ANNOTATIONS

EVOLUTION OF THE DOCTOR–PATIENT RELATIONSHIP[1]

THE "inviolability of the doctor–patient relationship" is currently being discussed and commented upon at length by both professional and lay people. This sudden interest in a relationship which has been taken for granted for centuries, is a phenomenon, the causes of which are investigated in an article entitled "Evolution of the Doctor–Patient Relationship." The following review is a brief summarization of the views set forth by the author.

In the early nineteen hundreds, there were two quite different types of doctor–patient relationships. On the one hand, there was the relationship the doctor established with his private patients and on the other, with his charity patients. While the doctor tended to be rather possessive with his private patients, the charity patients were regarded primarily as good sources for teaching purposes. Their diseases interested the doctor, they themselves did not. Although this attitude is still present today, it prevails to a lesser degree than formerly.

One of the most outstanding developments in the evolution of the doctor–patient relationship has been the acceptance, on the part of doctors, of the concept that mind and body are one. This has resulted in a growing realization of the significance of the patient's personality. The patient has psychological as well as physiologic problems and doctors must now be equipped to understand the destructive effect upon emotional stability of the impact of serious diseases, or conversely, the importance

[1] Means, J. H.: Evolution of the Doctor-Patient Relationship. *Bulletin of the New York Academy of Medicine,* September, 1953, 29, No. 9, pp. 725–732.

of the patient's emotions in the production of his illness. With such understanding, the doctor is able to treat his patient as a whole person and is more aware of the meaning of illness to the patient and his family.

Besides the psychological, there have been developments in the doctor–patient relationship in the social and economic fields. The self-sufficient general practitioner of old is gone and the only way modern medical care can be provided is by a multiplicity of skills. Under such circumstances a very real problem is created. How can the doctor's intimate and responsible relationship to his patient be maintained? The author believes that patients must be cared for by teams of doctors rather than solely by individual doctors. Within the team, if one physician is in command and is also responsible for integrating the entire effort, the author feels that an adequate doctor–patient relationship can be retained.

Means then discusses the manner in which a doctor is paid for his services and how this affects the doctor–patient relationship. While the patient is a proper problem for the doctor, the doctor must never become a problem to his patient. The fee-for-service method of payment produces anxiety in many patients as to their ability to pay the doctor, and thus introduces an emotional and often highly disruptive factor into the doctor–patient relationship. For this reason, the author believes that the fee-for-service method should be supplanted by an arrangement in which the patient prepays for complete medical and hospital care and the physician is paid by salary. However, the best medical-practice situation will be one which satisfies both patient and doctor. When there are differences between them they should be resolved by concessions on the part of the physician, for the patient's best interest must come first.

The evolution of the doctor–patient relationship will continue until every person can obtain medical care of the highest quality, in a manner which will impose no hardship upon him or his family. The passage from Plato's Republic quoted by the author defines the situation quite succinctly: "No physician, in so far as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true

physician is also a ruler having the human body as subject, and is not a mere money-maker."

KATHERINE SIMON

• • •

THE FAMILY AS A UNIT IN PUBLIC HEALTH RESEARCH[1]

ACCORDING to the article "The Family as a Unit in Public Health Research" by Margaret Merrell, classification and analysis on a family unit basis is necessary to gain a clear picture of the public health problems relating to families. The concept of the family unit depends on the nature of the study. To the sociologist, a family would include the members sharing board and a common dwelling unit either with or without regard to relationship, while to the geneticist, it may consist of certain blood relations, living and dead, regardless of place of abode.

The interpretation of family studies is influenced by whether the place of emphasis is upon the individual or the family. Individual members may be used as a basis of classification provided the family as a unit is kept intact.

Two illustrations are presented by Dr. Merrell in which the family is the real unit of study. In an analysis of the secondary attack rate in infectious disease, all members of the families of primary cases are pooled to determine age specific attack rates which are then compared with a group of control families. The study of measles and scarlet fever in Providence, R. I. in 1939 by E. B. Wilson and his associates utilized this method of analysis. Classification of married couples as to certain characteristics such as age and economic status when they became parents has also been used in studies of differential fertility. A cross tabulation of the combined information on both parents presents a more complete picture than charting the characteristics of the parents separately. Thus although the young wives have higher birth rates than older wives, these rates vary with the age of the husband. In the Indianapolis study

[1] Merrell, Margaret: The Family as a Unit in Public Health Research. *Human Biology*, February, 1952, 24, No. 1, 11 pps.