EVOLUTION OF THE DOCTOR-PATIENT RELATIONSHIP*

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THE inviolability of the doctor-patient relationship has been much in the public press of late. It has even become a political issue. In the recent campaign, for example, General Eisenhower on September 14th said, "We must preserve the completely voluntary relationship between doctor and patient. This means that there must be no intermediary—and that is what the government becomes if the doctors get paid, not by the patient, but by the government."

This sudden emergence into the limelight of something which through the centuries has been taken tacitly for granted, is a phenomenon, the causes of which deserve investigation. Since this is the "Historical and Cultural Medicine Section" it is appropriate that we delve for them a bit, into our professional subsoil. The moral character of our medical practice was defined by Hippocrates in the fifth century B.C. In his penetrating analysis of the motivations of the physician entitled "The Ethical Basis of Medical Practice," Dean Sperry of the Harvard Divinity School says, "the Hippocratic Oath has no parallel in the history of morals. Many ancient religions have the most detailed rules for their priesthoods, but these provisions concern ceremonial rather than ethical matters." And a generation or so later we find Plato in The Republic, declaring that "no physician, insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true physician is also a ruler having the human body as subject, and is not a mere money-maker." One wonders why the philosopher found it necessary to include the last clause. Was there some doubt in his mind of the steadfastness of physicians in living by the spirit of their ethic, or were some economic difficulties even at that early date creeping into the doctor-patient relationship? Certainly there

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can be no doubt of the economic implication of the statement of St. Luke four centuries later when he said, "And a woman having an issue of blood twelve years, which had spent all her living upon physicians, neither could be healed of any, came behind Him, and touched the border of His garment." Evidently there is nothing new about the high cost of medical care, nor are the economic problems of medicine of merely recent origin.

The intense public interest in these matters, however, is of very recent origin. Until but one century ago medicine both in its scientific and in its humanistic aspects has been very static. It was the application of the experimental method to medicine by Claude Bernard a century ago which led to the tremendous crescendo of antibiotics, hormones and other physiologically potent molecules which beset us today. But it is the disruption of the economies of many nations by the wars of the twentieth century that has produced the great sociological and economic problems of medicine which now confront us.

It is highly significant, I believe, that General Eisenhower linked the quality of the doctor-patient relationship to the manner in which the doctor receives his remuneration. What caused the General to make this association? I will guess that the idea was put in his mind by doctors rather than by patients, because as one looks about, it becomes evident that there is considerable contentment with medical affairs as they are among many of the doctors, but quite the opposite among the general run of patients. All is well in this best of possible medical worlds, medical orthodoxy claims, but many people, especially low income heads of families, live in dread of what medical care may cost them. Later General Eisenhower seems to have paid more attention to this conflict of interest, because in his New Orleans speech of October 9th, he admitted the inadequacy of existing private health insurance and said that the usefulness of federal loans or other aid to local health plans should be explored.

I first participated in the care of patients while we were still living in the culture of the nineteenth century, for that culture did not end with the ringing of bells and the blowing of whistles on January 1, 1900 (which too I can remember), but carried over into the twentieth century until the coming of the first world war.

In those days the practice of medicine was sharply divided into private and charitable. The medical schools had full time salaried

teachers in the preclinical sciences, but the clinicians all made their living in private practice and served the poor without pay for love, or for the sake of experience and kudos, in the wards and dispensaries of charitable voluntary, or in municipal hospitals. Of course a great many still do just that, but not all. The salaried teachers of clinical medicine first appeared in Boston when I was an intern in 1912, in the persons of David L. Edsall at the Massachusetts General Hospital and Henry A. Christian at the Peter Bent Brigham Hospital. You will forgive my speaking chiefly of Boston. I want to draw upon my personal experience, and it was in Boston that I have had most of it.

The evolution of the doctor-patient relationship, I fancy, has been of much the same pattern throughout the country. The most vivid thing I can remember about it in my early days, is that I cannot remember having heard much of anything about it. I never heard the term used until years afterward. Whatever our doctor-patient relationships were, they were largely unconscious. Nowadays it seems they are quite the opposite—they have actually become a problem. Of course in those early days we had such books as James Jackson's "Letters to a Young Physician" and Osler's "Aequanimitas" which touched upon such matters, but I don't think we students spent much time over them. We were more interested in diseases than in patients—so, seemingly, were our teachers.

Probably there were two quite different types of doctor-patient relationships in those days, and still are perhaps, but I hope to a diminishing degree. There was, on the one hand, the relationship which the doctor established with his private patients, and on the other, with his charity patients. Miles apart these were, as I observed them. The private relationship tended on the doctor's part to be a rather possessive one. To shift from one doctor to another was not always easy for the patient. Having chosen a doctor the patient was on the whole rather expected to stick by him. Certainly patients have no such feeling today—they go shopping about from doctor to doctor without a qualm, unless perchance an economic one.

We used to hear much in the private professional relationship of the famous bedside manner, in the words of the well known ballad, "the suave urbane physician." Such a manner if skilfully enacted might indeed increase a practice, yet intrinsically it had no merit. A consciously developed bedside manner, that is to say, one designed to impress

the patient with the doctor's authority and wisdom, has no place in good medical practice, but on the other hand, it is altogether desirable that doctors have good manners at the bedside, and in all their dealings with patients. As between a good bedside manner and good manners at the bedside, there is a world of difference.

The charity patients as met with in my intern days, so far as the attending physicians or surgeons were concerned, were regarded largely as teaching material. Their diseases were interesting, but not they themselves. It was to fill this gap in human relations in medicine that Dr. Richard C. Cabot introduced social workers into hospitals.

One of the most significant developments in the doctor-patient relationship since my intern days is the growing realization on the part of doctors, that body and mind are one, the gradual emergence of an understanding of the role of the patient's personality—his emotions—in the production of his illness, or conversely, of the destructive effect upon emotional integrity of the impact of serious crippling diseases such as deforming arthritis, or of life threatening diseases such as cancer or advancing arterial decay. The effort to, and the difficulty of, getting away from the terms "organic" and "functional" is evidence of what I mean. On ward rounds in my early days the neurotic was regarded as nothing to spend time over, whereas the patient with an interesting heart lesion might keep all hands entertained for an hour. The treatment of the heart lesion, however, was elementary, digitalis if the heart was incompetent, so-called eliminative treatment if the patient had a high degree of dropsy, whereas now we know well that the treatment of the neurotic patient is difficult and challenging. Moreover, the patient with the diseased heart has psychological problems as well as physiologic, and the doctor must treat them both, or better, treat him as a whole person.

Overstreet in his book, "The Mature Mind," says that "the characteristic knowledge of our century is psychological. Even the most dramatic advances in physics and chemistry are chiefly applications of known methods of research. But the attitude toward human nature and human experience that has come in our time is new." I believe that this is a correct statement, and that nowhere is it better exemplified than in the evolution of the doctor-patient relationship.

In 1934 my teacher, the late L. J. Henderson, made a good point about the doctor-patient relationship in a speech at the Harvard Medical

School. He likened a social system to a physicochemical system. Both are made up of heterogeneous components, the interactions of which determine the nature of the system as a whole. The components in the physicochemical system are molecules and ions; in the social system they are people of varied constitutions, reaction patterns, experience, and interests, which react upon one another in various ways. Henderson maintained further that a doctor and a patient constitute a social system. That each reacts upon the other through his behavior, and the expression of his sentiments. The physician's job is to understand his own behavior sufficiently so that it will act upon his patient beneficially, not injuriously. Before he can truly know his patient he must learn to know and understand himself. He must have insight as well as a benevolent motivation. In the matter of telling the truth to patients, Henderson took issue with Cabot on two scores, first, that sometimes what the doctor thinks is the truth, happens not to be so, and second, that it isn't what the doctor says that counts, but what the patient comprehends, and what it does to him. In the practice of medicine Henderson suggested a good principle is to do as little harm with words as possible.

In the attitudes of medical students, and particularly of interns and residents, I can see a steady improvement along these lines from the days of my own internship to the present time. The young medical people of today not only have vastly more scientific information available to them than had we, but in their doctor-patient relationships they have acquired an understanding of the meaning of illness to the patient and to his family, which was largely lacking when I began my professional work. They have come to know that in so-called organic disease the major problem in the care of the patient often lies in the realm of psychotherapy. They are the beneficiaries of a salutary evolution.

Besides the psychologic, the most important developments in the doctor-patient relationship since my intern days, are in the fields of the social and economic. Practitioners of medicine may be divided today between specialists and generalists, but the old style, largely self-sufficient general practitioner is gone except in sparsely settled regions. Even there he is on the way out, as rural health plans of one kind or another begin to take over. Modern medical care can only be provided by a multiplicity of skills, and a burning question has become, how can the physician's responsible relationship to his individual patient be retained under such circumstances?

At least two considerations are involved in the answer to this question, namely, how doctors are organized for care of patients, and as I indicated earlier, how doctors are paid for their work. I use the term "organization for care of the patient" advisedly. It has no relation to the term, "organized medicine" in its usual sense. The very complexity of modern medicine, the multiplicity of skills involved, the richness of the modern medical technology necessitates that the clinical approach to the case of every individual patient be organized in the sense that responsibility must be clearly placed, and the working of persons of separate skills be thoroughly coordinated. Otherwise there is chaos and the patient suffers in consequence.

All this amounts to saying that I believe that the time has come when patients must be cared for by teams or groups of doctors, not solely by individual doctors. Within a group, however, one individual doctor must be in command, or at least take the responsibility for integrating the effort. That such placing of responsibility within a group is quite possible, if there is the will to do it, has been thoroughly proved in experience. Every patient in a teaching hospital, and also in many others, is taken care of by a professional team. There is nothing to prevent office, dispensary or domiciliary care being given in the same manner. Indeed it is already being so given in many places and by a great variety of group organizations. The relation of doctors to patients in this aspect of the relationship is in process of active evolution.

One hears much nowadays, at least from doctors, about the "free choice of physician." So often is it used that perhaps it should be hyphenated. I have not, however, heard much about it from patients. It is evident that it is the doctors who are concerned about loss of free choice of physician, not the patients. Patients complain about several things, such as the high cost of medical care, the difficulty of getting a doctor—any doctor—to come to their domiciles at night, but they do not complain of having lost free-choice of physician.

Obviously there has been great social change since the beginning of the century—more people in cities—more old people—more people living alone—smaller and often broken families—more moving about. Under these circumstances the chance of any one physician being in charge of a patient year after year is much less than it formerly was. What patients want is to get physicians who are competent, who will see them promptly, and who will give their unhurried attention. Of

course they prefer, having found one they like, to stick by him as long as possible. There is always lost motion in changing physicians. The new one must be told the story all over again, and repeat various examinations which increase both the anxiety and the expense.

If a doctor takes a patient through an acute illness to recovery, it may not then be of great consequence if the patient goes to another doctor, if and when he has another illness. Continuity in the doctor-patient relationsihp is particularly desirable in chronic illness, particularly when that illness is shattering to the personality. In this field I am sure there is room for improvement in the doctor-patient relationship.

What the patient of today then chiefly wants to know, is how to find a good doctor, one who can give the kind of care I have indicated. Free choice of physician as an end in itself is unimportant. Rather than choose freely, having no valid criteria on which to base a choice, the patient would rather be told to whom to go by some reliable and disinterested authority.

Let us now consider the manner in which the doctor is paid for his services, and the bearing which this has upon the relationship which he develops with his patient. There are three current methods, fee-for-services, capitation, and salary. In our existing government medicine, e.g., Veterans Administration, armed forces, etc., all doctors are paid by salary. In the British National Health Service general practitioners are paid by capitation, so much per patient per year for all patients on their panel; specialists are paid by salary.

When doctors are paid by salary the salary may come, if not from government, then from practice groups of various types, employers, hospitals, labor unions, consumer sponsored cooperatives, or other prepayment health plans.

It has often been claimed that no third party, government or any other, should be allowed to come betwixt the doctor and his patient. Certainly I agree that insofar as the application of this principle is limited to the medical care of the patient by the doctor, it is absolutely correct. When, however, it is extended to include the manner in which the patient pays the doctor, then I am obliged to dissent. The patient is a proper problem for the doctor, but I am sure you will agree that never should a doctor allow himself to become a problem to his patient. Yet if on the fee-for-service basis a patient is concerned about how he will be able to pay the doctor, an economic, and hence emotionally

charged factor is introduced into the intimate doctor-patient relationship, which cannot but diminish the objectivity which should prevail, and which may even be highly disruptive.

The fee-for-service method, in my opinion, has about reached the end of its usefulness, and will become supplanted gradually, through the extension of any of the several possible comprehensive prepayment plans. Nor do I regard as an adequate solution the compromise method, now in increasing vogue, in which the patient prepays for medical care, but the doctor is paid by fee-for-service, for example Blue Shield. I firmly believe that the best arrangement is that in which the patient prepays for complete medical and hospital care and the doctor is paid by salary. If he is genuinely interested in medicine, and he should not be in the profession if he is not, he will do as good or better work when paid by salary, provided some safeguards are taken against his becoming overloaded, as he will on a fee-for-service basis. In the last analysis, however, I submit that the best medical practice situation will be that one in which both patient and doctor are satisfied with the arrangements. When there are differences between them they should be resolved by concessions on the part of the doctor. The patient's best interest should come first. If patients want comprehensive prepaid care, doctors should go along with it. The argument that it is not possible to give as good care under such circumstances, I for one, do not believe to be true.

The evolution of the doctor-patient relationship, as I have experienced it in the forty years since I first began caring for patients, has been in the realms of the psychologic, the sociologic, and the economic. It will continue in such ways, I believe, until every person has access to medical care of the highest quality which existing medical knowledge affords, and when he can obtain it in a manner which itself imposes no hardship upon him. I hope we shall have the genius to achieve this end by voluntary effort, but we cannot do so unless we are willing to break new trails.