Reviewing doctor- patient relationship: Where sociology meets medicine

S. Liyanagunawardena
University of Sri Jayewardenepura, Sri Lanka

Supuni@sjp.ac.lk

Abstract

The doctor-patient relationship forms the crux of the medical encounter and is linked to many positive patient-related outcomes. It has inspired much research interest- particularly in the western world- so much so that it has become a major research area under medical sociology. This paper attempts to review the literature on doctor-patient relationship by examining it under three broad, inter-related themes: a) power, b) communication and c) social and cultural dimensions.

In terms of power dynamics, literature often indicates the doctor-patient relationship as asymmetrical. Traditionally, the doctor is depicted as authoritative, and the patient submissive and passive. However, the current ideal is a patient-centred model, where the patient's voice is given due recognition. This attempt at redistributing power has led to a proliferation of research on patient expectations, empowerment and participation. Studies on a communicative theme focus on this relationship as a process towards achieving medical communication, which many have depicted as defective. Social and cultural dimensions may also affect the relationship, as the social gradient between the doctor and the patient may impede effective communication.

A majority of the global literature on doctor-patient relationship being based on a few countries, the overall picture that emerges from a literature review such as this would approximate the conditions in developed western countries, and hence not a fair representation of the scenario in, for instance, a developing country in Asia. Further research in such contexts is therefore required for a more accurate understanding of the phenomenon and its implications.

Key words: doctor- patient relationship, literature review, power dynamics, communication, social background

Introduction

The doctor-patient relationship is at the heart of the medical encounter, and forms the base for the therapeutic alliance between the two parties. Research demonstrates that a good relationship with the doctor may lead to positive outcomes in terms of increased patient satisfaction, greater compliance with the treatment and greater perceived improvement in patients' health (Garrity, 1981; Stewart, 1995; Williams, Weinman & Dale, 1998); hence the vital importance of a sound doctor- patient relationship towards the success of the medical encounter. Though it essentially comes under the purview of medicine, being an extremely complex human relationship, it has been of much scholarly interest to sociologists. This is evident from the burgeoning sociological literature on the theme, which is generally classified under the subfield known as *sociology of medicine*, *medical sociology* or *sociology of illness and health*.

The present study is an attempt to collate the theoretical and empirical research literature on doctor- patient relationship into a comprehensive review. For this purpose, the literature will be examined under three broad, inter-related themes: power, communication, and social and cultural dimensions.

Power dynamics: the mighty doctor

In analyzing the doctor- patient relationship, many scholars have presented it as an asymmetrical relationship with the doctor in the position of power. As Zaner (2000) points out, it is the doctor who is equipped with specialized knowledge and the power to cure (or exploit) the patient, due to which the very idea of seeking medical help is viewed as being powerless and vulnerable to medical authority. A post-structuralist perspective based on the seminal work of Michel Foucault (1973) focuses on the patient as a passive body subjected to the authority of the "medical gaze". The medical gaze (or medical perception) is structured along the biomedical model, which follows a naturalist epistemology (Gordon, 1988). It is therefore critiqued for the reductionist view of all illness as pathological; emphasizing on the physical (i.e. The diseased body) while ignoring the social aspects of illness (Gordon, 1988). The focus on a materialist diagnosis may deprive the patient of the opportunity of voicing his/her concerns. Armstrong (1983)

argues this to be a denial of the personhood of the patient, so much so that s/he is reduced into merely "a passive object in which was contained interesting pathology" (p102).

In Parsons' (1951) conceptualization, the 'sick role' is a type of social deviance enacted by the patient, and the role of social control (in terms of legitimizing the sick role) is ascribed to the doctor. There is a vast body of literature that extends this social control function of medicine into a 'medicalisation' of society, indicative of defining and treating non-medical issues as medical (Conrad, 1992). It has been viewed as a (more or less oppressive) power wielded by the medical profession over the entire society. Among the prominent critics of medicalisation, Zola (1975) demonstrates how medicine is gradually displacing law and religion from their social control functions, through defining many social deviances as 'illness'. Similarly, Illich (1975) accuses medicine for giving rise to iatrogenic illnesses, and in brief, for causing more harm than good. Marxists criticize medicine for reproducing the macro level social structures of oppression within the 'micropolitics' of doctor- patient relationship (Waitzkin, 1979).

The patient as expert and empowered

The literature that presents a victimized image of patients often considers them to be devoid of expert knowledge and power to act. A counter argument is that the patients have subjectively experienced and lived with the illness, thus making them 'experts by experience' (McLaughlin, 2009). This view is supported by the social constructionist perspective, according to which any illness condition contains a social dimension and is more or less socially constructed (Conrad & Barker, 2010). In addition, under the influence of consumerism, the doctor-patient relationship is reportedly become more of a consumer-provider relationship, with the focus upon serving the consumer/patient (Fochsen, Deshpande & Thorson, 2006). At present, *patient-centred care* is widely hailed as the ideal for medical care. A report by Institute of Medicine (IOM) in 2001 has defined patient-centred care as "care that is respectful of and responsive to individual patient preferences, needs, and values" and in which "patient values guide all clinical decisions" (Barry & Edgman-Levitan, 2012, p780). A similar policy initiative in the UK promotes 'expert patients', by encouraging the people's active participation in managing their own health (Wilson, 2001).

In view of patient participation and empowerment, technology plays a significant role. Patients who wish to play an active role in the medical encounter are reportedly becoming 'Internet-informed patients': they study medical information available on the World Wide Web

(Glick, 2013; Kivits, 2014), join support groups and forums online (Fox et al, 2005; Oh & Lee, 2012); and adopt digital technologies for self-monitoring and self-care (Lupton, 2013). Such involvement with technology can be viewed as a means of challenging the doctor's traditional dominance in the medical encounter. There is also evidence for benefits of 'e-health' engagement in terms of patient education, promoting efficiency and sharing responsibility and collaborative decision making; but on the other hand, it could lead to serious patient misinformation (Kivits, 2014). Besides, doctors may perceive patients' e-health engagements as a challenge to their medical expertise (Chandwani & Kulkarni, 2016).

However, research shows that patient participation in the medical consultation to be variable across a continuum. As indicated above, certain patients may wish to be fully involved in matters related to their own health. Some may wish for a certain degree of involvement: Mudiyanse et al (2015) indicate that a majority of the patient participants in their Sri Lankan study want their concerns to be taken into account, though they prefer their doctor to make the final decision. Others may wish to remain passive: Chiu et al (2015) identify that elderly patients prefer a paternalistic approach in which the doctor takes complete charge. Such preferences are depicted as often contingent upon individual and situational factors (Politi et al, 2013). Social and cultural context is also vital in determining patients' degree of participation in the medical encounter, as elaborated further along in this paper.

The notions of patient empowerment discussed above, however, are not without critique. Lupton (1997) points out that patients may oscillate between behaviours of 'active consumer' and 'dependent patient', which cannot be captured through a consumerist model of doctor- patient relationship. Wilson (2001) critiques the 'expert patient' policy initiative as a subtle invasion of the patients' privacy by the state medical authorities, providing them with greater power and access to all aspects of the patients' lives. The patient empowerment role of technology – particularly online support groups – has been problematized by Fox et al (2005), who argue that it may also propagate the biomedical perspectives on illness, thereby further constraining the patients and perpetuating the hold of medical power over them.

Communication

Literature focusing on communicative aspects of the doctor- patient relationship abounds. Ong et al (1995) identify three purposes of communication between a doctor and a patient, namely,

creating a good interpersonal relationship, exchanging information and making medical decisions. Benefits of good communication include accurate diagnoses and effective medical decision making, as well as patient health outcomes such as better emotional health, symptom resolution, improved physiological functioning (e.g. blood sugar and blood pressure levels) and pain control, and therefore, greater mutual satisfaction (Matusitz & Spear, 2014; Stewart, 1995).

Research into patients' perspective indicates that they wish for sound communication with the doctor. This is said to involve a shared understanding of information, confidentiality, approachability and trust (Abeysinghe, 2008; Matusitz & Spear, 2014; Russell, 2005). In terms of good communication, patients have certain expectations from their doctor: 'social niceties' (such as smiling, greeting, offering a seat etc), social talk, attentive listening, 'back channelling', using simple language, granting privacy, allowing adequate time for the consultation, non-verbal cues such as tone of voice, eye contact and facial expressions (Little et al, 2015; Mazzi et al, 2016; Marcinowicz et al, 2010; Mudiyanse et al, 2015; Sebastian et al, 2016). In addition, they expect the doctor to take the patient seriously, treat the patient as a whole-person and to be empathetic (Mazzi et al, 2016; Mudiyanse et al, 2015).

Such being the patient expectations from the doctor- patient relationship, are they actually being met? Many studies point to the contrary. Doctors have been reported to follow certain practices and behaviours which hinder- and may even sabotage- the medical communication process. For instance, studies show that doctors ask 94% of all the questions being exchanged, thus monopolizing the content and direction of the consultation (Wang, 2006); they hardly listen to patient narratives and cause frequent interruptions (Rhoades et al, 2001; West, 1984); they issue 'directives' (i.e. orders) which the patient is supposed to comply with (West, 1990); they may withhold information from patients through avoiding direct questions and deliberate use of medical jargon (Phillips, 1996). Even where doctors may practice all socially appropriate courtesies and put their medical knowledge to the best use, they may ignore the need to address the patients' anxiety, doubts and other existential concerns (Agledahl et al, 2011). Consequently, many patient 'agendas' (such as anxieties, side effects of medication and social concerns) could be left unexplored at the medical consultation (Barry et al, 2000). Time constraints are a further barrier: with the average duration of a medical consultation being rather low – from 11 minutes in USA (Rhoades et al, 2001) to approximately 3 minutes in China and Sri Lanka (Rannan-eliya et al,

2015; Xu, 2013) – it is hardly likely that the patients get sufficient time to voice their concerns at all.

The communication gap in the doctor- patient relationship is largely attributed to the influence of the biomedical approach in medicine. Doctors have been shown to reject any health-related belief that lies outside the biomedical system as 'misconceptions' (Fochsen et al, 2006). Their belief in "a single, underlying, universalizable truth, a unitary paradigm" is said to be characteristic of western biomedicine (Kleinman, 1997, p27). According to the biomedical model, communication should be focused on making a correct diagnosis, and therefore doctors are trained to "take charge of interviews and to avoid getting 'sidetracked' by patients' 'irrelevant' concerns" (Weston, 2001, p 438). To achieve this level of 'objectivity', they are *taught* to be impersonal and socially-'neutralized' in their behaviour towards patients (Beagan, 2000), leading to perceived doctor behaviours of being aloof, detached and unempathetic.

Social and cultural dimensions

Literature demonstrates the medical encounter to be rife with social implications. Verlinde et al (2012), in their systematic review, demonstrate the importance of socioeconomic status and the educational level in this regard. Accordingly, when the patient is less affluent and less educated, he/she is generally less communicative, less expressive, less assertive, asks fewer questions and participates less in the medical encounter; whereas the doctor too generally adopts a less explanatory and less participatory approach with such patients than s/he does with others (Verlinde et al, 2012). These findings are confirmed in an Indian study by Mehra (2014), where patients from low socioeconomic background were satisfied with their doctors' directive communication style that did not permit them much opportunity of participation; whereas their more affluent counterparts preferred their doctors to employ a more relational style.

In terms of race and ethnicity, Schouten and Meeuwesen's (2006) systematic survey of literature from 1974 to 2004 shows that there is less rapport between a doctor -patient dyad that is racially heterogeneous. Ethnic minority patients are reported to be less verbally expressive and less assertive in the medical interview than the White, whereas the doctors too are often less 'affective' towards the non-White (Schouten & Meeuwesen, 2006). Paternotte et al (2014) identify challenges to intercultural communication in terms of language differences, cultural perceptions of illness, social norms in communicating and doctors' prejudices and assumptions about racially

varied patients. On the other hand, Paul Emile (2012) depicts that the patients often prefer to be treated by physicians from a cultural background similar to theirs; and that accommodation of such wishes appears to offer considerable health benefits to the patient.

Research into gender effects in the doctor- patient relationship has identified distinct patterns of communication that distinguish male and female doctors. Female doctors are said to be more patient-centred, and engage and converse more with the patients, while providing more preventive services and psychosocial counselling (Bertakis, 2009; Roter, Hall & Aoki, 2002). Some studies report female doctors' consultations to be longer in duration (e.g. Meeuwesen et al, 1991). They interrupt patient narratives less often than their male counterparts do (Rhoades et al, 2001; West, 1984), and use a less authoritarian and more collaborative manner in giving directives (West, 1990; Meeuwesen et al, 1991). They presumably exert less authority as well, since West (1984; 1990) shows that patients tend to interrupt female doctors and even question their expertise more often than they do with the male. In addition, Tsugawa et al (2016) demonstrate the crucial clinical implications of such gendered differences in the practice patterns of doctors, since there was lower mortality and readmissions among the elderly patients treated by female doctors when compared to those treated by males.

Patient's gender is also significant in terms of its impact on the doctor- patient relationship. Several studies show this to be of material importance in selecting a doctor to consult- as both males and females prefer a doctor of the same gender as they are (Copeland et al, 2003; Himmelstein & Sanchez, 2015). This could be with good reason, for Sandhu et al (2009)'s review indicates that it is the same-gender doctor-patient dyads that are characterized by the highest degree of ease, with the female doctor- female patient consultations reported as the most patient-centric. Gender stereotypes could bias the doctor's attitude towards the patient, as depicted in Fochsen et al (2006)'s study in India.

Culture

Literature depicts the cultural setting of a doctor-patient relationship to be a potent determiner of its nature. A number of studies argue that the *dyadic* doctor- patient interaction commonly found in western literature is hardly applicable to the more collectivist cultures in Asia, where the medical encounter normally involves the doctor, the patient as well as the patient's family (Ishikawa & Yamazaki, 2005; Aslam et al, 2005). In fact, Aslam et al (2005) point out that

in a context such as in Pakistan, where medical expenses are borne by the family, decisions are taken by the collective, and religious concerns overrule the individual, the patient him/herself is often dwarfed in significance within the medical encounter.

The concept of *power distance* – described as the extent to which the less powerful persons accept the power inequalities in their society (Meeuwesen et al, 2009) – has been used to explore the cultural variations in the doctor- patient relationship. For instance, the vivid differences between doctors' attitudes in the USA and Philippines have been attributed to the contrasting power distance scores for the two countries (i.e. -92 for USA and 162 for Philippines) (Lawton et al, 2015). In Europe, the countries with a high power distance are reported as having shorter and more to-the-point medical consultations (Meeuwesen et al, 2009). Research from Asian countries such as Sri Lanka (Sachs, 1989) and India (Chandwani & Kulkarni, 2016; Mehra, 2014) mention the high power distance in the said cultures as a determinant of the distant relationship between the doctor and patient; whereas in Indonesia, it is linked to the patients' hesitation in expressing themselves during the medical interview (Claramita et al, 2013).

Patients' expectations from the doctor- patient relationship could also be strongly influenced by cultural settings, as pointed out by Sachs (1989). At a rural peripheral medical centre in Sri Lanka, she observed a drastic conflict between the patients' illness perceptions that were founded on Ayurvedic beliefs and the doctors' biomedical approach. Further, the medical encounter involved hardly any physical examination, little (if any) touch or eye contact, and few words, with the patient being prescribed an assortment of drugs. However, the patients were satisfied with this type of interaction, because they only look to the doctor as a technician with the skill to cure, having no expectation of cordiality (Sachs, 1989). This view strongly contends with the supposed universality of the western model of doctor- patient relationship, calling for a more culture-sensitive approach.

Discussion

In this paper, the contemporary literature on doctor-patient relationship was explored along the three themes of power, communication, and social and cultural aspects. In terms of power, the functionalist, Marxist and post-structuralist conceptualizations present the doctor as the powerful figure who subjugates the patient (and even the society in general) through medical expertise and the power associated with it (Foucault, 1976; Illich, 1975; Parsons, 1951; Waitzkin, 1979; Zola,

1975). On the other hand is a social constructionist counter-argument that postulates the patient as an 'expert' (mclaughlin, 2009). Further, the current trend is towards patient-centred care, where the patient is being looked upon as a whole person (Souliotis, 2016). Advocating patient's active participation in the medical encounter as well as in medical decision making should ideally subvert the traditional doctor-centred and paternalistic power structure of the doctor-patient relationship. However, such notions of patient empowerment are also being critiqued as a veiled perpetuation of medical dominance, leading to further subjugation of the patient (Fox et al, 2005; Wilson, 2001).

The theme of communication chiefly highlights the communication gaps in the relationship. It is evident that the biomedical approach followed by doctors is at odds with the patients' expectations of good communication, and that doctors' communication behaviours are often not adapted to the patients' needs (Phillips, 1996; Rhoades et al, 2001; West 1984; 1990; Weston, 2000). However, the patients themselves may not contribute equally to the communication process, due to individual, situational or cultural factors (Chiu et al, 2015; Politi et al, 2013; Mudiyanse et al, 2015). Literature on social and cultural dimensions of the doctor-patient relationship, the third theme explored in the present review, serves to clarify the implications of social class, race, ethnicity, education, gender and cultural background and how these factors influence and shape the relationship between the doctor and the patient (Meeuwesen et al, 2009; Sachs, 1989; Schouten & Meeuwesen, 2006; Verlinde et al, 2012; West, 1984).

On the whole, with the theoretical and empirical literature on doctor- patient relationship presenting the medical encounter as predominantly doctor-centred, the prominent model that emerges from the review is one of medical dominance and paternalism. However this review also highlights certain factors that challenge this power equation. One such factor is gender: where the doctor is female, there is greater patient centrism and patient empowerment (West, 1984; 1990). Another is the socioeconomic, educational, racial and ethnic backgrounds of the patient. Where the patient is affluent and well-educated, and belongs to the same race/ ethnicity as the doctor, he/she is more assertive and the medical consultation is more participatory (Schouten & Meeuwesen, 2006; Verlinde et al, 2012). A third factor is the patient's desire for active participation and demonstration of expert behaviours at the medical encounter (Glick, 2013; Chandwani & Kulkarni, 2016).

An important observation to be made through this review is the lacuna of literature from non-western countries. The doctor- patient relationship has been well documented in western countries such as the USA and the UK: but the gulf between national cultures raises serious doubt regarding the global applicability of such findings (Lawton et al, 2015; Sachs, 1989). A review of the nature that I have undertaken may suffer from the unequal representation of the global scene in the available literature, due to which the overall image of the doctor-patient relationship presented here could be distorted by being overly representative of the developed countries in the West.

Conclusions

This review has provided an overview of the doctor- patient relationship as depicted in theoretical and empirical literature. Through an exploration of the themes of power, communication and social dimensions, it delineates the doctor- patient relationship as more or less doctor-dominated, though with certain possibilities for subversion of the power structure. This is pivotal towards identifying it as a dynamic relationship, and research into such possibilities are needed to understand how to shape it in a manner that is more mutually beneficial. In addition, future research should be directed to investigating doctor- patient relationship in hitherto neglected social and cultural contexts in order to facilitate a more accurate understanding of the phenomenon and its implications at the global level.

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