DOCTOR-PATIENT RELATIONSHIP- A PARADIGM SHIFT

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“Primum non nocere”
“Above all, do no harm.”

(Hippocrates)

The doctor-patient relationship has been the keystone of the healthcare infrastructure. It covers fundamental responsibilities of a doctor/physician towards his patient and vice-versa. There are primarily, two ways of determining the nature of such a relationship, namely, contractual (a contract between medicine and society) or fiduciary (a relationship of trust). A rise in healthcare consumerism and human rights awareness, and with the Consumer Protection Act, 1986 thrown into the mix, this relationship has witnessed a paradigm shift, that has made the fixation of liability of the doctors an essential concern. As per an egalitarian practice, the doctor had the power and authority to decide best for his patient, However, due to the current socio-economic and politico-legal scenario, this sacred accord is undergoing a change, where patients can approach consumer forums and question the doctor’s discretion. A few international precedents have also been highlighted by the author to draw attention to the changing nature of the doctor-patient relationship.

This paper is an attempt to analyse the patterns of communication and discuss various models of the doctor-patient relationship. At the same time, the author intends to address the issue at hand, by suggesting how doctors can reduce liability and improve patient experience, in the light of a few guidelines laid down by the World Health Organization and Medical Council of India.

Keywords: doctor-patient relationship, patient experience, therapeutic dialogue, therapeutic privilege.
PARADIGM SHIFT

“The belief that doctors can act on behalf of their patients denies the existence of inevitable conflict” - Jay Katz

Doctor-Patient relationship envisages all interactions between a patient and a healthcare professional. These interactions establish the basis for interpersonal communication, trust, compliance and satisfaction. It is the core of medical ethics and has emerged as a subject of about 8000 articles, books, monograms, books and chapters in the modern medical literature.

However, this relationship has undergone an evolution from the Hippocratic model of ‘Silence and Paternalism’, which standardised the doctor’s authority over his patient, to one which makes the patient as a partner in managing care. Patients themselves have dramatically changed the social meaning of ‘patient’. With the advent of the Consumer Protection Act, 1986, the patient is understood as a ‘consumer of medical services’ with increased autonomy, which imposes a much-intensified accountability and a wide range of liability on the healthcare provider in terms of prevention and wellness. This has made the role of the patient far too complex than it used to be as it fails to recognize the uniqueness of experience of healthcare and has become an international cause célèbre.

MODELS OF DOCTOR-PATIENT RELATIONSHIP

Dr. E.J. Emanuel and Dr. Linda Emanuel successfully outline this relationship in the form of four models in their article named, “Four Models of Physician-Patient Relationship”, that continues to be one of the most cited Bioethics Review Articles of all times.

Paternalistic Model- Also referred to as the ‘Parental’ or ‘Priestly model’, that upholds the doctor’s discretion in the course of treatment. Physicians use their skills to determine the patient’s medical condition and the stages of the disease and to determine the medical tests or treatments most likely to restore his or her health or ameliorate pain.

Informative Model- Popularly known as the ‘Consumer Model’. Doctor divulges all the relevant information about the disease state, the nature of diagnosis and therapeutic interventions available, probability of risks and benefits of the interventions and any uncertainties of knowledge in order to avoid any future liability.

Interpretative Model- Doctor acts as a ‘Counsellor’, analogous to the Cabinet Ministry’s role to the head of State. This interaction is to elucidate and realise the patient’s values and

2 Indian Medical Council v. V.P. Shantha and Ors. 1995 SCC (6) 651
what he/she wants, to select from the available medical interventions that realise those values.

**Deliberative Model** - Doctor acts as a ‘Teacher’ or ‘Friend’ to help the patient in arriving at a final decision by engaging in a dialogue as to what course of action would be best.³

Until the 1960s, the healing fraternity followed a pattern of benevolent paternalism in the clinical realm. It precluded the doctors from including the patients in decision-making with respect to the course of treatment to be administered and it was presumed that the doctor will act silently and in the best interest of the patient. It was the latter half of the twentieth century that witnessed the inception of the concept of informed consent and disclosure of relevant information. This practice resulted in the importation of the notions of ‘patient autonomy’ and ‘shared decision making’ in the clinical practice.

Thus, the shift in the nature of this relationship can be better understood with the help of the following categorization:

- **Paternalism** - “Doctor knows Best.”
- **Radical individualism** - “It’s my body and I’ll do what I want with it.”
- **Reciprocal View** - “Can’t we all just get along.”

**COMMUNICATION MODELS**

The medical interview between a physician and his patient is the most crucial element of this relationship. It must essentially fulfil three functions:

- Information gathering
- Developing therapeutic relationship
- Informed Consent and Decision-making

There are international as well as domestic landmark judgements in which courts have laid down extensive guidelines with respect to determining the extent of ‘relevant information’ to be divulged and ‘essentials of real and valid consent.’⁴ The communications models may vary from case to case, keeping in mind the circumstances and full facts of each case. It can be broadly categorised into the following two types:

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• Therapeutic Dialogue- This category includes all the mandatory information that should in all cases be communicated to the patient, such as that related to nature of illness, expected outcome, range or alternatives of treatment, probability of risks and benefits etc.

• Therapeutic Privilege- This category refers to that part of the information that may result in a greater harm to the patient. Doctors have a discretion with respect to this type of information. It may include-predictable harm or the real state of affairs that may affect the patient in a negative way. The patient may expressly state an informed preference of non-disclosure. In most cases, the doctor is obligated to first perform a sensitivity test on the patient to know whether he or she is capable of digesting bad news.

CAUSE FOR ALARM AND FACTORS RESPONSIBLE

The reason why the author has spent the last 2000 words in describing the relationship between a doctor and patient is because of an undisputed fact as to how integral it is for the improvement of medical care and is now degrading. It was a primary determinant of quality of care which was built of trust and empathy. Doctors enjoyed a high status in the society and even regarded as Gods.

It is quite evident how this relationship has undergone a change from one that was once governed by human life ethics to one being governed by business ethics.

The author intends to shed light upon some of the numerous factors that are responsible for the deterioration of the doctor-patient relationship:

• Corporatization of Healthcare- The has essentially resulted in the formation of a profit reaping agenda over public good. Audit surveys these day include the total number of CT Scans, MRIs conducted over the number of patients cured or lives saved.

• Internet- The internet has resulted in a further decline of this relationship with the advent of various platforms like telemedicine, web doctors, etc.

• Medical Advertising- This is a coup de grace to the medical fraternity altogether. It has given a death blow to this relationship. There are a variety of advertisements that range from- “First time type”; i.e. a certain surgery was performed here for the first time; “I only Type”, i.e. only I can treat a certain problem; “Come where Action lies”,i.e. medical camps at low costs etc.

SUGGESTIONS

“Cure Sometimes, treat often, comfort always” —Hippocrates
Here is an attempt to highlight some of the salient push buttons that can help in improving the doctor-patient relationship:

- **Implementation of the Medical Council of India ‘Vision Scheme 2015’ Program** -
- **ATCOM** - A program that intends on adding a ‘Attitude and Communication Development’ Module in the medical curriculum.
- **TRACK** – increase transparency, respect, accountability, continuity and kindness.
- **Strict Enforcement of Indian Medical Council Act and Rules**, e.g. Bann on certain advertisements, Consent must be obtained from patient or immediate relatives (in case of comatose patient) before conducting any surgery.
- **Physicians, heal thyself** - Personality development of young doctors. Before attempting to heal others, the doctor must himself be fit.
- **Proper Documentation** - Prior written informed Consent, medical history of previous patients, confidentiality with respect to such documents must be maintained.
- **WHO Guidelines must be adhered to** - Strengthening medical education, recognizing patients as consumers with rights, proper redressal machinery with experts specialising in medicine, conducting regular audits etc.
- **World Medical Association Guidelines, 67th General Assembly** on ethics - Obsvance of right to health as a fundamental human right, power of choice and patient’s autonomy must be respected, Moral obligation of doctor comes first, legal obligations come second.

At the end of the day, who is it that the doctors really serve - themselves, their patients, insurers or the society at large?

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5 Paragraph-6.1, Chapter 6, Indian Medical Council (Professional Conducts, Ethics and Etiquette) Regulations Act, 2002.
6 Section C and Section D, Indian Medical Council (Professional Conducts, Ethics and Etiquette) Regulations Act, 2002.