The Doctor/Patient Relationship for the 21st Century

Clash of ‘cultural creatives’ and ‘traditionals’ helps focus the future of patient care

By Kent Bottles, MD

The triumph of bioethicists over medical paternalists has not made for happier participants in the therapeutic relationship. Patients miss the trust and warmth found in the personal bond with a caring, competent physician. Many aren’t sure their new status as consumers with legal rights is worth the cost.

While only too happy to shift as much responsibility as possible to demanding, empowered patients, disgruntled physicians miss the “greatest satisfaction of the practice of medicine (that personal bond).”

Bioethicists are hurting, too. Physicians and ungrateful patients do not sufficiently appreciate or even use the powerful tools that protect and define patients’ rights such as informed consent, advance directives, and the constitutional right to make one’s own medical decisions.

Since few are entirely satisfied with the current state of affairs, it makes sense to reexamine the doctor/patient relationship.

A ‘broader’ definition of health

Health care’s unhappy participants do not fight with one another in a vacuum. The world of 2001 is quite different from the world of 1927, when Francis Peabody wrote his often quoted article, “The Care of the Patient,” about the personal bond between caregiver and patient.

Or, as Carl Schneider paraphrased from a famous Cardozo quote, “The great tides and currents which engulf the rest of man, do not turn aside in their course and pass the doctors by.”

The global economy, information technology and genomics revolution are major factors that impact how the graying, more ethnically diverse patients of America will interact with their physicians in the coming years.

And some of these patients are demanding a broader definition of health than the one their doctors were taught in medical school.

Although most never even think about it, mainstream physicians operate under technical rationality as their epistemology of practice. This approach reverses systemic, preferably scientific, knowledge.

The clinical practice of medicine is regarded as the instrumental problem solving method, based on double blinded prospective studies.

Sparks can fly when a physician trained in this dogma opens the exam room door to encounter a “cultural creative” patient.

Armed with downloads from health related Web sites and advice gleaned from online chats with fellow
patients who have the same disease, the patient quotes Jean Houston to the bewildered clinician.

“The world is too complex for linear thinking now. To be smart in the global village means thinking with your stomach, thinking rhythmically, thinking organically, thinking in terms of yourself as an interwoven piece of nature.”

The number of cultural creative thinkers isn’t small. Sociologists Paul Ray and Sherry Ruth Anderson claim nearly one quarter (26 percent) of the American adult population—about 50 million people—are cultural creatives.

Ken Wilber’s A Theory of Everything offers a starting point for a broader definition of health that begins to satisfy both traditionalists and cultural creatives.

Western medicine has concentrated on the physical organism and relied upon physical therapies such as surgery and drugs. Health has been defined as “absence of disease” and this definition does not provide a framework for doing much except diagnosing and attempting to cure disease.

This approach ignores other goals that some patients are demanding:

- Restoring functional capacity
- Relieving suffering
- Preventing illness
- Caring for those who cannot be cured

A growing body of medical literature supports the notion that the patient’s interior states—emotions, attitude, imagery and intentions—play a role in both the cause and progression of physical illness.

The 629 million visits to alternative medical providers—a number greater than the total visits to primary care physicians—made by Americans in 1997 indicate that many patients are not willing to wait for the conclusive mind/body prospective study before seeking such care.

A broad definition of health would also include factors such as economics, insurance, social delivery systems and environmental pollution that are rarely under the control of the individual physician or patient.

Dr. Rachel Remen, a physician and Crohn’s disease patient who is medical director of the Commonwealth Cancer Help Program, does not
define health as the manipulation of the body, nor even the mind and emotions, to improve function.

Rather she would identify the real questions of health as not about the mechanisms of healing, but as about what gives meaning and purpose to our lives.\(^7\)

**The death of paternalism**

According to influential bioethicist Arthur Caplan, “The Freddy Kruger of bioethics for the better part of two decades has been the doctor who pushes his or her values onto the patient... This devil has been completely exercised and a large part of contemporary bioethics scholarship seems to be devoted to the task of assuring that the paternalistic doctor stays dead and buried.”\(^1\)

The bioethicists fought to give patients the ability to:
- Get information about their disease.
- Understand and rationally analyze all of these data.
- Apply their well-developed personal beliefs to this input.
- Make a medical decision for themselves.\(^2\)

“We must render a patient’s shifting of responsibility to the physician unacceptable, and we must insist that patients take primary responsibility for making decisions related to their health care.”\(^3\)

This triumph of the patients as captains of their own medical ships was a mutiny against the previous skipper—the paternalistic physician. He was accused of being “taken over by the guild concerns of medicine and... fighting against a future that threatens the traditional autonomy, status, and income of the profession.”\(^4\)

Ivan Illich derided them as gangsters. “Gangsters, for their own profit, corner a basic necessity by controlling supplies. Educators and doctors and social workers today... gain legal power to create the need that, by law, they alone will be allowed to serve.”\(^5\)

Jay Katz in the 1984 book The Silent World of Doctors and Patients argued that patients should decide between competing treatments, because they alone can evaluate and weigh the personal issues involved in making such an important choice.\(^6\)

Studies show that:
- “Patient activation” determines patient satisfaction.\(^7\)
- Mutually respectful behavior by both parties in the therapeutic relationship is the key ingredient for healing.\(^8\)

The largely unproven theory is that patient control leads to decreased stress; decreased stress leads to healthy immune systems; and healthy immune systems prevent disease.

The patient is also seen as having a moral duty to make his own medical decisions. He should not burden others, because no one else is ultimately responsible for him.\(^2\)

“The primary duty is to the self, and the primary job in life is development of this self.”\(^9\) Such an approach fits nicely into the parts of the American culture (traditional and modern) that prize independence and the individual over the community.

The irony of the complete victory of informed consent, advance directives and the constitutional right to make one’s own decisions is that few patients seem to care.\(^2\)

The measured effects of the Patient Self-Determination Act have been described as “small.”\(^10\) Systematic studies about the reality of informed consent in the real medical world “strongly suggest that refusals attributed to disclosures are rarely, if ever, seen.”\(^2\)

It is as if many patients did not absorb the central message of the film “Field of Dreams.” The bioethicists built an impressive structure, but few have come to use it.

**Bioethics and the real world**

Physicians sensitive to the paternalism charges always thought the world described by the bioethicist had little in common with the messy, ambiguous, confusing and time-pressured world of real-life people with real diseases.

Carl Schneider in The Practice of Autonomy analyzed in detail why some patients might not want to make their own medical decisions.\(^2\)

Schneider points out that few people approach any decisions in real life the way advocated by the bioethicists. Instead of gathering all the relevant information about their diseases, some people are like the MS patient who found the subject of his illness “altogether boring.”\(^2\)

Patients’ personal beliefs sometimes aren’t well developed or change during a medical crisis. And in the real world of modern medicine, decisions are made by a bewildering number of interdisciplinary team members and expert consultants, and even cost conscious third party payers.

This reality is quite different from the one-on-one decision making process described by informed consent regulations.
Medical decisions also come in a variety of flavors:

- Reversible vs. irreversible
- One-time vs. repeated
- Inpatient vs. outpatient
- Well-known family physician vs. unseen pathologist consultant

It should not come as a surprise to anyone that the patient may not want to make all his medical decisions. The rational approach of informed consent does not take into account the internal, cultural and societal factors included in Wilber's broader definition of health.

**Preserving kindness**

Students of decision making describe man "not as a rational calculator always ready to work out the best solution, but as a reluctant decisions maker—beset by conflict, doubts and worry, struggling with incongruous longings, antipathies, and loyalties, and seeking relief by procrastinating, rationalizing, or denying responsibility for his own choices."20

Patients may want to reasonably give up their right to make their own decision because they feel less competent than their physicians, because they are too exhausted, depressed, irritable, and confused by their illness to think straight and because they want to be manipulated into a course of action they desire but still resist.2

Physicians are uniquely qualified to make some medical decisions. They have more experience with disease, and they operate in a system of consultants, morbidity and mortality conferences, and ideally, autopsies that can discipline their decision making process and provide valuable feedback and continual improvement.2

Some patients believe they have more important work to do than make all their medical decisions. "I needed the doctors to take control so I could use all my energy for recovering."21

Schneider argues that patients really want autonomy, competence and kindness from their physicians.

Atul Gawande writes, "As the field grows ever more complex and technological, the real task isn’t to banish paternalism; the real task is to preserve kindness."22

"Some people may feel that the techniques...that a good clinician uses to persuade a patient to choose the treatment the physician desires smacks of paternalism...Preserving kindness involves (the physician) shouldering some of the responsibility for patients should they desire it,"21 writes Susan Zimmerman, a physician and mother of a child with a chronic condition.

Some physicians use the autonomy argument to pass burdensome problems on to patients who, after all, can be litigious should bad things happen. Gawande believes preserving kindness sometimes requires respecting the patient’s autonomy, sometimes taking on decisions from the patient, and sometimes proactively guiding patients to make the right decisions for themselves.22

**Finding the right balance**

While those Americans Ray and Anderson classify as traditional covet their independence, cultural creatives are likely to emphasize community over the individual. The independence fostered by patients making all their own decisions can result in consequences—increased distance between patient and family

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**Three Kinds of Patients**

| Moderns: | 48 percent of the population (93 million people). Moderns accept the commercialized urban industrial world. |
| Examples: | George W. Bush, Jay Leno, Bill Gates |
| Traditionals: | 24.5 percent of the population (48 million people). Tradtionals accept traditional male and female roles, country and small town values. |
| Examples: | Jesse Helms, Pat Robertson, M. Scott Peck |
| Cultural Creatives: | 26 percent of the population (50 million people) Cultural creatives reject materialism, cynicism, hedonism, social inequality and embrace transformational experience and globalism. |
| Examples: | Tony Blair, Bill Moyers, The Dalai Lama |

Adapted from Paul H. Ray and Sherry Ruth Anderson: The Cultural Creatives.
members, decreased intimacy, and increased self-absorption—that a cultural creative might not embrace.

The dependence fostered by an alternative model could result in consequences—reassurance, nurturing intimacy, and reliance on others—that a traditional might not find helpful in recovering from illness.

The consolidation of health care into large bureaucracies in response to cost containment also contributes to impersonal health care. Robert Murphy in a patient memoir observed that “the hospital has all the features of a bureaucracy and like bureaucracies everywhere it both breeds and feeds on impersonality.”

The Internet provides easy access for patients to all the medical literature and can be a useful tool for patients who want to make their own decisions. However, Schneider observes that one can “drown in a river of information just as they can be parched in a desert of ignorance.”

The impersonal nature of today’s communications—voice mail, e-mail, fax—led a Boston psychiatrist to write about toxic worry resulting from executives conducting business with few face to face meetings.

The rise of the bioethicists’ ideal of the relationship between doctor and patient as one of a consumer with legal rights and a provider of services with legal obligations needs refinement.

While the advantages of this approach have been useful in curtailing the obvious abuses of medical paternalism, Schneider’s analysis convincingly documents that it also creates problems for some patients and doctors.

A new model for the doctor/patient relationship would be most useful if it incorporated the best features of autonomy with Schneider’s views on kindness and competence.

**Development of a large group of cultural creatives who embrace interdependence rather than independence, the increasingly global nature of the economy, and some of the implications of the new genomic era of medicine may lead to a balanced physician/patient relationship.**

Technological advances in the past often added to the impersonal nature of medicine by inserting tests performed by technicians between the doctor and the patient.

The new genomic era of medicine with personalized drugs designed for each person’s genetic profile and genetic susceptibility testing that reveals each patient’s relative risk for developing a specific disease will require a close and personal relationship between patient and health care advisor.

These trends of the new millennium seem to require a revival of the personal bond described by Peabody in 1927.

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**References:**

In the past two centuries doctors have had a dominant role in health care. They examine their patients, diagnose illnesses and prescribe a cure to make them better. The profession of a doctor has been legalized; medical associations make sure that there are no quacks among them. With better methods in medicine doctors have been able to treat their patients more effectively. However, this may change in the 21st century. In the next two decades the WHO estimates that 22% of the population in the world’s richer countries will be over 65, more than double the percentage of 1990. Many of those will be suffering from chronic diseases and infectious illnesses will be spreading at a rapid pace throughout the slums of the Third World. A doctor-patient relationship (DPR) is considered to be the core element in the ethical principles of medicine. DPR is usually developed when a physician tends to a patient’s medical needs via check-up, diagnosis, and treatment in an agreeable manner. Due to the relationship, the doctor owes a responsibility to the patient to proceed toward the ailment or conclude the relationship successfully. In particular, it is essential that primary care physicians develop a satisfactory DPR in order to deliver prime health care to patients. Fundamentals for Dynamic DPR. News-Medical, viewed 21 November 2020, https://www.news-medical.net/health/DoctorPatient-Relationship.aspx. Suggested Reading. Primary care for acute health conditions declined dramatically since UK lockdown. Request PDF | On Jan 1, 2014, Sonika Goel and others published Informed Patients; The Changed Scenario of Doctor-Patient Relationship in 21st Century. | Find, read and cite all the research you need on ResearchGate. Results indicated that the method of indexing can moderate the strength of the relationship between spatial ability and performance. Interestingly, the impact of team size on a decision making task was moderated by spatial ability of the strongest link. Furthermore, the strongest link was also a greater predictor of reconnaissance than team size.