening with medical practice. An American physician describe the French scientific doctors in this way, 'The triumph with these physicians is in the dead room'⁷⁸.

For most of the nineteenth century, physicians continued to practice medicine in the ancient tradition of close monitoring of the patient and reliance on the physician's knowledge of the specific patient in context. The doctor-patient relationship had changed little since ancient Greek times; although doctors had some understanding of anatomy and chemistry, they still understood disease and treatment in the holistic way defined in the fifth century B.C. Until the discovery and acceptance of germ theory, a good doctor was one who had extensive experience and good judgment. Most important, at least to physicians, the physician derived status and authority from the relationship with sick patients⁷⁹.

In the U.S, the belief in patient-specific diagnosis and therapy was strong, especially in the southern U.S.; these physicians believed that a single disease could take on a variety of forms depending on the patient, and disease-specific treatments were suspect and professionally illegitimate⁸⁰. 'Inhabitants of Hot climates will not bear the same mode of treatment as those of Cold,' taught David Hosack at the College of Physicians and Surgeons in New York City at the turn of the nineteenth century. The emphasis on climate and patient types indicates the deep roots of the notion of patient uniqueness in medical thought and practice⁸¹.

Beyond regional differences, ideas of constitution and temperament were strongly held by American and some European doctors. A person's unique constitution, shaped by heredity and life experiences, interacted with the climate, region, and country where he or she lived. The concept of constitution and temperament unfortunately provided a rationale for belief in the fundamental inequality of those differing in social class, race and gender, i.e. women, blacks and the working class⁸².

In the late nineteenth century, with the discoveries of anthrax and tuberculosis bacteria, germ theory was born. At first disbelieved, it gradually transformed medicine and upgraded the public image of doctor: The microscope was soon a requisite office tool for the study of blood, urine and feces⁸³, and, like the stethoscope, became a badge of scientific medicine.

By the early twentieth century, the patient-doctor relationship began to change. The physician was an expert in science and the individual patient's symptoms were no longer crucial for treatment⁸⁴. This new kind of physician gained status from the knowledge of science, rather than from caring for sick people. The physiology laboratory had replaced the patient laboratory, and the patient was treated based on principles discovered in the laboratory. The patient was no longer central to the understanding of disease⁸⁵. Although many general

practitioners resisted, the reorganization of American medical education in the early twentieth century confirmed this model, as institutions such as Harvard and Johns Hopkins medical schools adopted science. This new medicine, based on a fascination with science and technology began to spread.

The development of medicine as a science and the introduction of technical devices starting with the stethoscope, and later sphygmomanometers to measure blood pressure, tipped the balance of power from patient to doctor. The doctor was the one skilled in their use. Changes in hospitals and laboratories as well as the arrival of students at the bedside impinged on the connection between physician and patients. After 1870's, the focus had centred on differential diagnosis, matching symptoms to the underlying lesion, an abnormality in structure or function; therapy and prognosis dependent on a particular diagnosis. Scientific medicine impressed the public; the doctor had the power to see the future by means of prognosis. However, the power to cure was only a little better than that of the traditional doctors.

Conclusion

In summary, the history of the patient-doctor relationship plays a central role in defining medical practice and medical theory. Patients play an important role in establishing the physician's professional identity and provide a means to study disease processes⁸⁶. The healing relationship was fundamentally changed with the understanding of physiological processes; after that it made little difference whether that process was occurring on in an Irish immigrant or a laboratory dog⁸⁷. The physician's presence at the bedside became much less important than the laboratory tests or X-rays in the patient's welfare. Indeed, the ultimate example of the scientific physician might be one who, like Martin Arrowsmith (in Sinclair Lewis' 1925 novel), left patients altogether for the laboratory bench⁸⁸.

It is obvious that the roots of the current difficulties between patients and doctors are found in this history. With the relatively recent re-discovery of the patient-centred clinical method, the pendulum is now swinging back toward a more balanced approach incorporating both the art and science of medicine. "It is more important to know what patient has a disease, than what disease the patient has."⁸⁹ Modern doctors engage in a respectful collaboration with patients and their families as much as possible depending on the circumstances rather than look down on them from pedestals.

Part 2 of this paper will discuss the impact of social change on the patient-doctor relationship.

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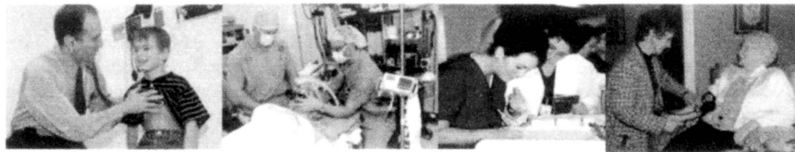
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