TION OF HEALTH CARE; MEDICINE, SOCIOLOGY OF; *and* SOCIAL MEDICINE. *Other relevant material may be found under* MEDICAL MALPRACTICE; MEDICAL PROFESSION, *article on* MEDICAL PROFESSIONALISM; PATERNALISM; PATIENTS' RIGHTS MOVEMENT; *and* RIGHTS, *article on* RIGHTS IN BIOETHICS.]

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IV
CONTEMPORARY MEDICAL PERSPECTIVE

Concepts of the therapeutic relationship have undergone evolution, particularly during this century. The conventional, idealized view of the physician simply attending to the sick patient has been altered and transformed by the awareness that this interaction is a complex personal relationship occurring within a social matrix. Conceptual understanding requires knowledge not only of what both doctor and patient bring to the relationship, but also of what social norms and forces are acting on the two.

However, it is the presence or possibility of serious illness that governs the genesis of a therapeutic relationship. Whether the doctor is caring for a person who has fallen ill or is looking after a well patient and fostering the bond of trust between them in anticipation of possible sickness, the phenomenon of illness remains the central point around which the relationship is built.

The phenomenon of illness

Whatever the cause, from fractures to cancer, the sick person undergoes a specific set of events that characterize the experience of illness. The sick person suffers a series of symptoms—alien body sensations and a loss of normal function occurring in a body he only poorly understands. He is disconnected from his normal world by his symptoms (from inability to walk to sensory deprivation), by external forces such as hospitalization or avoidance by others, and by his loss of interest in things and in persons.

The well individual functions with a sense of indestructibility that acts to deny the possibility of injury or death; the sick person is threatened with loss of his own sense of indestructibility. Further, in illness the ability to reason is weakened in the patient and cognitive function can be qualitatively impaired. Normal thought continually strives to comprehend the world, but the significance of events is often beyond the grasp and scope of the sick.

Perhaps the most powerful factor in the illness syndrome is the fact that the sick person must endure the loss of his sense of his own ability to control himself, his body, and his world. Maintaining control over oneself is so deep a human need that one might see all the other phenomena of illness as doing harm not only in their own right, but doubly so as they reinforce the sick person's perception that he is no longer in control (Cassell, 1976, pp. 25 ff.).

It should be understood that in any given instance of a doctor–patient interaction the extent to which these factors are operative may vary markedly. The degree to which the sick person loses his sense of his own indestructibility, becomes disconnected, finds his reasoning insufficient, and loses his control of self and of

world varies with the severity of the sickness and the patient's perception of illness, as well as other personality and social factors. The patient may be entirely well, as in a preventive medical examination, or catastrophically ill following a heart attack. But however well or ill the patient is, the individual interaction with the physician takes place within a framework informed, at least in part, by past, present, or the possibility of future illness. The events in the set described above, which occur in illness, derive their force by their interplay with the personalities of both the patient and the physician, as well as the setting in which the interaction takes place.

The personality of the patient is of real import because features of illness such as the loss of control or the sense of disconnection may be better tolerated or, conversely, be more threatening to one individual than to another. It is for this reason that, in terms of the care of patients, the disease that causes an illness cannot be truly understood without the physician's understanding of the person in whom the disease occurs. The personality of the doctor is of concern insofar as individual physicians deal better or worse with some or all of the phenomena of illness. In seeking a therapeutic relationship, then, a patient—in addition to looking for a technically competent practitioner—is searching for a physician who is prepared to attend to personal factors that are or will be of serious consequence in his illness (Balint).

The setting in which the relationship takes place also influences how forcefully certain aspects of illness will operate. Impersonal versus personal settings and attitudes, high technology versus low technology settings—all have both positive and negative effects.

The physician in the therapeutic relationship

With the view of illness described above in mind, it is necessary to see what the doctor and the patient each bring to the therapeutic relationship aside from their personalities. The physician brings technical expertise drawn from training and experience. The technical knowledge includes not only the technical skills involved in the treatment of the patient but also the system of reasoning, knowledge, cares, and concerns by virtue of which medicine and society bring order into and remove mystery from the manifestations of illness. It is more important that the doctor's explanations be culturally consonant than that they be true, since all explanations of illness as well as role relationships between doctor (healer) and patient are related to the belief system of the culture in which they occur (Ackerknecht). This is underscored by the fact that explanations of illness for most of the world's history and in most cultures have proved inadequate or false with the passage of time and the progress of scientific inquiry, despite the fact that they served their function while extant.

While technical expertise is part of the doctor's manifest contribution known to all participants, the physician also brings healing skills of which neither he nor the patient may be aware, particularly in Western scientific medicine. The healing factors, which are also of personal, moral concern for the patient, are necessary for dealing with those aspects of the illness syndrome identified above. The high social status accorded physicians in this society (and healers in almost all groups) allows them to replace the ill person's loss of social connection with their own connectedness. Physicians and clergy travel between the world of the well and the world of the sick and the dying. The physicians' own often overdeveloped sense of invulnerability and their patients' frequent attribution to them of exaggerated power over illness help supplant the sick person's loss of the sense of omnipotence. In addition, the doctor's rational system of explanations reinforces the patient's system of reason so that the mysteries of illness are again contained. Reflect, in this aspect, on how important it is that the patient's illness have a name, since the word is often seen as containing the thing (Laín Entralgo, 1970). The disease concepts of Western medicine can be seen in this light as a highly useful and effective conceptual structure. Finally, the physician serves as an alternative mode of control for the patient, restoring some balance to the relationship of the person with his body, as well as with the outer world.

The physician also brings to the relationship access to other parts of the medical care system such as medical specialists, drug prescriptions, diagnostic treatment facilities, hospitals, or other institutions. This function has become increasingly important in the highly technical and specialized medical care world of modern Western cultures. The social and moral functions of physicians have been much discussed in recent years with special attention paid to their ability to provide access to and legitimate the

sick role, without which the patient cannot assume the special position assigned to the sick in this and other societies (Parsons). The importance of this function is illustrated by the change in the status of the alcoholic, as alcoholism has changed from being a moral problem to being an illness as well. Part of the same function is the ability of the physician to legitimate or even enforce the reentry of the sick person to the healthy world. This role is exemplified by the success of the rehabilitation movement since the Second World War in having society consider the physically disabled as healthy. The doctor also carries a legal mantle, shown by his sole right legally to pronounce death, as well as a host of certification functions. Finally, physicians, more than most, are expected to be honest, objective as well as empathetic, trustworthy, kind, and gentle.

It has been pointed out that physicians also serve a quasi-missionary function, which seems to compel them to convert their patients to their own standards for health and moral beliefs (Balint). This educational process may, when extreme, apply to all aspects of the patient's life, but it certainly applies to matters connected with health or sickness. Attitudes toward drug use, exercise, and cigarette smoking are obvious examples. Less apparent to both doctor and patient but no less important are basic beliefs about sickness and its causes and about attitudes toward the body. Each episode of illness for which the patient sees the physician provides the doctor with an opportunity to transmit his own beliefs. For one, it is that illness must be borne in passive silence; for another, the opposite. One doctor may transmit the attitude that the body is full of dangerous, hidden mysteries that may strike at any time, while another teaches that the body is a mutable friend. In this aspect of the relationship as in others, the patient is not merely a passive recipient. The patient may reject the lesson and the physician with it. Indeed, the patient may be teacher. Physicians are exposed to wide variations in human behavior, mostly because their daily confrontation with illness and their experience in treating a variety of persons inevitably shape their lives, their work, and their moral beliefs.

The patient in the therapeutic relationship

The patient brings to his relationship his need, manifested by the symptoms of his disease. As part of the process of socialization, starting in infancy, individuals in any group become aware of the acceptable mode in which symptoms must be expressed and aware of those problems which warrant the care of the doctor (Cassell, 1976). The patient also brings to the transaction a desire to get better as part of his social responsibility. Patients are expected to be honest and trusting in the relationship as well as to provide physical access to their person in a manner not usually accorded strangers. Finally, of course, the patient provides monetary reward to the doctor.

The patient, acting as client, also exercises powerful controls over both the form and substance of the physician's act. The patient may exercise this control through a self-determined referral system in which he seeks consultation on his own from more highly trained specialists if he perceives his illness to be beyond the competence of his primary physician. By questioning the diagnosis or treatment, he may cause his own physician to seek consultation, broaden the range of diagnostic tests, force hospitalization, or merely increase the time spent in his care. Such demands may be explicit but are more often made by the continued presentation of his symptoms to the physician. Client demand may induce physicians as a group to change what is considered proper practice. The rapid introduction of the Papanicolaou cervical smear ("Pap smear") into the routine examination was due as much to patient demand as to professional education. Of greater importance to ethical issues are currently increasing client demand for full explanations of diagnosis and treatment, for protection of the rights of patients and experimental subjects, and for a right to determine the care of the dying. In part, the modern patient has been able to increase his role in determining the nature of his care because of widespread and increasing knowledge among laymen about science and recent medical advances. In this sense, the patient becomes an intellectual partner in his own care. If his demands are perceived as excessive by the physician, however, the patient may diminish the bond of trust that holds the physician to him. Increasing fear of malpractice actions is the opposite face of the patient's desire for autonomy, and such fears also diminish the trust between physician and patient. Although the word *client* is used to refer to the patient, it should be seen as applying also to the patient's family and to the wider community.

Two views of the relationship: social implications

The elements of the therapeutic relationship described above lead to a picture of the interaction that is different in emphasis from that described by social scientists over the past few decades. Following Talcott Parsons's lead, or in reaction to it, social scientists have tended to see the doctor–patient relationship in terms of social roles, role conflicts, or power conflicts within the role model (Parsons and Fox). Their view of medicine has inevitably been *technico-social,* whereas that described above is a *technico-personal* view of the doctor–patient interaction. There are several reasons for the disparity of these two views, and the reasons are important to understanding the relationship. In the technico-social view, the sick person is seen simply as a well person with a disease, rather than as qualitatively different, not only physically but also socially, emotionally, and even cognitively. Indeed, the disease model is so widely accepted that the facets of illness described above, apart from the disease that caused them, have been insufficiently studied. When it is not understood that the relationship between doctor and patient is an important part of the process of returning to health, and it is believed that the physician's role in the care of the sick is primarily the application of technology for cure, then health can be seen as a commodity. In its most radical form, that view of medicine suggests that a surgeon performing an appendectomy is not different from a cabinetmaker building furniture, and the product (health), as well as the doctor–patient relationship itself, can be described in the usual economic or market terms. The more usual derivation of the technico-social view of medicine is that health is believed to be primarily the result of medical care (Winkelstein). More recently, as preventive medicine has been widely accepted, health is also thought to be the result of preventive care. In both instances access to health is seen as access to care. Such commodity views of medicine are true only to a limited degree. The healthy in a population are primarily those who have never been seriously ill. Indeed, epidemiologic evidence makes it clear that health is related far more to behavioral, social, and environmental factors than to medical care. Most medical care, then, is properly seen as illness care, not health care.

Therefore, the two views of the therapeutic relationship, primarily personal and primarily social, rest on differing views of the nature and source of health and the function of medical care. Two developments of modern society may tend to widen the divergence of these beliefs rather than effecting a necessary amalgam. The first, supporting the technico-social view, is the increasing use of the technology of medicine, paraprofessionals, and nonmedical personnel—which suggests that the involvement of physicians is either not necessary or even wasteful. The second, supporting the technico-personal view, is the increasing size of the aging population with its great burden of disease and disability. Here and in the chronic and incurable diseases that increasingly fill the disease picture of modern societies, patients and society are better served by a medicine resting on a basic understanding of the personal nature of the therapeutic relationship. This is underscored by recently highlighted problems in the care of the dying resulting from overzealous application of technology in the absence of sufficient personal and moral human understanding.

It seems important, however, that both major views of the therapeutic relationship be better studied and understood. To deny the importance of a wide social view of medicine would be to deny what could be gained from a much wider dissemination and utilization of modern medical technology. On the other hand, to deny the intimately personal nature of illness and the ethical as well as technical function of physicians as healers is to force medicine increasingly into a technological mold whose benefits may be many, but whose cost in human terms is also high. The care of the sick, whatever technology may be involved, ultimately arises from bonds among humans based in conscience, moral values, and the knowledge of the right.

Conclusion

The viewpoint of someone considering ethical issues in medical care will be greatly influenced by his perspective on the therapeutic relationship. The question of paternalism on the part of physicians and the related issue of the autonomy of the sick cannot be discussed without some reference to the respective characteristics and roles of the doctor and the sick person. If the sick person is regarded merely as a normally well person with a disease, and the doctor–patient relationship is looked at in mechanistic technico-social terms (a view Parsons did not

hold, since he recognized the importance of the psychological issues involved), then ethical problems within medicine can be examined in the same light as ethical issues in politics. If the technico-personal perspective is followed and the sick person is seen as a wholly dependent creature having no autonomy because of his illness, then ethical issues in medicine can be looked at in the same light as the parent–child relationship. Both views are oversimplifications, which, moreover, miss an essential element in the therapeutic relationship—variation with time and situation. The complexity of the relationship—and part of the problem it poses for ethical analysis—derives not only from the number of variables present (social, technical, psychological, and economic) but from the fact that the doctor–patient relationship is not a thing but a process. As such, change is a key element: change over time in the same illness episode, change from episode to episode, change deriving from different modes of medical care delivery, and even change that comes from treatment by different types of medical specialists. It is precisely the complexity and variability of the therapeutic relationship that pose a challenge to ethical analysis.

ERIC J. CASSELL

[*While all the articles in this entry are relevant, see especially the articles* SOCIOHISTORICAL PERSPECTIVES *and* CONTEMPORARY SOCIOLOGICAL ANALYSIS. *For discussion of related ideas, see the entries:* CARE; HEALTH AND DISEASE, *articles on* A SOCIOLOGICAL AND ACTION PERSPECTIVE *and* PHILOSOPHICAL PERSPECTIVES; *and* PATERNALISM. *See also:* AGING AND THE AGED, *articles on* SOCIAL IMPLICATIONS OF AGING *and* HEALTH CARE AND RESEARCH IN THE AGED; INFORMED CONSENT IN THE THERAPEUTIC RELATIONSHIP; MEDICAL MALPRACTICE; MEDICAL PROFESSION, *article on* MEDICAL PROFESSIONALISM; RIGHT TO REFUSE MEDICAL CARE; RIGHTS, *article on* RIGHTS IN BIOETHICS; *and* TRUTH-TELLING. *See* APPENDIX, SECTION I, MEDICAL ETHICS: STATEMENTS OF POLICY DEFINITIONS AND RULES (BRITISH MEDICAL ASSOCIATION); *and* SECTION IV, AMERICAN OSTEOPATHIC ASSOCIATION, *and* AMERICAN PSYCHOLOGICAL ASSOCIATION.

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THERAPEUTIC RELATIONSHIP, INFORMED CONSENT IN

See INFORMED CONSENT IN THE THERAPEUTIC RELATIONSHIP.

THERAPIES, DYNAMIC

See DYNAMIC THERAPIES.

THERAPIES, MENTAL HEALTH

See MENTAL HEALTH THERAPIES.

THERAPIES, SELF-REALIZATION

See SELF-REALIZATION THERAPIES.

THERAPY AND VIOLENCE

See VIOLENCE AND THERAPY.

THERAPY, ELECTROCONVULSIVE

See ELECTROCONVULSIVE THERAPY.

THERAPY, GENETIC

See GENE THERAPY.