A Contribution to the Philosophy of Medicine

The Basic Models of the Doctor-Patient Relationship

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INTRODUCTION

When a person leaves the culture in which he was born and raised and migrates to another, he usually experiences his new social setting as something strange—and in some ways threatening—and he is stimulated to master it by conscious efforts at understanding. To some extent every immigrant to the United States reacts in this manner to the American scene. Similarly, the American tourist in Europe or South America "scrutinizes" the social setting which is taken for granted by the natives. To scrutinize—and criticize—the pattern of other peoples' lives is obviously both common and easy. It also happens, however, that people exposed to cross cultural experiences turn their attention to the very customs which formed the social matrix of their lives in the past. Lastly, to study the "customs" which shape and govern one's day-to-day life is most difficult of all.[1]

In many ways the psychoanalyst is like a person who has migrated from one culture to another. To him the relationship between physician and patient—which is like a custom that is taken for granted in medical practice and which he himself so treated in his early history—has become an object of study. While the precise nature and extent of the influence which psychoanalysis and so-called dynamic psychiatry have had on modern medicine are debatable, it seems to us that the most decisive effect has been that of making physicians explicitly aware of the possible significance of their relationship to patients.

The question naturally arises as to "What is a doctor-patient relationship?" It is our aim to discuss this question and to show that certain philosophical preconceptions associated with the notions of "disease," "treatment," and "cure" have a profound bearing on both the theory and the practice of medicine.*

WHAT IS A HUMAN RELATIONSHIP?

The concept of a relationship is a novel one in medicine. Traditionally, physicians have been concerned with "things," for example, anatomical structures, lesions, bacteria, and the like. In modern times the scope has been broadened to include the concept of "function." The phenomenon of a human relationship is often viewed as though it were a "thing" or a "function." It is, in fact, neither. Rather it is an abstraction, appropriate for the description and handling of certain observational facts. Moreover, it is

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* In our approach to this subject we have been influenced by psychologic (psychoanalytic), sociologic, and philosophic considerations. See in this connection References 2-4 and Szasz, T. S.: On the Theory of Psychoanalytic Treatment, read before the Annual Meeting of the American Psychoanalytic Association, Atlantic City, N. J., May 7, 1955; Internat. J. Psychoanal., to be published.

an abstraction which presupposes concepts of both structure and function.

The foregoing comments may be clarified by concrete illustrations. Psychiatrists often suggest to their medical colleagues that the physician's relationship with his patient "per se" helps the latter. This creates the impression (whether so intended or not) that the relationship is a thing, which works not unlike the way that vitamins do in a case of vitamin deficiency. Another idea is that the doctor-patient relationship depends mainly on what the physician does (or thinks or feels). Then it is viewed not unlike a function.

When we consider a relationship in which there is joint participation of the two persons involved, "relationship" refers to neither a structure nor a function (such as the "personality" of the physician or patient). It is, rather, an abstraction embodying the activities of two interacting systems (persons).[5]

TABLE 1.—*Three Basic Models of the Physician-Patient Relationship*

	Model	Physician's Role	Patient's Role	Clinical Application of Model	Prototype of Model
1.	Activity-passivity	Does something to patient	Recipient (unable to respond or inert)	Anesthesia, acute trauma, coma, delirium, etc.	Parent-infant
2.	Guidance-cooperation	Tells patient what to do	Cooperator (obeys)	Acute infectious processes, etc.	Parent-child (adolescent)
3.	Mutual participation	Helps patient to help himself	Participant in "partnership" (uses expert help)	Most chronic illnesses, psychoanalysis, etc.	Adult-adult

THREE BASIC MODELS OF THE DOCTOR-PATIENT RELATIONSHIP

The three basic models of the doctor-patient relationship (see Table 1), which we will describe, embrace modes of interaction ubiquitous in human relationships and in no way specific for the contact between physician and patient. The specificity of the medical situation probably derives from a combination of these modes of interaction with certain technical procedures and social settings.

1. *The Model of Activity-Passivity.*—Historically, this is the oldest conceptual model. Psychologically, it is not an interaction, because it is based on the effect of one person on another in such a way and under such circumstances that the person acted upon is unable to contribute actively, or is considered to be inanimate. This frame of reference (in which the physician does something to the patient) underlies the application of some of the outstanding advances of modern medicine (e. g., anesthesia and surgery, antibiotics, etc.). The physician is active; the patient, passive. This orientation has originated in—and is entirely appropriate for—the treatment of emergencies (e. g., for the patient who is severely injured, bleeding, delirious, or in coma). "Treatment" takes place irrespective of the patient's contribution and regardless of the outcome. There is a similarity here between the patient and a helpless infant, on the one hand, and between the physician and a parent, on the other. It may be recalled that psychoanalysis, too, evolved from a procedure (hypnosis) which was based on this model. Various physical measures to which psychotics are subjected today are another example of the activity-passivity frame of reference.

2. *The Model of Guidance-Cooperation.*—This model underlies much of medical practice. It is employed in situations which are less desperate than those previously mentioned (e. g., acute infections). Although the patient is ill, he is conscious and has feelings and aspirations of his own. Since he suffers from pain, anxiety, and other distressing symptoms, he seeks help and is ready and willing to "cooperate." When he turns to a physician, he places the latter (even if only in some limited ways) in a

position of power. This is due not only to a "transference reaction" (i. e., his regarding the physician as he did his father when he was a child) but also to the fact that the physician possesses knowledge of his bodily processes which he does not have. In some ways it may seem that this, like the first model, is an active-passive phenomenon. Actually, this is more apparent than real. Both persons are "active" in that they contribute to the relationship and what ensues from it. The main difference between the two participants pertains to power, and to its actual or potential use. The more powerful of the two (parent, physician, employer, etc.) will speak of guidance or leadership and will expect cooperation of the other member of the pair (child, patient, employee, etc.). The patient is expected to "look up to" and to "obey" his doctor. Moreover, he is neither to question nor to argue or disagree with the orders he receives. This model has its prototype in the relationship of the parent and his (adolescent) child. Often, threats and other undisguised weapons of force are employed, even though presumably these are for the patient's "own good." It should be added that the possibility of the exploitation of the situation—as in any relationship between persons of unequal power—for the sole benefit of the physician, albeit under the guise of altruism, is ever present.

3. *The Model of Mutual Participation.*—Philosophically, this model is predicated on the postulate that equality among human beings is desirable. It is fundamental to the social structure of democracy and has played a crucial role in occidental civilization for more than two hundred years. Psychologically, mutuality rests on complex processes of identification—which facilitate conceiving of others in terms of oneself—together with maintaining and tolerating the discrete individuality of the observer and the observed. It is crucial to this type of interaction that the participants (1) have approximately equal power, (2) be mutually interdependent (i. e., need each other), and (3) engage in activity that will be in some ways satisfying to both.

This model is favored by patients who, for various reasons, want to take care of themselves (at least in part). This may be an overcompensatory attempt at mastering anxieties associated with helplessness and passivity. It may also be "realistic" and necessary, as, for example, in the management of most chronic illnesses (e. g., diabetes mellitus, chronic heart disease, etc.). Here the patient's own experiences provide reliable and important clues for therapy. Moreover, the treatment program itself is principally carried out by the patient. Essentially, the physician helps the patient to help himself.

In an evolutionary sense, the pattern of mutual participation is more highly developed than the other two models of the doctor-patient relationship. It requires a more complex psychological and social organization on the part of both participants. Accordingly, it is rarely appropriate for children or for those persons who are mentally deficient, very poorly educated, or profoundly immature. On the other hand, the greater the intellectual, educational, and general experiential similarity between physician and patient the more appropriate and necessary this model of therapy becomes.

THE BASIC MODELS AND THE PSYCHOLOGY OF THE PHYSICIAN

Consideration of why physicians seek one or another type of relationship with patients (or seek patients who fit into a particular relationship) would carry us beyond the scope of this essay. Yet, it must be emphasized that as long as this subject is approached with the sentimental viewpoint that a physician is simply motivated by a wish to help others (not that we deny this wish), no scientific study of the subject can be undertaken. Scientific investigation is possible only if value judgment is subrogated, at least temporarily, to a candid scrutiny of the physician's actual behavior with his patients.

The activity-passivity model places the physician in absolute control of the situation. In this way it gratifies needs for mastery and contributes to feelings of superiority.† At the

† References 6 and 7.

same time it requires that the physician disidentify with the patient as a person.

Somewhat similar is the guidance-cooperation model. The disidentification with the patient, however, is less complete. The physician, like the parent of a growing child, could be said to see in the patient a human being potentially (but not yet) like himself (or like he wishes to be). In addition to the gratifications already mentioned, this relationship provides an opportunity to recreate and to gratify the "Pygmalion Complex." Thus, the physician can mold others into his own image, as God is said to have created man (or he may mold them into his own image of what they should be like, as in Shaw's "Pygmalion"). This type of relationship is of importance in education, as the transmission of more or less stable cultural values (and of language itself) shows. It requires that the physician be convinced he is "right" in his notion of what is "best" for the patient. He will then try to induce the patient to accept his aims as the patient's own.

The model of mutual participation, as suggested earlier, is essentially foreign to medicine. This relationship, characterized by a high degree of empathy, has elements often associated with the notions of friendship and partnership and the imparting of expert advice. The physician may be said to help the patient to help himself. The physician's gratification cannot stem from power or from the control over someone else. His satisfactions are derived from more abstract kinds of mastery, which are as yet poorly understood.

It is evident that in each of the categories mentioned the satisfactions of physician and patient complement each other. This makes for stability in a paired system. Such stability, however, must be temporary, since the physician strives to alter the patient's state. The comatose patient, for example, either will recover to a more healthy, conscious condition or he will die. If he improves, the doctor-patient relationship must change. It is at this point that the physician's inner (usually unacknowledged) needs are most likely to interfere with what is "best" for the patient. At this juncture, the physician either changes his "attitude" (not a consciously or deliberately assumed role) to complement the patient's emergent needs or he foists upon the patient the same role of helpless passivity from which he (allegedly) tried to rescue him in the first place. Here we touch on a subject rich in psychological and sociological complexities. The process of change the physician must undergo to have a mutually constructive experience with the patient is similar to a very familiar process: namely, the need for the parent to behave ever differently toward his growing child.

WHAT IS "GOOD MEDICINE"?

Let us now consider the problem of "good medicine" from the viewpoint of human relationships. The function of sciences is not to tell us what is good or bad but rather to help us understand how things work. "Good" and "bad" are personal judgments, usually decided on the basis of whether or not the object under consideration satisfies us. In viewing the doctor-patient relationship we cannot conclude, however, that anything which satisfies—irrespective of other considerations—is "good." Further complications arise when the method is questioned by which we ascertain whether or not a particular need has been satisfied. Do we take the patient's word for it? Or do we place ourselves into the traditional parental role of "knowing what is best" for our patients (children)?

The shortcomings and dangers inherent in these and in other attempts to clarify some of the most basic aspects of our daily life are too well known to require documentation. It is this very complexity of the situation which has led, as is the rule in scientific work, to an essentially arbitrary simplification of the structure of our field of observation.‡

‡ We omit any discussion of the physician's technical skill, training, equipment, etc. These factors, of course, are of importance, and we do not minimize them. The problem of what is "good medicine" can be considered from a number of viewpoints (e. g., technical skill, economic considerations, social roles, human relationships, etc.). Our scope in this essay is limited to but one—sometimes quite unimportant—aspect of the contact between physician and patient.

Let us present an example. A patient consults a physician because of pain and other symptoms resulting from a duodenal ulcer. Both physician and patient assume that the latter would be better off without these discomforts. The situation now may be structured as follows: healing of the ulcer is "good," whereas its persistence is "bad." What we wish to emphasize is the fact that physician and patient agree (explicitly or otherwise) as to what is good and bad. Without such agreement it is meaningless to speak of a therapeutic relationship.

In other words, the notions of "normal," "abnormal," "symptom," "disease," and the like are social conventions. These definitions often are set by the medical world and are usually tacitly accepted by others. The fact that there is agreement renders it difficult to perceive their changing (and relativistic) character. A brief example will clarify this statement. Some years ago—and among the uneducated even today—fever was regarded as something "bad" ("abnormal," a "symptom"), to be combated. The current scientific opinion is that it is the organism's response to certain types of influences (e. g., infection) and that within limits the manifestation itself should not be "treated."

The issue of agreement is of interest because it has direct bearing on the three models of the doctor-patient relationship. In the first two models "agreement" between physician and patient is taken for granted. The comatose patient obviously can not disagree. According to the second model, the patient does not possess the knowledge to dispute the physician's word. The third category differs in that the physician does not profess to know exactly what is best for the patient. The search for this becomes the essence of the therapeutic interaction. The patient's own experiences furnish indispensable information for eventual agreement, under otherwise favorable circumstances, as to what "health" might be for him.

The characteristics of the different types of doctor-patient relationships are summarized in Table 2. In this connection, some comments will be made on a subject which essentially is philosophical but which continues to plague many medical discussions; namely, the problem of comparing the efficacy of different therapeutic measures. Such comparisons are implicitly based on the following conceptual scheme: We postulate disease "A," from which many patients suffer. Therapies "B," "C," and "D" are given to groups of patients suffering with disease "A," and the results are compared. It is usually overlooked that, for the results to be meaningful, significant conceptual similarities must exist between the operations which are compared. The three categories of the doctor-patient relationship are concretely useful in delineating areas within which meaningful comparisons can be made. Comparisons between therapies belonging to different categories are philosophically (and logically) meaningless and lead to fruitless controversy.

To illustrate this thesis let us consider some examples. A typical comparison, with which we can begin, is that of the various agents used in the treatment of lobar pneumonia: type-specific antisera, sulfonamides, and penicillin. Each superseded the other, as the increased efficacy of the newer preparations was demonstrated. This sort of comparison is meaningful because there is agreement as to what is being treated and as to what constitutes a "successful" result. There should be no need to belabor this point. What is important is that this conceptual model of therapeutic comparisons is constantly used in situations in which it does not apply; that is, in situations in which there is clear-cut disagreement as to what constitutes "cure." In this connection, the problem of peptic ulcer will exemplify a group of illnesses in which several therapeutic approaches are possible.

This question is often posed: Is surgical, medical or psychiatric treatment the "best" for peptic ulcer?§ Unless we specify conditions, goals, and the "price" we are willing to pay (in the largest sense of the word), the

§ Such a question is roughly comparable to asking, "Is an automobile or an airplane better?" —without specifying for what. See Rapoport.[8]

Table 2.—*Analysis of the Concepts of "Disease," "Treatment," and "Therapeutic Result"*

Doctor-Patient Relationship	The Meaning of "Treatment"	The "Therapeutic Result"	The Notions of Disease and Health	In Medicine (Illustrative Examples)	In Psychiatry (Illustrative Examples)
1. Activity-passivity	Whatever the physician does; the actual operations (procedures) which he employs	Alteration in the structure and/or function of the patient's body (or behavior, as determined by the physician's judgment); the patient's judgment does not enter into the evaluation of results; e. g., T & A is "successful" irrespective of how patient feels afterward	The presence or absence of some unwanted structure or function The actual state of affairs — The same state without the disability	1. Treatment of the unconscious patient; for example, the patient in diabetic coma; cerebral hemorrhage; shock due to acute injury; etc. 2. Major surgical operation under general anesthesia	1. Hypnosis 2. Convulsive treatments (electroshock, insulin, etc.) 3. Surgical treatments (lobotomy, etc.)
2. Guidance-cooperation	Whatever the physician does; similar to the above	Similar to the above, albeit patient's judgment is no longer completely irrelevant; success of therapy is still the physician's private decision; if patient agrees, he is a good patient, but if he disagrees he is bad or "uncooperative"	The presence or absence of "signs" and "symptoms"; the physician's particular concept of "Disease" (e. g., infection) — "Health" (usually, no disease; e. g., no infection)	Most of general medicine and the postoperative care of surgical patients (e. g., prescription of drugs, "advice" to smoke less, etc.)	1. "Suggestion," counseling, therapy based on "advice," etc. 2. Some modifications of psychoanalytic therapy 3. So-called psychotherapy "combined" with physical therapies (e. g., electric shock)
3. Mutual participation	An abstraction of one aspect of the relationship, embodying the activities of both participants; "treatment" cannot be said to take place unless both participants orient themselves to the task ahead	Much more poorly defined than in the previous models: evaluation of the result will depend on both the physician's and the patient's judgments and is further complicated by the fact that these may change in the very process of treatment	The notions of disease and health lose most of their relevance in this context; the notions of more-or-less successful (for certain purposes) modes of behavior, adaptation, or integration take the place of the earlier, more categorical concepts	The treatment of patients with certain chronic diseases or structural defects; for example, the management of diabetes mellitus or of myasthenia gravis; "rehabilitation" of patients with orthopedic defects, such as learning the use of prostheses, etc.	1. Psychoanalysis 2. Some modifications of psychoanalytic therapy

question is meaningless. In the case of peptic ulcer, it is immediately apparent that each therapeutic approach implies a different conception of "disease" and correspondingly divergent notions of "cure." At the risk of slight overstatement, it can be said that according to the surgical viewpoint the disease is the "lesion," treatment aims at its eradication (by surgical means), and cure consists of its persistent absence (nonrecurrence). If a patient undergoes a vagotomy and all evidence of the lesion disappears, he is considered cured even if he develops another (apparently unrelated) illness six months later. It should be emphasized that no criticism of this frame of reference is intended. The foregoing (surgical) approach is entirely appropriate, and accusations of "narrowness" are no more (nor less) justified than they would be against any other specialized branch of knowledge.

To continue our analysis of therapeutic comparisons, let us consider the same patient (with peptic ulcer) in the hands of an internist. This specialist might have a somewhat different idea of what is wrong with him than did the surgeon. He might regard peptic ulcer as an essentially chronic disease (perhaps due to heredity and other "predispositions"), with which the patient probably will have to live as comfortably as possible for years. This point is emphasized to demonstrate that the surgeon and the internist do not treat the "same disease." How then can the two methods of treatment and their results be compared? The most that can be hoped for is to be able to determine to what extent each method is appropriate and successful within its own frame of reference.

If we take our hypothetical patient to a psychoanalyst, the situation is even more radically different. This specialist will state that he is not treating the "ulcer" and might even go so far as to say that he is not treating the patient for his ulcer. The psychoanalyst (or psychiatrist) has his own ideas about what constitutes "disease," "treatment," and "cure."||

|| References 9 and 10.

CONCLUSIONS

Comments have been made on some factors which provide satisfactions to both patient and physician in various therapeutic relationships. In conclusion, we call attention to two important considerations regarding the complementary situations described.

First, it might be thought that one of the three basic models of the doctor-patient relationship is in some fundamental (perhaps ethical) way "better" than another. In particular, it might be considered that it is better to identify with the patient than to treat him like a helplessly sick person. We have tried to avoid such an inference. In our opinion, each of the three types of therapeutic relationship is entirely appropriate under certain circumstances and each is inappropriate under others.

Secondly, we will comment on the therapeutic relationship as a situation (more or less fixed in time) and as a process (leading to change in one or both participants). Most of our previous comments have dealt with the relationship as a situation. It is, however, also a process in that the patient may change not only in terms of his symptoms but also in the way he wishes to relate to his doctor. A typical example is the patient with diabetes mellitus who, when first seen, is in coma. At this time, the relationship must be based on the activity-passivity model. Later, he has to be educated (guided) at the level of cooperation. Finally, ideally, he is treated as a full-fledged partner in the management of his own health (mutual participation). Confronted by a problem of this type, the physician is called upon to change through a corresponding spectrum of attitudes. If he cannot make these changes, he may interfere with the patient's progress and may promote an arrest at some intermediate stage in the evolution toward relative self-management. The other possibility in this situation is that both physician and patient will become dissatisfied with each other. This outcome, however unfortunate, is probably the commonest one. Most of us can probably verify it first-hand in the roles of both physician and patient.[11]

At such juncture, the physician usually feels that the patient is "uncooperative" and "difficult," whereas the patient regards the physician as "unsympathetic" and lacking in understanding of his personally unique needs. Both are correct. Both are confronted by the wish to induce changes in the other. As we well know, this is no easy task. The dilemma is usually resolved when the patient seeks another physician, one who is more attuned to his (new) needs. Conversely, the physician will "seek" a new patient, usually one who will benefit from the physician's (old) needs and corresponding attitudes. And so life goes on.

The pattern described accounts for the familiar fact that patients often choose physicians not solely, or even primarily, on the basis of technical skill. Considerable weight is given to the type of human relationship which they foster. Some patients prefer to be "unconscious" (figuratively speaking), irrespective of what ails them. Others go to the other extreme. The majority probably falls somewhere between these two polar opposites. Physicians, motivated by similar personal "conflicts" form a complementary series. Thus, there is an interlocking integration of the sick and his healer.

SUMMARY

The introduction of the construct of "human relationship" represents an addition to the repertoire of fundamental medical concepts.

Three basic models of the doctor-patient relationship are described with examples. The models are (*a*) Activity-passivity. The comatose patient is completely helpless. The physician must take over and do something to him. (*b*) Guidance-cooperation. The patient with an acute infectious process seeks help and is ready and willing to cooperate. He turns to the physician for guidance. (*c*) Mutual participation. The patient with a chronic disease is aided to help himself.

The physician's own inner needs (and satisfactions) form a complementary series with those of the patient.

The general problem usually referred to with the question "what is good medicine?" is briefly considered. Different types of doctor-patient relationships imply different concepts of "disease," "treatment," and "cure." This is of importance in comparing diverse therapeutic methods. Meaningful comparisons can be made only if interventions are based on the same frame of reference.

It has been emphasized that different types of doctor-patient relationships are necessary and appropriate for various circumstances. Problems in human contact between physician and patient often arise if in the course of treatment changes require an alteration in the pattern of the doctor-patient relationship. This may lead to a dissolution of the relationship.

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