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The Doctor-Patient Relationship, Its Place in Modern Medicine -- A Dilemma

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A medical student views the dilemma faced in rendering modern, efficient medical services while striving to maintain the recognition and observance of the fact of each patient as individual.

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In modern society, the individual finds himself increasingly dehumanized, and medicine is no exception. The growth of medical science and technology and the population explosion have led to an age of specialty care and overcrowded clinics. In many cases it seems, at least to the medical student, that individual patients blend into an endless sea of faces and, in the final analysis, become little more than a composite of clinical findings, laboratory tests and x-rays. The causes for this are myriad, but there is no question that few physicians, medical students or patients are happy with the effects.

The sanctity of the "doctor-patient" relationship has been a cornerstone of medicine for centuries. We are taught that each patient is an individual, and that the essence of good medical care rests on the recognition and observance of this fact.

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There are serious discrepancies between fact and ideal, however, and oftentimes they are most striking to the newly initiated medical student. Patients become cases to be presented at Clinical Correlations or Clinical Pathological Conferences. A disease often becomes a puzzle to be solved rather than a patient to be cured. This is especially true in the pre-clinical years, but the attitude carries over into the latter years of medical school, internship and residency. Of necessity, the patient often sees a succession of doctors and physicians, especially in large urban hospitals, where there is an endless stream of patients at overcrowded, overappointed clinics. An individual patient and doctor may see each other no more than once.

The physician is the victim of his own profession. While trying to improve his patient care, he has jeopardized his relationship with those he treats. He has sacrificed individual attention for quality and efficiency. It is not a sacrifice made willingly and many men are now forming and testing plans that would resolve this conflict of interests.

This dilemma is expressed in another way in the question of the individual and his right to life. Classically, the physician's role has been that of bettering the health and prolonging the life of each of his patients. Recent rapid growth in population has changed this somewhat. It is apparent that with a population which may easily reach seven billion by the year two thousand, prolonging one man's life may well indirectly shorten the life of another and, indeed, in some parts of the world this is already the case. Some have suggested that the physician must now preserve the quality rather than the quantity of life. Again medicine is in a quandary.

Two clinical situations illustrate this indecision very well. The first involves the care of the mentally retarded, chronically ill and aging. One might argue that if only a given number of individuals are to survive, then only those who are healthiest should do so. Happily, this position has been rejected by medical personnel. In the majority of cases, every effort is made to afford these patients a more comfortable life. In cases of severe physical or mental debilitation, palliative treatment and supportive care may be recommended, but in general, these are situations in which nothing further can be done for the patient. Death is a reality of existence and quite rightly, the physician recognizes his patient's right to approach it with dignity.

I feel a somewhat different philosophy is expressed in current medical attitudes toward the unborn, however. The clamor for liberalization of abortion laws by a growing segment of the medical community and a majority of medical students can not be ignored. The urgency with which fertility control and family planning are being advocated by all sectors of the medical community is no less noteworthy. The duplicity of our

attitudes is inescapable. As physicians, we feel obligated to better the status of those already alive while directing our energies toward the prevention of further life, by contraception, if possible, or by abortion if this fails. Though some individuals may assert that this attitude is a consistent one, it seems to me a rationalization born of necessity at best.

On one level, the physician dedicates himself to the individual's right to live, while on another he would deny him the right to create life. It is clear to many that a family of two children is the fastest way to achieve population equilibrium. It is not clear, however, that this situation is to be forced on the individual by the physician. The search for modern contraception centers around efficient long-term, fool-proof methods. A prime consideration is that these new forms be simple and palatable to the population. Those who work in these fields seem more concerned with overall effectiveness of method rather than mortality or morbidity of the individual. Indeed, some physicians feel that they should be the ones to enforce limitations of family size on the population. It is not uncommon to cite decrease of mortality through better medical care as a prime cause for the present overpopulation crisis; and many people look to the physician for a solution to this crisis. While medicine may provide the technical knowledge to achieve such a solution, the physician must remain a consultant rather than an enforcer. He must not sacrifice the freedom of his patient by taking advantage of the doctor's position of influence and trust.

The physician is in a precarious position. He must attain objectivity in diagnosis and treatment of a large number of patients without losing sight of them as individuals. He must propose but not enforce, for to do so would be to violate the trust of his patient. In his approach to any therapy, I believe that the welfare of the individual patient must remain his ultimate concern.