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The Doctor–Patient Relationship

1. "A pint of blood was extracted from his right arm, and a half-pint from his left shoulder, followed by an emetic, two physics, and an enema comprising fifteen substances; the royal head was then shaved and a blister raised; then a sneezing powder, more emetics, and bleeding, soothing potions, a plaster of pitch and pigeon dung on his feet, potions containing ten different substances, chiefly herbs, finally forty drops of extract of human skull, and the application of bezoar stone; after which his majesty died."

The foregoing is a description of a heroic treatment of King Charles II (Van Dyke, 1947).*

2. A 35-year-old woman suddenly developed a toxic megacolon and was admitted to the hospital on an emergency basis. She is known to have ulcerative colitis, which has been under control until now. Her physician had left the country on vacation two days prior to this acute exacerbation.

The history of medical therapeutics until about 100–150 years ago is largely that of the doctor–patient relationship and the "placebo effect." Most ministrations by physicians would have been more harmful than beneficial to the patient, but for the natural recuperative powers of the human organism supported by the beneficial effects of the doctor–patient relationship. Four of the most famous medications used by physicians until about the 18th century were unicorn's horn, used to detect and protect against poisons in wines; bezoar stones, as antidotes for all kinds of poisons; theriac, as a universal antidote; and powdered Egyptian mummy, as a universal remedy, including wound healing (Shapiro, 1960). The unicorn's horn usually came from the ivory of the narwhal or elephant, according to Shapiro. Doctors were dangerous to patients!

*As quoted by Shapiro (1960). Reprinted with permission.

What is surprising, however, is that despite such noxious treatments, many patients in fact got better or even recovered completely.

The benefits of the placebo effect are psychologically determined by *expectations* and *hopes* shared by the patient and the doctor. Action, ritual, faith, and enthusiasm are important ingredients (Findley, 1953). The physiological mechanism and the pathways by which these effects are mediated are largely unknown, but at least one has been clarified in recent experiments (Levine *et al.*, 1978) that have demonstrated the physiological mechanism underlying one important type of placebo effect, that is, relief of *dental* pain by injection of a pharmacologically inactive (placebo) solution. Patients with dental pain who responded to placebo injection (placebo responders) and a matched sample of control patients with dental pain who did not (placebo nonresponders) were given placebo injections plus naloxone, a drug that blocks opiate-receptor sites in the brain. Naloxone blocked the pain relief in the placebo responders, but had no effect on the pain in control patients. These findings strongly suggest that placebo responders experience relief from pain by secreting endorphins, which are known to relieve pain by activating opiate receptor sites (see Chapter 9). Hypnotic relief of pain, on the other hand, does not work by this mechanism—it is *not* blocked by naloxone (Goldstein, 1976).

Balint (1964) calls the doctor "the most frequently prescribed drug." In this context, the doctor–patient relationship exerts major therapeutic influence. Sometimes this may be dramatically demonstrated when a patient, suddenly realizing that his trusted physician is not available, has an acute exacerbation of disease. This is especially true when the physician "covering" for the absent doctor is new to the patient and does not have an ongoing relationship with the patient (vignette 2).

The doctor–patient relationship involves, in addition to expectation of help, some specific therapeutic elements. *First,* an ongoing supportive relationship with a respected and competent professional may serve as a buffer against excessive anxiety and strain for the patient as he attempts to cope with illness. *Second,* as we will see in Chapter 20, many of the physician's activities (as in taking the medical and personal history and in performing the physical examination) may in themselves have intrinsic psychotherapeutic effects and serve to consolidate the supportive, trusting aspects of the relationship. *Third,* by providing the patient with an opportunity to share life problems, the physician may relieve the sense of helplessness and hopelessness that goes with feeling alone in the face of vexing, threatening, and sometimes overwhelming conflictual situations and feelings. *Fourth,* the physician as an objective observer may serve as a source of information (education) and counseling that

help the patient to cope with his problems. *Fifth,* we know that the patient brings to the relationship with the doctor preexisting unconscious feelings, attitudes, and expectations. The latter are reactivated feelings, attitudes, and expectations that the patient originally experienced as a child toward caretaking adults, most often parents and older members of the nuclear family, and often, too, the family physician or pediatrician who cared for the patient in childhood. The reexperiencing of these reactivated inner (memory) feelings, attitudes, and expectations *as current responses belonging to the physician* is called *transference.* The phenomenon of transference may exert a powerful influence on the patient's mental and emotional state, and the concomitant physiological events may then influence pathophysiological processes (Zinn, 1990) (see Chapter 4). A "positive" (i.e., trusting, loving, respectful) transference component in the doctor–patient relationship may help to modulate stress responses, induce relaxation, and permit recuperative forces to take hold, and so serve to augment beneficial effects of medications and other therapeutic measures. These phenomena will be further discussed in Chapter 20.

Of course, the physician also brings unconscious attitudes, feelings, and expectations to the relationship and should be alert to elements in his own makeup that may intrude into his relationship with particular patients.

Obviously, a good ongoing doctor–patient relationship makes it easier for the physician to recognize heterothetic help-seeking behavior and to deal with it appropriately. And the physician who knows his patient and family and takes the opportunity to stay abreast of these aspects of the patient's life on the occasion of regular physical checkups or on other occasions will be optimally situated to help his patient when trouble of any sort develops. In a good doctor–patient relationship, the patient feels that the physician will be available to answer questions, listen to life problems, and provide helpful information and counsel. Reentering a trusting relationship with the physician may re-create the physiological and psychological states associated with comfort and healing (Adler and Hammet, 1973).

Clarification and education are important aspects of the modern doctor–patient relationship. Participation in a shared belief system, by rendering anxiety-producing symptoms comprehensible, may in itself exert beneficial effects through reduction of anxiety and associated physiological processes. In the past and in other cultures, symbolic manipulation as practiced by shamans in rituals has been shown to be effective in healing certain medical conditions (Levi-Strauss, 1963). Clarification and education allow the patient to understand and share the assumptions on which the physician bases his treatment plan. To achieve this, the

physician must first understand the patient's ideas and concepts about the illness and how it may be managed. Kleinman *et al.* (1978) suggest the following line of inquiry to elicit the patient's ideas about the illness:

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused you?
8. What do you fear most about your sickness?

Once the patient's model is understood, the doctor is in a position to discuss with the patient the *discrepancies* in their respective models and to share his own understanding of the illness. Some *compromise* may be necessary if elements of the patient's model, although medically incorrect, have such preemptive importance for the patient that he cannot give them up, for example, in the case of the "sick Tarzan" (Chapter 16), the idea of "moving blood" as being so important in treatment.

The educational activities of the physician need not and should not be confined just to the illness at hand, but should include education concerning prevention of disease and hygienic principles of living and should be ongoing in nature.

The modern doctor–patient relationship is rooted in magic and primitive superstitions (e.g., of the shaman), and it exploits placebo phenomena when and as appropriate. It has developed into *much more than that, however,* and more, too, than simply the "art of medicine" as practiced by intuitive, empathic, and humane physicians. It now also includes implicit psychotherapeutic elements and explicit specific technical procedures that can be understood as applications of basic principles of human behavior and of mental phenomena to the practice of medicine. Properly managed, its effects can articulate synergistically with those of other therapeutic procedures, such as use of drugs and corrective surgery. The patient's expectation that the doctor will help is based, then, not only on magical beliefs but also on the scientific principles of modern medical biology and behavioral science (see Chapter 20).

Open and comfortable communication between the patient and the doctor is essential for this synergistic linkage to occur. In its absence, patients may fail to comply with the doctor's prescriptions, otherwise effective medications may turn out to be less than optimally effective, and valid surgical procedures may have unexpected adverse side effects

because of the patient's anxiety and mistrust. Conversely, some patients may fall victim to scientifically unsound treatment methods (e.g., laetrile) administered by the equivalent of modern-day shamans rather than seek help from a competent physician.

SUMMARY

Despite ineffective and often harmful methods, prescientific medicine was often effective, probably because of the effects of placebo phenomena and nonspecific supportive aspects of the doctor–patient relationship.

Current understanding of the doctor–patient relationship regards it as rooted in shamanistic magic and placebo effects, but specific psychotherapeutic elements are now included that link it effectively and understandably to the effects of conventional medical procedures. An ongoing, open channel of communication between the physician and the patient is essential for an effective doctor–patient relationship to develop. In addition, the physician must understand the patient's own ideas and models of illness and educate the patient so that he and the patient can ultimately share common belief systems and common goals for the treatment.

IMPLICATIONS

For the Patient

The patient's ideas about illness and the pattern of his participation in the doctor–patient relationship are based on his past experiences and cultural expectations. *Discrepancy* between the patient's and the doctor's models of illness may interfere with development of an optimal doctor–patient relationship because a shared belief system—an important ingredient of a good doctor–patient relationship—does not exist. A patient's *lack of compliance or cooperation* with the medical regimen may be a sign of a poor doctor–patient relationship or deterioration of a previously good one.

For the Physician

An understanding of the patient's ideas and models about illness and health care is essential for an optimal doctor–patient relationship.

Specific questions are necessary to elicit this information. The patient's cultural background and his family's attitude toward illness are important data in this regard. The physician may judiciously utilize the powerful doctor–patient relationship as a *therapeutic tool* and should pay attention to it in his work with patients.

For the Community and the Health-Care System

Education of the general public concerning illness and health care is important, since shared expectations play an important role in fostering good doctor–patient relationships. Medical education should inform students about the therapeutic significance and use of the doctor–patient relationship in addition to the technical aspects of treatment in the practice of scientific and effective medicine.

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RECOMMENDED READING

Balint M: *The Doctor, His Patient, and the Illness.* New York, International Universities Press, 1964. This is a classic, describing the discussions between Dr. Balint, a psychoanalytically oriented psychiatrist, and a number of general practitioners in England about their patients. A good discussion on the relationship between the doctor and the patient and also on psychological understanding of patients. Has interesting vignettes and case histories.

Kleinman A, Eisenberg L, Good B: Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 88:251–258, 1978. A good discussion on the cultural patterning of sickness and care, with emphasis on understanding the patient's models concerning illness.

Levi-Strauss C: *Structural Anthropology.* New York, Basic Books, 1963. A classic. Contains very interesting and vivid descriptions of symbolic manipulation of shamans. Fascinating reading.

Quill TE: Recognizing and adjusting to barriers in doctor–patient communication. *Ann Intern Med* 111:51–57, 1989. A nice article that describes the nature and signs of explicit and implicit barriers in doctor–patient communication and suggests the means of dealing with them.