University of Nebraska Medical Center
BREAKTHROUGHS FOR LIFE

University of Nebraska Medical Center
DigitalCommons@UNMC

MD Theses

Special Collections

1967

# Doctor-Patient relationship

Bryan Dale Spader
*University of Nebraska Medical Center*

This manuscript is historical in nature and may not reflect current medical research and practice. Search PubMed for current research.

Follow this and additional works at: https://digitalcommons.unmc.edu/mdtheses

## Recommended Citation

Spader, Bryan Dale, "Doctor-Patient relationship" (1967). *MD Theses*. 2939.
https://digitalcommons.unmc.edu/mdtheses/2939

This Thesis is brought to you for free and open access by the Special Collections at DigitalCommons@UNMC. It has been accepted for inclusion in MD Theses by an authorized administrator of DigitalCommons@UNMC. For more information, please contact digitalcommons@unmc.edu.

# The Doctor - Patient Relationship

by

Bryan Spader

1967

University of Nebraska College of Medicine

# INTRODUCTION

This paper is an analysis of the doctor-patient relationship from the sociological prospective. There are three basic components in this analysis. They are: the doctor role, the patient role, and the dynamics or interaction between these two roles.

The information in this analysis is of two general types, theory information and research information. The theory is taken from Talcott Parsons and is based upon an unpublished medical study done in the Boston, Massachusetts area. The research information is summarized from reports found in various books and journals.

I have found that much has been written about the doctor-patient relationship. However, very little information is available which is based on systematic and objective research. This is especially true of the section dealing with third party medicine. Research is just beginning in this area. This paper is an attempt in organizing the available information in this area which is based on systematic and objective research.

I would like to thank Dr. Richard Kurtz, Medical Sociologist at the Nebraska Psychiatric Institute, for reading this paper and offering quite useful suggestions. Dr. Kurtz was also very helpful in giving an over view of medical sociology. This type of prospective is very helpful, but also very difficult for the uninitiated to gain on his own.

I would also like to thank Dr. Cora Martin, Social Psychologist at Omaha University, for her guidance with the recent literature on this subject.

Finally, I would like to thank Mr. Pete Boughn, Public Relations Director at the Nebraska College of Medicine, and Dr. Max Fitch, for their suggestions for improvement on the manuscript.

TABLE OF CONTENTS

Present Knowledge - Parsons

Much has been written about the doctor-patient relationship, most of which falls in the category of philosophy, some of which falls into the category of theory, and a lesser amount falls into the category of basic research.

"As the growing literature attests, there is no dearth of relevant theoretical formulations; (in the area of the doctor-patient relationship) however; empirical studies which present data to support existing analyses are relatively sparse."[1]

In 1951, Talcott Parsons in his book, The Social System, analyzed the patient role, the doctor role and developed a theory concerning the relationship between the two. In this book, chapter 10 is devoted to: "The Case of Modern Medical Practice".[2] In this chapter, Parsons proposes to bring together the threads of the preceding four hundred twenty-seven pages by "a more extensive analysis of some strategic features of an important sub-system of modern western society. For this purpose we have chosen modern medical practice. This field has been a subject of long-standing interest on the author's part as a result of which he has a greater command of the empirical material in this field than in most others."[3] Much of this knowledge was gained in a field study of medical practice which was carried out mainly in the Boston area in the late 1940's. Parsons never published his findings. But, many of his observations are presented in this chapter of his book.

Now, with this perspective, we can proceed with the presentation of Parson's theory of the doctor-patient relationship.

## The Functional Setting

Medical practice has been traditionally oriented to treating cases which have already developed a pathological state. Recently there has been increasing emphasis on preventive medicine. The problem of health is intimately involved in the functional prerequisites of the social system. Health is included in the functional needs of the members of society. Illness incapacitates the effective performance of social roles. And, to the degree that illness is controllable, there is a functional interest of the society in the minimization of illness. Some illness is unpreventable; however, there are also some illnesses in which motivational factors play a role. Differential exposure to injury or infection is certainly motivated, and the role of unconscious wishes to be injured or to become ill have been demonstrated. Also falling in the realm of motivational illness are psycho-somatic illnesses and some mental illnesses. In fact, there is an increasing tendency in medicine to refer to <u>all</u> disease as being psychosomatic.

Hence illness becomes an integral part of the social equilibrium itself. With this background, it is possible to define illness as ...."a state of disturbance in the 'normal' functioning

of the total human individual, including both the state of the organism as a biological system and of his personal and social adjustments. It is thus partly biological and partly socially defined."[4] Medical practice then is "...a mechanism in the social system for coping with the illness of its members. It involves a set of institutionalized roles..."[5] as well as a special relation to certain aspects of modern society's cultural tradition. One of the unique features in modern western society is the application of a highly developed level of scientific knowledge to the problems of illness and health. However there is also an element of the past in our society conceiving of illness in supernatural terms. And in certain aspects of our culture we find attitudes in between the magical and the scientific which might be referred to as superstition or as pseudo-scientific beliefs and practices. There are the patent medicines, the cults, such as Christian Science, and there is a certain amount of resistance to scientific innovation within the medical profession itself.

The Doctor Role

The doctor-patient relationship is a social situation and therefore, it can be analyzed in terms of pattern variables. Pattern variables were described by Parsons as representing dilemmas faced by individual actors in attempting to define and orient to

social situations. These patterned variables include Affectivity - Affective Neutrality, Specificity - Diffuseness, Universalism - Particularism, Ascription - Achievement, Self Orientation - Collectivity Orientation.

"The role of the medical practitioner belongs to the general class of professional roles, a subclass of occupational roles....In common with predominate patterns of occupational roles generally in our society it is therefore in addition to its incorporation of achievement values, universalistic, functionally specific, and affectively neutral. Unlike the role of the businessman, however, it is collectivity-oriented not self-oriented."[6]

The norm of functional specificity serves to define and restrict the doctor's access to privileged information and contact, in terms of a criterion of technical relevance, and this restriction functions to allay the anxieties of the patient about the possible consequences of such privileges.

The norm of affective neutrality defines the expected attitudes within these limits: keeping the relationship "professional" and affectively neutral serves to protect both parties from inappropriate and potentially dangerous involvements, and permits the doctor to give technical considerations his full attention.

The norm of collectivity orientation acts as a guarantee to the patient that any private information obtained will be utilized for the patient's benefit alone, and not in the slightest for the personal gain of the physician.

Also in understanding the role of the physician, it is important to consider two classes of physicians. There is the general practitioner and the specialist. Specialization is increasing and therefore the practitioner is becoming more and more involved in a complex organization in the practice of medicine.

The Patient Role

There appear to be four aspects of the institutionalized expectation system relative to the sick role. First of all is the exemption of the patient from normal social responsibilities. This requires legitimization and includes both rights and obligations upon the patient. The patient has the right not to work, but the obligation to stay in bed for example. The second aspect is the institutionalized definition that the sick person cannot be expected to get well by an act of decision or will. In other words, while the illness lasts he can't help it. The acceptance of this aspect is obviously necessary for the acceptance of help. The third element is the definition of the condition of illness as being undesirable. The patient has the obligation to want to get well. The fourth element is the obligation to seek technically competent help. Thus the ill person has the obligation to seek out a physician and cooperate with him in the process of trying to get well.

In terms of the pattern variables, the patient role is inherently universalistic, that is generalized objective criteria determine

if one is sick and the degree of the illness; functionally specific, that is confined to the sphere of health; affectively neutral, that is the expected behavior is focused on the objective problem, not on the individual's feelings; collectively-oriented, that is the patient, as soon as he has consulted a physician, assumes the obligation to cooperate to the best of his ability.

Dynamics of Doctor-Patient Relationship

"There are two particularly important broad consequences of the features of the situation of the sick person for the problem of the institutional structuring of medical practice. One is that combination of helplessness, lack of technical competence, and emotional disturbance make him a peculiarly vulnerable object for exploitation....There is in fact a very real problem of how, in such a situation, the very possible exploitation is at least minimized. The other general point is the related one that the situation of the patient is such as to make a high level of rationality of judgement peculiarly difficult."[7]

The role of the physician centers on his responsibility for the welfare of his patient. In meeting this responsibility, he is expected to acquire and use high technical competence in medical science. However, there are areas of uncertainty and frustration in the practice of medicine. There are diseases which are incurable and there are times when, even though every aspect of the physician's approach was competent, success is not achieved. The general effect of the existence of large factors of uncertainty,

exerts strains upon the physician and makes it more difficult for him to maintain a purely rational orientation. However, the function of "doing everything possible" is institutionalized.

The physician deals with human beings in situations which often involve intimacies. One whole class of these concerns the body. The amounts and occasions of bodily exposure and contact are carefully regulated in our society. "It is essential for the physician to have access to the body of his patient in order to perform his function."[8]

Also, some of the procedures involved in treatment such as drawing blood or injection of drugs with a needle often involve emotion reactions by patients. The point Parsons is making is that in the doctor-patient relationships inevitably, there are very complex, often emotional reactions with the typical, not only the abnormal patients. Similar considerations apply to the physician in the psychologically significant private affairs of his patients. The relationship is expected to be one of mutual trust. It is quite largely the physicians role to dispel doubts on the part of the patient.

In the therapeutic setting, both the doctor and the patient with his family are under strong emotional pressures to get something done. The result is a general bias in favor of active intervention, for example, giving the benefit of the doubt to operating in surgical cases.

PRESENT KNOWLEDGE - OTHERS

Role of Doctor

The Handbook of Medical Sociology[9] suggests that, "The practitioner is the representative of dominant cultural values..., the practitioner is the symbol of the well and normal, of the non-ill encountering the ill. It might be guessed that his role as symbol of health is actually equal in importance to--and indeed inseparable from--his role as a technically equipped curative agent."

In an article in the anthropological journal, Human Organization,[10] Barbara G. Myerhoff and William R. Larson suggest that the doctor is becoming less of a charismatic and more of a cultural hero. They suggest that at present the most important source creating and perpetuating culture heroes is the mass media, and television is the most important form of mass media. Recently the doctor has become more popular on television, vying in popularity with the ubiquitous cowboy. There are two kinds of popular heroes: cultural and charismatic. The physician depicted by the mass media has some qualities of both, however, he appears to be losing charisma and becoming a culture hero. It is suggested that this change can be seen by noting the changing doctor image from the intuitive wisdom of Dr. Christian to the emphasis on the technical skill of Ben Casey. Or again one can compare the old Dr. Kildare with the new Dr. Kildare.

The culture hero is a socializing agent who serves as a model (the embodiment of tradition), exemplifying how people should behave

in recurring life crises--birth, love, death, illness. These authors point out that certain aspects of our society such as social mobility and rapid rates of change enhance the importance of such a role. The doctor is losing charisima, while his scientific practice glows with promise. Doctors are thought of as being interchangeable, but the gift of grace is given to the position in the process Weber called routinization of the charisma. The article ends with an air of pessimism, suggesting that as the public becomes increasingly medically sophisticated and begins to penetrate the mysteries that surround treatment, the belief in the charisima and authority of science may also fade, leaving the patient no basis for hope and faith so that occupational effectiveness of the practitioner may be impaired.

I find this latter suggestion somewhat socially naive in that it fails to distinguish between the method of science and technology. Science explains why things occur and why medicines work, but technology provides the tools which make new cures possible on a large scale. Hence, it would seem to me that one does not give up aid from a specialist, even though he may understand the theory behind the treatment of his disease. It would seem to me that the practitioner may become a more and more highly trained technician and that it is not so much his understanding of the disease that the patient seeks as it is his highly specialized skill in treating the disease. An educated general public cannot be expected to gain this ability.

Yet, there may be changing societal attitudes toward the physician. Gamson[11] found that those persons who rated physicians high in prestige also rated physicians high on the medical hostility scale. It is suggested that the ambivalent feelings may arise because of a discrepancy between occupational standards (high) and role performance (not so high). Whatever the explanation, this study suggests that at least some people have ambivalent feelings about the doctor.

It is also possible that the ambivalence may arise because of the nature of the dotor role. Although the patient initiates the relationship, and has some influence, the practitioner has a greater, nearly exclusive control of psychological and social leverage. The practitioner has much more to do with defining the patient role than the patient has to do with defining the practitioner role. The physician must first separate the ill person from his society in order to form a therapeutic relationship.[12] Perhaps being required to play the patient role with its lack of power and authority is the cause of the hostility some feel toward the doctor. The study pointed out that it was the persons who rated the physician highest in prestige that also rated him highest on the hostility scale. Perhaps these persons are quite sensitive to power and prestige, i.e. admire it in others; but, when they are required to personally subjugate themselves to another's power, they rebel.

Not only do physicians require authority with reference to their patients, but they also require individual authority. That is, physicians require freedom to make professional decisions according to their own trained judgments rather than according to the dictates of superiors in a bureaucratic hierarchy. In a study of physicians in hierarchies,[13] it was found that there are "real" and "official" limits to professional freedom. The hierarchy functioned as long as the supervision came from an M.D. in the form of advice. The doctor role requires freedom for professional decisions, but allows supervision in the form of advice from other doctors.

One of the pattern variables of the doctor role mentioned by Parsons was affective neutrality. The doctor must learn to react to illness and death in a "professional manner." How does a doctor develop this aspect of his role? Daniels performed a study of forty-six interns with reference to their modes of affective involvement with patients and mechanisms of control over affective involvement.[14] This experimenter found that there were two types of affective involvement, that based upon aspects of the illness itself and that based upon the personality of the patient. Concerning the affective involvement based upon aspects of the illness, there are three variations of affect: a. almost complete lack of any affective involvement; b. somewhat intellectualized understanding of the patient's problem with commitment to disinterested service to all whose illness leads them to need help; c. complete emotional identification in which the intern empathetically suffers a great deal.

The results of the investigation showed that (b) is explicitly prescribed by the medical system; (a) is permitted; and (c) is controlled in an indirect way by normative, instrumental, and situational influences. Affect based on personality is specifically proscribed.

This research extends Parsons' speculations. The goal does seem to be affective neutrality; however, a certain amount of individual variation in its development is found at least in interns. In other words, some learn to play the doctor role better than others.

In fact, a doctor is always a person in addition to being a doctor. He has many roles in addition to the doctor role including that of father, husband. He is also a member of a certain socioeconomic status. It is not possible for a man to totally isolate one role from other aspects of his life. Thus the individual doctor role will be influenced by other aspects of the doctor's life. The work of Hollingshead and Redlich has shown that the amount and type of medical care varies with socioeconomic class. It is especially true that psychiatrists seem to function best with patients who have backgrounds and a socioeconomic level similar to that of the psychiatrist.[15] Of the subculture which divides the patient - practitioner relationship, the subculture of the medical profession itself may well be the most critical.[16]

Most of what has been written about the doctor role has been concerned with the role which is applicable to treatment of acute

illness. However, there is recent evidence that it may be of value to delineate two types of doctor roles, one developed for the treatment of chronic illness, and one developed for the treatment of acute illness. Cogswell and Weir claim there is a new doctor role in the process of development.[17] According to these authors, medical professionals find the ~~acute~~ sick role for acute illness inadequate in chronic illness. Medical professionals are required to cultivate a new role in relation to chronic patients. The treatment of the chronically ill may be divided into three parts:

a. Exercising technical competence. This includes examination, diagnosis and evaluation of the problem with prescription for appropriate therapy.
b. Teaching--This includes teaching the patient to implement as much of his own care as feasible. Hence, the patient is taught about his disease, about self-diagnosis, and about self-treatment.
c. Socializing--The patient must be evaluated in terms of the abilities he has left. His disease process will require the more of less learning of new roles.

As a result of data recorded by the two trained observers mentioned above in a hospital setting, the experimenters conclude that the new role is quite well developed with respect to (a), exercising technical competence; is less well developed with respect to (b) teaching; and that (c) socializing, is hardly developed at all, except that it is recognized as a problem.

The above study is an appropriate study with which to conclude the discussion of the doctor role. It would seem to leave the issue somewhat unsettled, as indeed it is. It raises important questions: Is the doctor role too broad a topic to consider in general? Might

not future studies profit from a delineation of several types of doctor roles? The above study suggests that the doctor role will be significantly different in acute illness from what it is in chronic illness. Perhaps, there is also a difference between the industrial physician and the private physician, the urban physician and the rural, the specialist and the non-specialist, etc. It has been the practice to consider the doctor role and to interchange the various types of doctors. However, it might prove productive to delineate several types of doctor roles. Research should be done in this area.

The Patient Role

The physician has been emphasized as the definer of the doctor-patient relationship, however, the patient also exerts an influence. The right of choice of practitioners by the patient is the source of the patient's ability to influence the doctor-patient relationship. Freidson[18] suggests that, although the practitioner claims that his skills are so esoteric that the client is in no position to evaluate them and that only a colleague is able to evaluate his skills, nevertheless, the physician is dependent upon the laymen for his livelihood. The physician is dependent upon the patient's choice. The patients evaluate the doctor by non-professional criteria, and they interact with the doctor on the basis of non-professional norms.

Freidson uses the term "lay referral structure" to refer to the process of seeking help in illness, which includes a network of potential consultants, ranging from the intimate and informal confines of the nuclear family through successively more select, distant, and authoritative laymen, until the professional is reached. Obviously the referral system may be quite prolonged and complex or quite truncated. In what Freidson calls the indigenous extended system, the clientele of a community may show a high degree of resistance to using medical services; or in the truncated system, they may visit the professional without discussing their illness with anyone else.

At any rate, client choices are a form of social contact. They can determine the survival of a profession or specialty. On the basis of interviews with urban patients, Freidson concluded that the first visit to a practitioner is often tentative. The patient passes through a referral structure on the way to the physician, and also on the way back from the physician, discussing the doctor's behavior, diagnosis, and prescription with his fellows. The patient may decide not to return.

Finally, Freidson has delineated what he calls dependent and independent practice. In independent practice, the physician is independent of his colleagues and is located within a lay referral system. Hence, he is least able to resist control by clients and most able to resist control by colleagues. On the other hand, in dependent practice, a professional colleague or organization decides that a client needs the services of a professional and transfers the client. This type of practitioner is most able to resist control by clients and least able to resist control by colleagues.

Not only do patients have the power to exert a degree of control over the practitioner, but they also have the power to either follow or not follow the medical regime suggested by their doctor. Davis and Eichorn[19] studied four hundred thirty-five farmers with cardiovascular impairment by interviewing them in 1956 and again in 1960. The purpose of their study was to determine some ways that social psychological factors figure in the acceptance and re-

jection of medical regimens. After the diagnosis of cardiovascular disease was made, each patient was given a list of "does" and "don'ts" and the dependent variable studied was degree of compliance with the list. Their regimens were prescribed in all cases. It was discovered that 42% complied with two out of three selected regimens. Only 9% complied with all three. What were some of the factors affecting compliance, i.e. independent variables: See Table II.

One must be careful not to generalize too much from this study. Cardiac disease is a special case. One might be able to generalize to other chronic processes, but not to acute processes. The treatment involved in cardiovascular disease is largely aimed at prevention of further impairment, and often very little can be done to reverse existing damage. Hence, the patient may often become discouraged with the regimen. He is required to change some of his habits, as smoking, and to modify his diet for the rest of his life. And the benefits are often not apparent to him. Hence, one would expect less compliance here than in the regimen for acute diseases. At any rate, the patient does have the right to either follow or not follow a medical regimen.

Now we shall go into more detail concerning the social patterns accompanying the seeking, finding and carrying out of medical care. Suchman[20] has divided this process into five stages. First is the symptom experience stage (the decision something is wrong). It includes physical, cognitive, and emotional components. Second is the assumption of the sick role stage (the decision one is sick and

needs professional care). The lay referral system is most important here. The ill person seeks confirmation, advice, reassurance, and finally a form of provisional validation which temporarily excuses him from normal obligations. Then is the medical care contact stage (the decision to seek professional medical care). Here the ill person seeks sanctioning to become legitimately ill or to return to normal activities if the sanction is not given. Fourth is the dependent-patient role stage (decision to transfer control to the physician and to accept and follow prescribed treatment). This is where the ill person becomes a patient. Here there may be physical, administrative, social, or psychological barriers which interfere with the course of treatment. Fifth is the recovery or rehabilitation stage (the decision to relinquish the patient role). Here the patient is dismissed from active medical care and is expected to resume his old role or a new one of the chronically ill, depending upon the course of his illness. In acute illness few problems are encountered here, but, chronic illness, rehabilitation, a process of resocialization, may be necessary.

Using the above framework, Suchman analyzed data obtained from a large scale community survey of health status and medical care. 5,340 persons representing 2,115 families in the Washington Heights district of New York City were interviewed. Out of the sample a subsample was selected of persons currently experiencing a relatively serious illness (three or more doctor visits, incapacitation for five or more consecutive days or required hospitalization of one

or more days). A questionnaire which was divided into the five stages of illness was given to these persons. A sample of 137 was obtained. The findings are presented in Table III.

This study is subject to the limitations of all surveys. It measures subjective attitudes of persons. Also, it is limited to a particular community. Hence, one would not be surprised to find variations in future studies of other communities. However, it is certainly enlightening and represents information based on research in an area where only speculation existed previously.

Another interesting study was done by Rasengren.[21] His study was concerned with the sick role during pregnancy. The purpose of the research was to study the characteristics of women who seem motivated to assume the contingent role of the sick and to determine whether physiological correlates are to be found associated with it. Seventy-six patients, forty-four charity hospital patients and thirty-two private patients were selected. Three categories of information were used, one an hour long interview with the patients, the second an interview of the doctors involved, the third the medical record of the patients, including their delivery record.

The sick role expectations of the patients were evaluated according to Parson's theoretical model. This included three behavioral dimensions: a. exemption from normal social responsibilities during pregnancy; b. extent and kinds of changes anticipated in normal life as a consequence of child birth; c. extent of acceptance of subordinate role to attending doctor. And two attitudinal dimensions:

a. extent of concern over organic and morphological processes of child birth; b. extent of acceptance of pain and suffering during pregnancy. The responses were scored on a fifteen point scale with fifteen showing the most and zero showing the least sick role expectations.

The results of the research showed sick role score to be negatively correlated with the subject's education; family income, ways of life, positive aspirations, the husbands education, and his occupational status. It was positively correlated with the subject's sick role expectations, her negative aspirations, her labor time, and the month of pregnancy at the time of interview. There was also positive correlation between extent of sick role score and the number of conflicting cultural values which were expressed. There was positive correlation between sick role expectations and extent of social mobility, either up or down, i.e. social status change.

In private patients, the higher the income, the higher the sick role score. In clinic patients, the higher the income, the lower the sick role score. Patients the obstetricians rated as being high in sick role had significantly higher sick role expectations than those the obstetricians rated low.

There was a significant positive correlation between high labor time in a previous pregnancy and high sick role expectations in the twenty-three women who were multigravidas.

There was a definite trend for women who had role conflict with their obstetrician (they and he had different sick role concepts) to have more difficulty in labor.

This study shows that although there are physiological factors related to the sick role expectations in pregnancy, there are social factors which are also important.

A study by Shuman[22] is also pertinent to this discussion. His study was based on information obtained from trained staff interviews of a representative cross-section of adults in the Washington Heights district of New York City. His findings were as follows:

1. Social factors predispose toward illness, but illness may also affect social factors as when medical cost reduces economic status.

2. Health status influences one's medical orientation, but such health orientation may also affect one's state of health, especially in the area of preventive medical behavior.

3. Health status largely determines the medical care one received, but the nature and quality of such care may, in turn, aid or hinder one's return to health.

4. Medical orientation influences the care one seeks, but good or bad experiences with medical care may affect subsequent health orientation.

The discussion concerning the doctor role was concluded with a discussion of chronic illness. The special case of chronic illness seems an appropriate conclusion for the discussion of the patient role as well.

Kasselbaum and Baumann[23] did a study in which a questionnaire was given to 201 chronically ill outpatients in an urban clinic. These experimenters point out that sick role expectations are influenced not only by the individual's previous social roles, but also by the effects of his specific diagnosis on his ability to

perform them. The sick role evokes a set of patterned expectations which define the norms and behavior appropriate to this new deviant status; however, people vary in relation to norms: a. People who occupy different positions in the social structure may hold different norms pertaining to the same role. b. People differ in the intensity with which different norms are held, and in their evaluation of norms.

With the above ideas in mind, the special case of the chronically ill may be analyzed. This subtype of sick role departs from the model in the following ways:

a. Chronic illness is not temporary--by definition.
b. Incapacity for other roles is often partial.
c. Norms prescribing permissive treatment may require redefinition in the chronically ill.
d. Chronic illness is not random; it is associated with advancing age. Thus there are two roles here--aging and sick role - which may be mixed up. For the aging person is also exempt from responsibilities for his condition; nor can he arrest it by his own volition. Failure to distinguish between the two may lead to a strained doctor-patient relationship.

In this particular study the three most common diagnoses were arteriosclerosis, diabetes mellitus, and psychoneuroses in that order. Women predominated three to one and all were in the $5,200 income category. Twenty statements were rated on a seven point scale from strongly dislike to strongly like. Then factor analysis was used to isolate factors. With this method, four factors were isolated, and these were interpreted as representing four dimensions of the sick role:

1. Dependence - This factor was found to be related to the older age group, to men, to foreign born and to low education.

2. Reciprocity - (High degree of supportive interpersonal relations) This factor was higher in women, those with no occupation, and in arteriosclerotics.
3. High Role Performance - This factor was found more in the older age group, foreign born, the less educated, the no occupation and blue collar workers, in the arteriosclerotics, and multiple diagnoses.
4. Denial - This factor was found more in men, older age group, foreign born, the less educated, the multiple diagnoses and the no occupation group.

Hence in the patient role, as well as in the doctor role, there may be different norms pertaining to the role, depending on a number of social factors. And as this last study indicates there may be variation in the intensity with which various norms are held, again depending upon a variety of social factors.

Interaction Processes in the Doctor-Patient Relationship.

The doctor-patient relationship is a special type of small group called a dyad. As Becker and Useem point out, "...there are certain interhuman relations common to all dyads."[24] Therefore the doctor-patient relationship has certain attributes which derive from the fact that it is a dyadic relationship.

What is a dyad? "Two persons may be classified as a dyad when intimate, face-to-face relations between them have persisted over a length of time sufficient for the establishment of a discernable pattern of interacting personalities."[25] To be a dyad a pair must show patterned mutual action. It cannot be a case of, "She's my sweetie, but doesn't know it."

What are the qualities of the dyad? Becker and Useem suggest the following:[26]

1. Pattern - not depersonalization - The patterned interaction rarely if ever becomes a superpersonal structure in the minds of the members. The responsibility for action is manifest to all acquainted with the situation and cannot be ignored by saying, "Why doesn't someone do something about this?"
2. Definiteness of Status - Most persons enter into a dyadic relation because it gives opportunities for harmonious interactions of an ego-satisfying nature. But even in dyads not voluntarily initiated, the cultural ideal is harmony and society expects the display of amity. However, the greater the intimacy of the pair the larger the number of conflicts that can arise.[27]
3. Result of loss of one member - In the dyad as opposed to other groups, the loss of one member not only destroys the pattern but also results in changes, sometimes radical, in the personality of each member. However, all dyads eventually become broken dyads.
4. Limited Meaning in the Pair - "Symphysis of interaction and participation in joint experiences result in concepts,

ideas, habits, and shared memories which to the members are symbolic of the pair."[28] These limited meanings tend to establish norms of action...Limited meaning is primarily a pair phenomenon.

5. Division of Functions - In every dyad there is a separation of functions, roles, obligations, and rights stemming from both external and internal conditions. Disparity between the external (cultural) and internal (personal) may be resolved by elaboration of a public dyad pattern "and a private dyad pattern".
6. The pair and social organization - The relation between the pair and the social organization is of a twofold nature. First, the larger socio-cultural environment sets the conditions and circumstances for the rise and functioning of the dyad. Secondly, the continuance of the social structure is, in part, contingent on the functioning of pair relations.
7. Classification of Dyads - for classification of dyads see Table IV. The doctor-patient pair is an example of the Aider-Aided pair a subgroup of segmentalized dyads. This type is more patterned by cultural definitions than is the comprehensive type dyad. Concerning the Aider-aided pair, here one individual is dependent upon another for help in solving some personal problem. The aider usually remains more objective, the result being that the pair pattern is usually more "real" for the aided than for the aider.

In more recent work with the dyad, Borgata and Guerrin[29] used a modified Bales' Interaction Process Analysis. The experiment was conducted in three steps. In the first step background information was accumulated including such assessments as personality and intelligence. The second step involved participation of a five person discussion group for twenty minute units of interaction concerning four different topics. The third step involved participation of a two person group with three topics being discussed. Then there were three twenty minute discussion periods with the two person group.

It was found that the first part of the session is often devoted to familiarization and assessment of the status of others. The second part of the session is critical to the development of structure

of the group. After the second session, the developmental trends tend to be relatively smooth and stable. There is high tension originally which tends to decrease with time. However, the degree of emotional involvement increases with time.

The doctor-patient relationship is by definition a special type of dyad. And as mentioned above the relationship takes on certain qualities simply because it is dyadic in nature. To view the doctor-patient relationship as a dyad then, is helpful; however, it is an incomplete view, for the field of forces involved here includes at the very least, the influence of major reference groups of each participant: for the doctor, his profession and for the patient, his family.[30] Developments in the evolution of the modern family and technological developments in modern medicine have converged to remove much of the treatment of illness from the home into specialized health-care agencies such as the hospital. These recent changes have resulted in changes in the fields of forces involved in the doctor-patient relationship.

Bloom in his book, The Doctor and His Patient[31] develops a working model for the doctor-patient relationship. He begins by presenting the three basic types of relationships of Szasy and Hallenler:

1. Activity-Passivity - This type relationship arose in and is appropriate to emergencies. It is similar to the parent-infant relationship. The patient is totally helpless and unable to follow orders.
2. Guidance-Cooperation - This type applies to most acute disorders, especially those of the infectious type. The patient is aware of his surroundings and can follow directions. This type is similar in form to the parent-child or parent-adolescent relationship.

3. Mutual Participation - This type of relationship makes its appearance in the management of chronic illness, where the therapy is carried out by the patient with only occasional consultations with the physician. This type is similar in form to the adult-adult relationship. It requires a fairly complex patient to make it function correctly.

Bloom also uses field theory and suggests that one must see the doctor and patient within a field whose elements include more than personality and technical skill. For a graphic field theory model, see Table V.

The field of the physician includes:

a. Individual predispositions of the physician.
b. Standards of professional behavior which have been internalized.
c. Specific stimulus complex provided by the patient, perceived as a medical problem.

The field of the patient includes:

a. Individual predispositions of the patient.
b. Cultural standards of the sick role which have been internalized.
c. Specific symptoms which define his specific illness.
d. Significant others, i.e. father, mother, etc.

When these particular fields come together in the interaction process, which is the doctor patient relationship, the relationship is defined by the peculiar interaction pattern which occurs within the framework of the socio-cultural matrix and the application of objective principles of medical science. It is this peculiar interaction process with which we are mainly concerned. But one must keep in mind the field of forces which the patient and the doctor bring into the situation.

The expectations of the participants in the doctor-patient relationship is an important factor in whether the relationship functions. Ort, Ford and Liske[32] studied the expectations of medical participants

by using a thirty item sentence completion form, which they gave to ninety respondents. Thirty were medical school faculty members; twenty-seven were senior medical students; and forty-five were practitioners. They found:

a. The emphasis was placed on the relationship itself, with little attention to the beginning or termination of the relationship.
b. They saw the doctor as the dominant member in the relationship.
c. Patient plays a subordinate part--is to express the need for help and the desire to get well. He is expected to trust the doctor, adjust to his condition and respond to treatment.
d. Doctor expects the patient to reciprocate his attentions by communicating, cooperating, and expressing appreciation.
e. Doctor perceives self as one in control, but his authority is seen as being primarily in medical matters.
f. The control has two sources, one intellectual (the doctor's special knowledge) and one affective. The intellectual aspect results in diagnosis and treatment; whereas, the affective results in affiliation, help, and care.

For a working model of the doctor-patient relationship based on these results see Table VI. The doctor derives intellectual satisfaction from the diagnosis and treatment. He also derives satisfaction from the affective element, i.e. establishing rapport with his patient and receiving patient's appreciation for his help and care. However, the most dissatisfactions seem to derive on the affective level, i.e. patient is uncooperative or lacks confidence in the doctor or gratitude for his services.

One of the aspects of dyads mentioned earlier is that over time the degree of emotional involvement tends to increase at the risk of Parson's ideal of affective neutrality. However, in the doctor-patient relationship a certain amount of social distance must be maintained. In a study of social distance between clients and

professionals,[33] 25 ministers, 43 physicians, and 51 psychotherapists were ranked on various dimensions of social distance from clients - normative, interactive, cultural, and personal distance. The study found ministers closest and psychotherapists farthest with physicians in between on all dimensions of social distance. The evidence was that social distance between clients and their professionals is a long-run or stable phenomenon. A stable dyadic relationship is promoted by varying degrees of social distance depending on the nature of the relationship. Professional-client relationships are more one-sided than most dyads. Two problems arise from this disparity of authority. One is that it may be used in a way opposed to the client's interest. The second is that once the one-sided relationship is instituted, the professional has a tendency to seek to maintain his authority, i.e. to continue the relationship. The first problem is partly solved by a professional community which maintains standards. This community tends to separate the professional from his client in all four dimensions of distance. The second problem is partly solved by the professional consciously seeking to "maintain his distance". Because of their greater distance from clients, the physician and psychotherapist enjoy considerably more power and objectivity than do ministers.

Mechanic[34] studied the communication process in the therapist-patient relationship. He suggests that the definition of a person as mentally ill, may eventuate in his entering a therapeutic rela-

tionship. The therapeutic process is social and for the patient may be viewed as a transition into a new land of communication and a new role network. The therapeutic situation is seen by Mechanic as different from other role situations in three regards:

a. In the therapeutic relationship, the patient is encouraged to express his "deeper" thoughts openly (permissive situation).
b. The therapist occupies an institutionally defined role of a nature such that the patient is not likely to be openly rejected or humiliated (information is private).

Yet, it is interesting that the patient and therapist seem to work best together when they come to the situation with similar social backgrounds. A study by Ross[35] showed that social class distribution of medical care and morbidity are inversely related. The use of physicians increases as social class rises, but the amount of disability and morbidity increases as social class (including income, education and occupational elements) decreases.

c. The patient in therapy is expected to enter a temporarily defined "patient role" and other roles are defined as irrelevant. The patient is expected to relate his problem to the therapist and in so doing take on the role of the patient.

From studies of the therapist-patient relationship Mechanic suggests the following facts concerning the relationship.

a. In the initial interviews, the patient seeks out cues as to what the therapist will be like and as to whether he should continue the relationship.
b. An important factor in the efficacy of the relationship is the degree of which the patient feels committed to it.
c. The focus of the therapeutic relationship is interaction.
d. The eventual success of therapy is dependent upon the degree to which the therapist and the patient can share a common frame of reference and this is likely to be influenced by factors relevant to social strata.

The therapeutic relationship may be seen largely as a matter of resocialization and re-education of the patient. The therapist teaches the patient how to recognize norms, if not to conform to them.

At first glance psychotherapy may seem different from general medicine, and one might question whether principles applicable to one are applicable to the other. However, I think the difference here does not merit making a separate category for consideration for psychotherapy. Rather, I think psychotherapy might be classified with the role involved with the treatment of chronic disease processes. Psychotherapy and the general rehabilitative process are quite similar in concept and principle.

The rehabilitation process is conceptualized as a form of social experience and is divided into four stages by Mitsos:[36]

a. Illness behavior disequilibrium phase - crisis interval related to emergence of socially disturbing shifts in the role expectations between the handicapped status and that of the unimpaired.
b. Pre-client phase - person in a major predicament. He may resolve the crisis by seeking help or use a defense mechanism as denial of his problem.
c. Client role phase - establishment of an interpersonal climate which permits and stimulates the client to concentrate his energies on consuming help.
d. Social reintegration phase - achieving optimal autonomy and relearning appropriate roles.

Relatively recently a new aspect of the doctor-patient relationship has appeared. This aspect is termed "third party medicine,"[37] by Field, who has presented a fascinating discussion of this topic. According to Field, the increasing complexity of modern medicine (a technological factor) and the growing functional significance of

health (a social factor), have led to an increase in the costs of medical services and to the rise of "organizational" as against the more traditional "solo" mode of employing and remunerating the physician for his work. There has arisen considerable controversy on the modes of organizing and financing medical services and their influence on the doctor-patient relationship. This problem has become one of the stormiest social and political issues of the mid-century America.

At any rate, Field conducted a study of 1650 Soviet citizens now living in either West Germany or the U.S. These individuals had experienced both third part medicine and fee for service medicine.

He found that 75% of the West German group preferred West German medicine (insurance medicine) because it delivered what Soviet medicine often only promised. But 73% of the United States group preferred Soviet medicine, because although, Soviet medicine provided less adequate care, at least the (Soviet citizens) had legitimate claim to it--not as charity, but as a constitutional right.

With a third party system, the doctor is placed in a new situation, where both he and the patient are related to a third party. See Table VII for structural model. In this structure, a new situation arises where the doctor meets increased pressure from patients to outsmart and take advantage of the third party. A new mechanism is needed here to maintain the proper relationship. In Russia and Britain, the "disinterested" physician has had to become the physician devoted to the third party. But when this structure breaks down, one may find the physician and

the patient aligned against the third party. In other words, one begins to get some of the problems unique to the triad.

Field suggests that the third party may impose three types of influences on the doctor patient relationship:

a. Third party may see that funds are spent in the wisest, most economical way.
b. Pressures may be imposed by the third party in modalities of therapy and in assignment of certain standards.
c. Third party may directly interfere and dictation over professional matters as under certain military or political conditions.

This whole area of third party medicine, in terms of increasing voluntary group and institutional practice by physicians, and especially in terms of government being the third party as has become the case with both uses of federal grants and the passage of Medicare, has become very important aspect of the doctor-patient relationship and suggests a whole new dimension to research in this area.

TABLE I - PARSONS SUMMARY

Doctor Role

1. Achievement values of medicine

Pattern Variables:

2. Universalistic
3. Functionally specific
4. Affectively neutral
5. Collectivity - oriented

Patient or Sick Role

Rights

1. Exemption from normal social responsibilities
2. Not his fault - not expected to get well by an act or will

Duties

3. Definition of illness being undesirable
4. Obligation to seek technically competent help

Pattern Variables:

5. Universalistic
6. Functionally specific
7. Affectively neutral
8. Collectively - oriented

Doctor-Patient Relationship

1. Built-in safe guards against vulnerability of patient mostly based on informal mechanisms.
2. Function of physician "doing everything possible" is institutionalized.
3. The amounts and occasions of bodily exposure carefully regulated by society.
4. Relationship expected to be one of mutual trust.
5. Resistance to outside and formal control.
6. Bias in favor of active intervention.

TABLE II Factors Affecting Compliance with Medical Regime

1. Work values, especially in farmers may conflict with health values.
2. Difference in education had little effect, but over the four year time interval, there was a tendency to less compliance with increased education.
3. A cardiac impaired longer is less likely to stop complying than the farmer who has had cardiac impairment for less than nine years.
4. The younger person (< 45) is more likely to continue complying than the older person (> 45).
5. Decision to comply is influenced by interaction between the doctor and patient. A more formal relationship with the doctor serves to elicit more compliance.
6. Those who were positively influenced by someone other than the doctor were more likely to comply.

TABLE III

Findings on Five Stages of Illness

Stage I - Symptom Experience Stage

1. Pain was the most important first sign (66%) followed by chills and fever (17%) and shortness of breath (10%).

2. Time began - 60% during day, 20% during evening.

3. Symptoms were usually severe, continuous (70%), incapacitating, and unalleviated (80%).

4. 75% saw symptoms immediately as an indication of illness.

5. 75% thought of contacting a doctor immediately.

6. Severity of symptoms directly related to seeking professional help.

7. Sex - women twice as likely to report severe symptoms, to view symptoms seriously, and to become concerned. However, the sexes were equal in interpreting symptoms as illness.

8. Age - Older persons showed greater incapacity.

9. Socioeconomic - Lower classes showed somewhat more incapacity, but differences slight.

Stage II - Assumption of Sick Role Stage

1. 74% discussed symptoms with someone before seeking professional help - most to one other (48%) with only 5% speaking to three or more.

2. Discussed with other immediately in 91%.

3. a. Discussed with relative in 84%, usually the spouse (53%).
   b. 66% discussants integrated symptoms as illness; 54% recommended a doctor be consulted.
   c. 25% of discussants offered a diagnosis of a specific illness.

4. Almost all followed discussant's advice - so discussant left sick person with fairly clear plan of action in 78% of cases. (Perhaps biggest function of discussant is supportive one).

5. Women, younger persons, and upper socioeconomic status were more likely to discuss with several persons.

Stage III - Medical Care Contact Stage.

1. a. 65% sought professional help immediately.
   b. Why 35% did not.
      1. symptoms not serious 48%
      2. inability to quit work or responsibilities (24%)

2. 75% of those who delayed sought professional help within one week.

3. Financial considerations seemed unimportant as a deterrent.

4. The more serious the perceived illness, the more likely the person is to contact physician early (90 v.s. 45%)

5. 57% of physicians seen were 1st visits - only 1/3 saw their "family doctor" and their patients were mostly older and of upper socioeconomic status.

6. Non family doctor seen was result of referral in 53%.

7. Patient went alone to doctor (40%) and with spouse (33%).

8. 76% talked over the doctor's recommendations with someone, usually the spouse (50%) or some other relative (28%).

9. 97% followed the doctors orders.

Stage IV - Dependent-Patient Role Stage.

1. 62% thought doctor was primarily interested in the welfare of his patients.

2. Only 20% felt the doctor did not help them much.

3. Most people said it was hard to go to bed (74%) and to give up responsibilities (58%).

4. But 90% were willing to follow the doctor's orders. Most turned responsibilities over to their family.

5. Most were satisfied with care and physician - patient relationship.

Stage V - Recover Stage.

Most have less dificulty relinquishing the sick role than in taking it on.

TABLE IV Classification of Dyads

I. Comprehensive Dyads -- large portion of personality involved

A. Friendship Pairs

B. Sexual Pairs

C. Generation pairs i.e. mother - father

II. Segmentalized Dyads -- segmental parts of personality involved

A. Aider - Aided pairs -- as doctor-patient

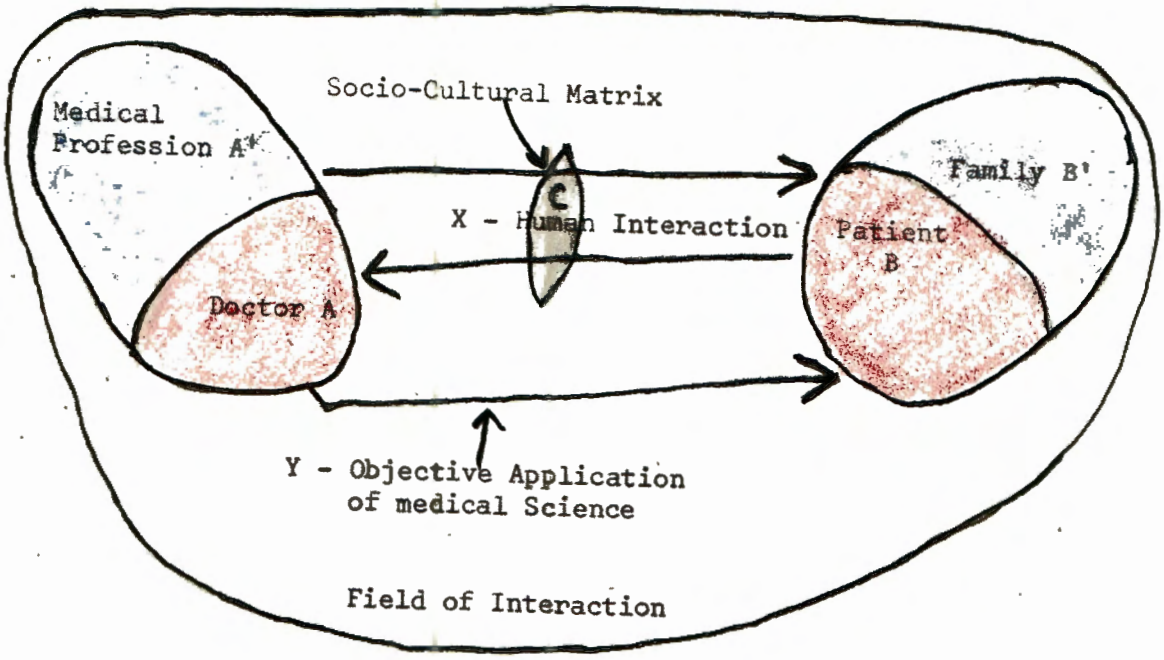
B. Teacher - Pupil pairs

C. Ordinated pairs as foreman - worker

D. Common interest pairs as artist - artist

E. Patterned contact pairs as shopper - shopper

TABLE V Doctor-Patient Model




Interaction Model
by Bloom

TABLE VI Structural Model by Ort, Ford, and Liske

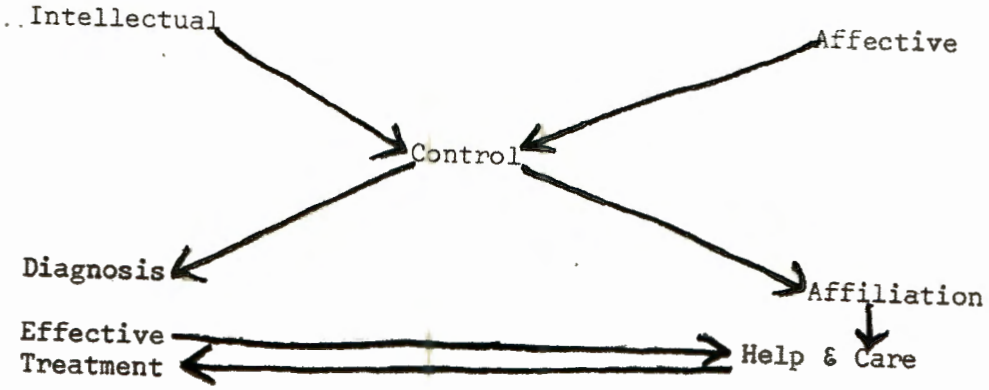
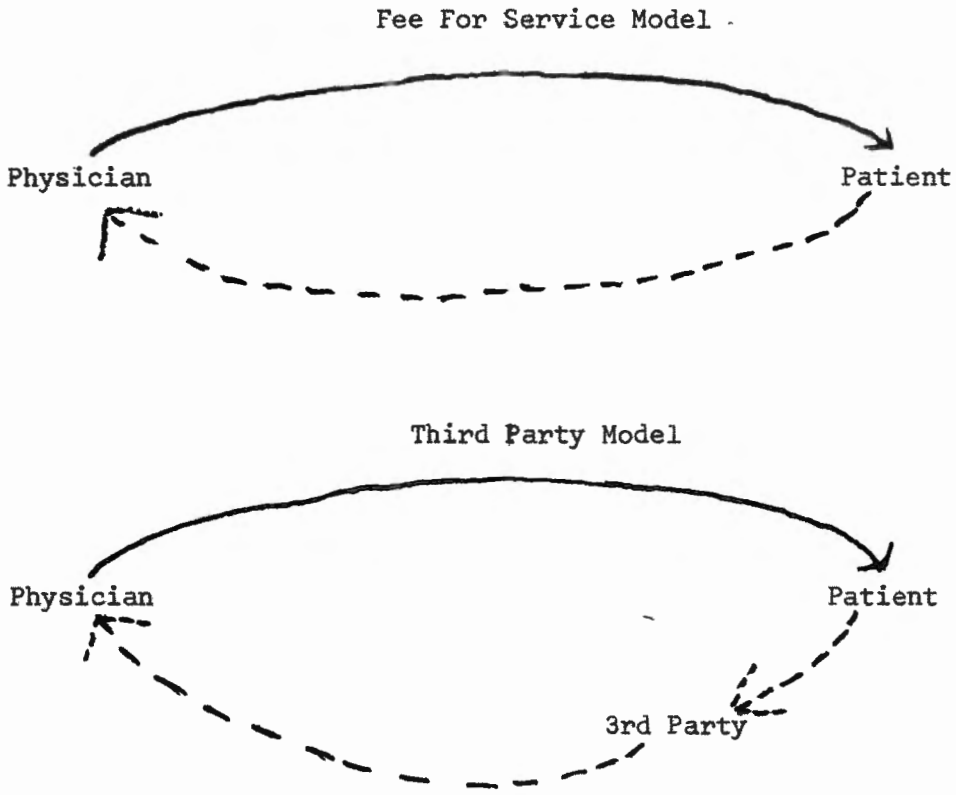


TABLE VII Structural Comparison



## SUMMARY STATEMENT

This paper has been an attempt to present the doctor-patient relationship from a sociological point of view. Hence, sociological concepts such as group, and interaction are used in an attempt to clarify certain aspects of this important interactional system.

The paper falls easily into two major areas, as does knowledge in the field of sociology. These two major areas are theory and research.

The theory presented is that of Talcott Parsons with his classic definition of the sick role and his theoretical presentation of the expectations on the part of both the doctor and the patient in the doctor-patient relationship.

The research presented is all very recent except for some of the general important background research such as that on the dyad. The doctor-patient relationship has only recently become an area where sociological study has become productive. Within the past ten to fifteen years, there have been sociologists specializing in the sociology of medicine. These people are becoming quite prolific in their writings. Some of these sociologists, especially David Mechanic, are making significant contributions.

An area which is just beginning to be studied is that of the third party medicine. Third party medicine includes more than just government in medicine. It also includes other groups such as laboratory technicians, X-ray technicians, social workers, etc. as well as government. Obviously then, third party medicine existed before medicare. But it has only been very recently that the tools of sociology have begun to be applied to this fascinating area.

## BIBLIOGRAPHY


1. Parsons, T.: The Social System, ed 2, Glencoe, Illinois: The Free Press, 1951, p 428

2. Ibid., pp 428-452

3. Ibid., pp 428-429

4. Ibid., p 421

5. Ibid., p 432

6. Ibid., p 434

7. Ibid., pp 445-446

8. Ibid., p 452

9. Handbook of Medical Sociology, ed 1, H. E. Freeman, S. Levine, and L. G. Reeder (ed), Englewood Cliffs: Prentice Hall, 1963, pp 278-279

10. Myerhoff, B. G., and Larson, W. R., The Doctor as Culture Hero: The Routinization of Charisma, Human Organization 24:188-191, Fall 1965

11. Gamson, W. A. and Schaum, H., Some Undercurrents in the Prestige of Physicians, American Journal of Sociology 68:463-470, Jan. 1963

12. Handbook of Medical Sociology, Op. Cit., p 279

13. Goss, M. E. W., Influence and Authority Among Physicians in an Outpatient Clinic, American Sociology Review 26:39-50, Nov. 1961

14. Daniels, M. J., Affect and its Control in the Medical Intern, American Journal of Sociology 66:259-267, March 1961

15. Handbook of Medical Sociology, Op. Cit., p 281

16. Ibid., p 283

17. Cogswell, B. and Weir, D. D., A Role in Process: The Development of Medical Professional's Role in Long-term Care of Chronically Diseased Patients, Journal of Health and Human Behavior 5: 181-196, Summer and Fall 1964

18. Freidson, E., Client Control and Medical Practice, American Journal of Sociology 65:374-382, Jan. 1960

19. Davis, M. S. and Eichorn, R. L., Compliance with Medical Regimens: A Panel Study, Journal of Health and Human Behavior 4:240-249, Winter 1963

20. Suchman, E. A., Stages of Illness and Medical Care, Journal of Health and Human Behavior 6:114-128, Fall 1965

21. Rosengren, W.R., The Sick Role During Pregnancy: A Note on Research in Progress, Journal of Health and Human Behavior 8:213-218, Fall 1963

22. Schumann, E. A., Social Patterns of Illness and Medical Care, Journal Health and Human Behavior 6:2-14, Spring 1965

23. Kasselbaum, G. G. and Baumann, B. O., Dimensions of the Sick Role in Chronic Illness, Journal of Health and Human Behavior 6:16-27, Spring 1965

24. Becker, H. and Useem, Ruth, Sociological Analysis of the Dyad, American Sociology Review 7:13-26, April 1942

25. Ibid., p 13

26. Ibid., pp 13-26

27. Moreno, S. L., Mental Catharsis and Psychodrama, Sociometry 3:209-244, July 1940

28. Becker, H and Useem, R., Op. Cit., p 17

29. Borgata, E. F. and Guerrin, R. F., The Two Person Group: Some Notes on Theory and Research, Sociology and Social Research 45:3-13, June 1960

30. Bloom, S. W.: The Doctor and His Patient, ed 1, New York City: Russell Sage Foundation, 1963, p 5

31. Ibid., pp 10-125

32. Ort, R. S., Ford, A. B., and Liske, R. E., The Doctor Patient Relationship as Described by Physicians and Medical Students, Journal of Health and Human Behavior 5:2-14, Spring 1964

33. Kadushin, C., Social Distance Between Client and Professional, American Journal of Sociology 67:517-31, March 1962

34. Mechanic, D., Role Expectations and Communication in the Therapist-patient Relationship, Journal of Health and Human Behavior 2:190-198, Fall 1961

35. Ross, J. A., Social Class and Medical Care, Journal of Health and Human Behavior 3:35-40, Spring 1962

36. Mitsos, S. B., Rehabilitation as Planned Social Change: A Conceptual Framework, Journal of Health and Human Behavior 5:2-14, Spring 1964

37. Field, M. G., The Perspective of Fee-for-service and Third Party Medicine, Journal of Health and Human Behavior 2:252-262, Winter 1961