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Examining the Power Dynamics in the Patient-Doctor Relationship in Bio-medicalized Countries:
a Historical and Sociocultural Framework

by Molly Dickerson

Fall 2022

SIT Global Health and Development Policy

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Abstract

Medical humanities research is an increasingly important field of study for medical care. Power dynamics that exist between doctor and patient during the clinical encounter are an integral factor for improving health outcomes and patient satisfaction with their clinician. This research study sought to determine the power dynamics that exist within the patient-doctor relationship in Switzerland and other bio-medicalized countries with similar patient-provider experiences through a historical and sociocultural lens. Four interviews were conducted alongside preliminary research, and the power dynamics identified through this study were social, economic, knowledge-based, and communication. Historical human philosophies about the universe, the role of God, humanity, health, sickness, and death and societal norms of misogyny were cemented into the foundations of modern medicine and remain interwoven into clinical encounters today, causing friction in a world trying to move towards more equality both in and out of patient-centered care. The results of this sociological approach to understanding the challenges to positive intrapersonal relationships in the clinical encounter support the need for more holistic, culturally competent, and compassionate healthcare.

Acknowledgements

Thank you to my SIT advisors and all of the interviewees who made this independent study project possible. Thank you to Claire Barthélémy who was invaluable in discussing my research topics with me. I would also like to thank my USC sociology professor, Andrea Henderson, for teaching me how to think like a sociologist. Finally, I would like to thank my mom for being a role model to me in demonstrating the importance of truth-telling during research.

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Introduction

Over the course of history, the practice of healthcare has been present and evolving across many different cultures. From priests to shamans to energy healers to the modern day "Western" physician, humankind has sought out ways to treat sickness and protect ourselves from death. As modern medicine has become more accessible, effective, and commonplace in many countries, the field of medical humanities has emerged as an ethics-based approach to healthcare. Terms such as social determinants of health, psychosocial models of disease, and cultural competency care are increasingly utilized today. Patients are demanding more coordinative, comprehensive, and culturally sensitive care in clinical situations. However, certain asymmetrical power dynamics between patient and doctor remain ingrained and reinforced by historical and cultural systems of power that affect patient-doctor relationship. The patient-doctor relationship has been defined as "a consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient" (Chipidza, et al, 2015). According to WHO, "The doctor–patient relationship is forged or destroyed by the attitude and behavior of the doctor, by the perceptions and reactions of the patient, and by the prevailing systems which are conducive or otherwise towards developing a bond of trust and empathy between them"

Many patients in biomedicalized countries, or those with what is referred to as "western" healthcare or "modern medicine", feel that their care is disjointed and overspecialized, or their relationships with their physicians have been strained due to social, economic, knowledge-based, or communication factors. Understanding and improving patient-doctor intrapersonal communication is important because it improves health outcomes and drives down healthcare spending. In this research study, I seek to identify the dynamics present in clinical encounters in westernized healthcare and how they have evolved over centuries and through different cultures. This research focuses on Switzerland, but I have also expanded the research scope to countries of similar healthcare systems and development, countries with allopathic medicine to contextualize Switzerland. Furthermore, analysis of similar countries will provide a better understanding of the evolution of the role of the physician and patient and how that affects the wellbeing of patients today and their satisfaction with their physicians.

Analysis of secondary sources of literature were combined with 4 semi-structured interviews. Three experts in humanitarian efforts and healthcare education and one physician were interviewed about patient-doctor relationships and the dynamics existing within clinical encounters today and in the past. 4 dynamics were identified that are inextricably linked with asymmetrical power positioning between patient and doctor: social, economic, knowledge-based, and communication. “Scholars addressing human right issues have focused on systems of discrimination and on exposing how power works subtly, implicitly, or overtly in norms—favoring, for example, white, male, heterosexual, Western, industrialized people.” These same systems were used in the creation of healthcare and have remained cemented into the clinical encounter today.

Methodology

The original research question of this research was, what are the dynamics that exist in the patient-doctor relationship in Switzerland, to be examined under a historical and sociocultural framework. Throughout the course of this study, the research maintained a focus on Switzerland but also gathered research on countries with similar healthcare practices and beliefs, also known as biomedicalized countries. These countries share characteristics under the categorization of what is known as “western medicine,” such as medical orthodoxy, conventional or allopathic medicine (National Cancer Institute). The research was mixed methods, consisting of interviews and secondary data analysis. Qualitative data from 4 semi-structured interviews with three experts and one physician were the primary sources used for this paper. This research was supported by both qualitative data and quantitative data from scientific studies, medical humanities literature, systematic reviews, and two novels.

In order to collect my data, I reached out to professionals from in-class lectures and from independent research. I contacted Dr. Eytan, a psychiatrist and educator at the University of Geneva via email, explained my topic, and asked to interview him about the evolution of the traditional role of doctor and patient in the clinical encounter. I chose this source because in the class lecture he gave thorough insight into the role of culture in healthcare and the importance of understanding how every clinical encounter is a cross-cultural encounter. In this semi-structured formal interview, I asked questions such as “How has the role of the doctor changed over time with the rise of biomedicalism and patient access to information through technology?”

My second interview was a semi-structured formal interview conducted with Markus Schefer, member of the United Nations Office of High Commissioner for Human Rights, Disability and Human Rights Council. I reached out to Dr. Schefer through email and conducted a 45 minute zoom meeting with him. There was limited information gathered from this interview, as he did not have any professional focus on patient-doctor relationship for persons with disabilities. This is discussed further in my limitations.

My third interview was an informal semi-structured group interview with Emily Christie, who works for UNAIDS. We connected through SIT when she gave a presentation for the Global

Health and Development Policy program about the barriers to healthcare for people living with AIDS. As an often stigmatized population, people with AIDS could represent a vulnerable population interacting with professionals in the healthcare system. I asked her questions about common barriers to quality care and medical discrimination.

Finally, my interviews concluded with Pablo Diaz Badial, a physician at Hospital La Tour in Geneva and former physician at Doctors Without Borders. I was referred to Dr. Badial by an academic advisor. This was an informal semi-structured narrative interview. Dr. Badial went to medical school in Mexico for 6 years, and took a 5 year sabbatical with Doctors Without Borders. He then continued his career in internal medicine in Geneva, Switzerland. He now heads the Covid response and management unit at Hospital La Tour in Geneva. He has been practicing medicine for around 20 years. I spoke to Dr. Badial about clinical communication styles, medical school training, and challenges within the patient-doctor relationship from both doctoral and patient perspectives.

Limitations of Research and Ethics Considerations

In my interview with Markus Schefer, member of the United Nations Office of High Commissioner for Human Rights, Disability and Human Rights Council, my intention was to gather the main complaints of persons with disabilities about their social and financial experiences within healthcare and their commonly chronic care management from a member of the committee representing them. The World Health Organization states, “Persons with disability include people who are traditionally understood as disabled, such as children born with cerebral palsy, wheelchair users, persons who are blind or deaf or people with intellectual impairments or mental health conditions, and also the wider group of persons who experience difficulties in functioning due to a wide range of conditions such as noncommunicable diseases, infectious diseases, neurological disorders, injuries, and conditions that result from the aging process." (WHO, 2015).

Due to the large bandwidth of the term "disability," Marcus Schefer stated that he was unable to provide his perspective. The reason I wanted to highlight the experience of persons with disabilities in clinical encounters is that persons with disabilities often require more specialized or comprehensive healthcare for at least one point in their lives. Furthermore, as a population cohort, persons with disabilities are a part of a minority group, and minority groups are disproportionately vulnerable to systemic discrimination, even in healthcare. According to the World Health Organization, disability is recognized as a global public health issue, a human rights issue, and a development priority.

WHO guidelines state,

> "Disability is a global public health issue because people with disability, throughout the life course, face widespread barriers in accessing health and related services, such as rehabilitation, and have worse health outcomes than people without disability. Some health conditions may also be a risk factor for other health problems, which are often poorly managed, such as a higher incidence of obesity in people with Down syndrome and higher prevalence of diabetes or bowel cancer in people with schizophrenia. Disability is also a human rights issue because adults, adolescents and children with disability experience stigmatization, discrimination and inequalities; they are subject to multiple violations of their rights including their dignity, for instance through acts of violence, abuse, prejudice and disrespect because of their disability, and they are denied

> autonomy. Disability is a development priority because of its higher prevalence in lower-income countries and because disability and poverty reinforce and perpetuate one another. Poverty increases the likelihood of impairments through malnutrition, poor health care, and dangerous living, working and traveling conditions. Disability may lead to a lower standard of living and poverty through lack of access to education and employment, and through increased expenditure related to disability" (WHO, 2015).

Relating to the medical field specifically, WHO states,

> "People with disabilities face widespread barriers in accessing services, such as those for health care (including medical care, therapy and assistive technologies), education, employment, and social services, including housing and transport. The origin of these barriers lies in, for example, inadequate legislation, policies and strategies; the lack of service provision; problems with the delivery of services; a lack of awareness and understanding about disability; negative attitudes and discrimination; lack of accessibility; inadequate funding; and lack of participation in decisions that directly affect their lives" (WHO, 2015).

Disability also disproportionately affects women, older people, and poor people, which can lead to "double discrimination," as women, for example, face increased discrimination throughout all facets of life, including healthcare (WHO, 2015). This is discussed in the social dynamics and the intersection of gender sections of this research paper. The intent of including the relationship between doctors and patients with disabilities was due to my hypothesis that those who are more vulnerable to experiencing discrimination may also face increased discrimination or dismissal in the clinical encounter. The interview was halted due to the use of the term “vulnerable populations”, as Dr. Schefer asserted that persons with disabilities were not vulnerable or part of a vulnerable population, as it is case-dependent. The use of this term brought up the ethical consideration of maintaining human dignity through communication and language, which is one of the 4 main dynamics discussed in this paper. As power is a main theme of this research, the use of language and word choice in the giving or taking away of patient power is explored.

All participants in this study were made aware of their rights to confidentiality and anonymity. These interviewees were asked for consent to record the interview for playback purposes, and all participants consented to being referenced and identified in this research paper. Communication with participants has been continuous and clarifications have been sought out in the case of needing further information or consent. There has been no contact with vulnerable populations in the making of this research paper, and all participants have been given informed consent.

Literature Review

Medical humanities has historically been pushed to the wayside of medical literature, yet it is a growing field of research due to the demand for more sensitive and culturally competent care. While there is not robust information available about clinical communication curriculum in medical schools or even in practice, I was able to piece together historical literature and artifacts with current experiences in healthcare settings in Switzerland and other biomedicalized countries.

There were a few articles that were invaluable in contextualizing the interviews I conducted for this research. The first was one published in the Journal of Medical Ethics: Medical Humanities in 2002, written by two professors at the University of Geneva Bioethics Research and Teaching Unit: Professor A. Mauron and Professor M. Louis-Courvoisier. Professor M. Louis-Courvoisier also is a faculty member in the Medical Humanities Programme at UNIGE. The article, titled, "He found me very well; for me, I was still feeling sick': The Strange Worlds of Physicians and Patients in the 18th and 21st Centuries"*,* compares the the role of the physician and the patient in Europe in these two time periods and how they have evolved. This piece is referenced a lot throughout this study to support data collected from primary source interviews. Much of the data used in this reference was collected from patient letters written to a 18th century physician called Samuel Tissot, which revealed first-hand accounts of patient disappointments in the clinical encounter. This article was scanned systematically from 4 lenses of the dynamics in patient-doctor relationship: social, economic, knowledge-based, and communication styles. This article was relevant specifically to the history of the Swiss clinical encounter throughout history, and it also incorporated research about open versus closed perceptions of professionals, which was utilized when exploring the knowledge-based dynamics in the clinical meeting.

Considering the role of gender is integral to examining the social dynamics that live within the patient-doctor partnership. The intersection of gender was explored both in the past and present through a non-fictional and historical novel by Elinor Cleghorn called *Unwell Women.* A feminist scholar and patient with lupus, Elinor Cleghorn delves into the intersection of gender divisions, stereotypes, and inequities within healthcare throughout history and in present-day systems of medical orthodoxy. Cleghorn gathered research for her book about the social history of women, contemporary and modern literature about medical culture, and feminist discourse on bodily autonomy. From this novel, the presence of gender discrimination in the clinical encounter was contextualized in real-world settings beyond healthcare. She draws conclusions about how certain standards in western healthcare came about through studying the evolution of knowledge and treatment of womens bodies from the Third Century BCE to the present. Cleghorn asserts that the detached and dismissive approach to treating womens chronic pain and chronic illness has its roots in historical cultural views of women's bodies as defective and value as lesser. She also highlights the even further mistreatment that black women face in healthcare settings and how that disproportionately increases mortality in black women.

To explore the power dynamic of medical authority versus patient, as well as the effects of the separation and medicalization of healthcare in the Western world, a novel by Harriet Beinfeld, L.Ac. and Efrem Korngold, L.Ac., O.M.D. titled *Between Heaven and Earth: A Guide to Chinese Medicine,* conveys the different directions eastern vs. western medicine took and the role of societal and cultural norms that have driven the stark divide between the two types of medicine today. These authors explore the eastern view of the body as a garden and the western view of the body as a machine. In the Western world, the body as a machine places the doctor as the mechanic, and then connects this dynamic to the presence of patient dissatisfaction with the disjointed nature of healthcare in biomedicalized countries. While there is slight bias towards the cultural sensitivities of eastern medicine, ultimately, this book is a call to action for "combining eastern traditions with western sensibilities in a unique blend that is relevant today," but it is geared towards the western world to use for integration.

Further peer-reviewed research consisted of publications in biomedical and medical education journals. Research concerning the TarMed system was taken from national databases and official public sites. A systematic review of 67 countries, published in, was utilized to examine the length of clinical consultations and discussed the implications of the differences in time with physicians on health outcomes. The World Health Organization made three recommendations in its public health advisory on improving patient-doctor relations, based on a 2011 conference in South-East Asia where these topics were discussed at great length. The World Health organization was also referenced for the purpose of understanding barriers to equality for persons with disabilities and how this affects patient-provider relationship. This organization, based out of Geneva, is recognized and respected internationally.

Analysis

Dynamic 1: Social Dynamics in the Patient-Doctor Relationship

Historical Accounts of Patient Dissatisfaction

In the late 18th Century, the medical field was ruled by one famous Swiss Enlightenment physician named Samuel Tissot. Dr. Tissot was renowned across Europe and provided consultations for at least 1300 patients who were ill. Over the course of his career, he received thousands of letters from patients. The letters contained explanations of symptoms, anecdotes of life with illness, medical questions, and patients' emotional states which displayed their fears, sorrows, and frustrations. Some expressed frustrations about their clinical experiences and their lack of trust towards physicians (Louis-Courvoisier & Mauron, 2002). One man's words, enclosed in a letter sent to Dr. Tissot, sounded almost like a plea to healthcare professionals. After being dismissed repeatedly by physicians who said there was no medical problem present, he wrote "they don't feel as I do the ailments they describe better" (Louis-Courvoisier &

Mauron, 2002). Another woman who wrote to Dr. Tissot was suffering from an engorgement of the spleen; She wrote of the dismissal and humiliation she faced when attempting to express to several doctors that she thought she was suffering from this engorgement. She wrote that they believed she must have been joking, saying that "when one is suffering and when there is an engorgement, one doesn't walk as easily…, and that the cheerfulness wouldn't be so evident if I [she] were as sick as I [she] pretended". Another chronically ill patient of Doctor Tissot is dismayed at the memory of another physician calling them a "hypochondriac." These patients were among many who displayed a frustration with the denial of their experiences in 18th century Europe. This denial could take the form of simply implying good health due to the lack of irregular medical findings or the invisibility of the condition, or even go as far as condemning the patient as crazy, delusional, or dramatic. The question is why doctors, whose goals would seemingly be to help and guide the patient towards wellbeing, so often invalidate or dismiss the patient's feelings.

Medical Expertise, Status, and Authority

In Western medical settings, the traditional depiction of the doctor was a paternalistic, authority figure who was seen as omniscient, even to the point of being seen as a "kind of demi-god" (Louis-Courvoisier & Mauron, 2002). In an interview with Pablo Diaz Badial, a doctor at Hospital La Tour, he joked of the traditional social hierarchy heard throughout healthcare settings, which is the doctor at the top, then god, then the patient (P. Diaz Badial, personal communication, November 15, 2022). According to Beinfeld and Korngold, "as doctors became the experts, they acquired a type of power over their patients," one that is innate to the relationship, a result of the information holder interacting with the information seeker. "Mastery of medicine became a technically sophisticated and exclusive high priesthood. The common person could not possibly gain access to and interpret the data necessary to administer medical care" (Beinfield & Korngold, 1991). The doctor possessed knowledge, status, and expertise that should go uncontested, and the patient must abide solely by the opinions or recommendation of the clinician (Dornan et. al, 2020). For many sick patients, who were suffering from illnesses that were not quickly or easily diagnosed and treated, this posed problems not only for their relationship with their physician but also with being able to continue searching for explanations of their pain or illness, and it slowed progress towards rehabilitation.The traditional or historically accepted encounter would exist within the plane of the patient surrendering all control or opinion to the will or words of the doctor. When the doctor did not possess the knowledge of the patients symptoms or illness, these societal and self-imposed expectations of patriarchal authority and "all-knowingness" led to friction in this relationship, and many patients expressed feeling dismissed, blamed, or abandoned in the process of searching for a diagnosis (Louis-Courvoisier & Mauron, 2002). Over the last few centuries, the patient-doctor relationship has shifted, with patients demanding more comprehensive and continuity-coordinative care. A patient-led initiative, the clinical encounter has shifted away from the omniscient patriarchal figure of the doctor towards a cooperation of health management between two equal partners: patient and doctor (Eytan, personal communication, October 25, 2022). In this new age philosophy, the patient is the expert of their own disease, making the relationship one of two experts, with the role of the doctor being to grant patients access to the tools and materials they need to take charge of their own health. In the cases of chronic illness, the patient potentially possesses further knowledge that is not even available to or recognized by the doctor due to their lived experiences (Eytan, personal communication, October 25, 2022). Yet present-day patients still complain of the same frustrations in the clinical encounter: dismissal, denial, blame, or disbelief of the patient experience. According to Dr. Eytan, although the relationship has evolved, traditional social dynamics that have historically existed both within and out of healthcare remained ingrained in the patient-doctor relationship and within communication in healthcare settings (Eytan, personal communication, October 25, 2022). With this shift towards the patient as a partner of expertise, patients are now arriving at the doctor's office with knowledge, suggestions, and expectations of how the interaction should go, yet there is a collision between these new proponents and historical social dynamics interwoven into medical training and clinical communication. This sense of professional omniscience and superiority still may reign true despite more liberal patient access to medical knowledge as a result of technology, literature, and social media. This is a component of the discordance between patient and clinician due to social dynamics.

The Intersection of Gender

The intersection of gender within healthcare is important to include in the analysis of the dynamics within clinical encounters. As noted by Elinor Cleghorn, a patient with lupus and author of the novel *Unwell Women*, "at every stage in its long history, medicine has absorbed and enforced socially constructed gender divisions." Dating back to the Third Century BCE, women's bodies were denied legitimacy and dignity, as "male dominance–and with it the superiority of the male body– was cemented into medicine's very foundations" (Cleghorn, 2021). The renowned Greek philosopher Aristotle theorized the female body as the secondary '"inverse" of the male body, with its genitalia "turned outside in"' and having faulty or deficient anatomy (Cleghorn, 2021). Medicine has historically hailed one female organ as sacred, divine, mysteriously powerful, and derivative of a woman's purpose; yet, simultaneously, medicine has used it to strip women of autonomy over their own bodies; this organ is the uterus. The "myth of the uterus" has long been used to govern women by the claim that the uterus itself mysteriously and uncontrollably governs women, and that women are unreliable narrators of their own lives because they are at the mercy of such a powerful hormonal anatomical piece. This appears in historical clinical settings; women's narratives of their sickness and their pain were not often taken seriously or treated with the agency of a man's due to the "secrets and curiosities" of the uterus.

These socially constructed gender roles and behaviors have been cemented into society long before the evolution of modern medicine, and today they "negatively impact the care, treatment, and diagnosis of all people who identify as women" (Cleghorn, 2021). Gender inequity in modern medicine reveals the same dismissal of women's pain. As noted by Elinor Cleghorn, "women are more likely to be offered minor tranquilizers and antidepressants than analgesic pain medication. Women are less likely to be referred for further diagnostic investigations than men are. And women's pain is much more likely to be seen as having an emotional or psychological cause, rather than a bodily or biological one" (Cleghorn, 2021). Furthermore, Cleghorn highlights the "false but pervasive belief that Black women feel less pain, because they are assumed to have 'thicker skin' and 'less sensitive nerve endings.'" These beliefs "originate from dehumanizing falsehoods perpetuated to justify white history's horrific abuses of enslaved Black people" (Cleghorn, 2021). These lingering and pervasive historical beliefs lead to worsened health outcomes for black women today. In the United Kingdom, "black women are five times more likely to die from complications of pregnancy and during childbirth than white women. In the US, Black women have the highest rates of maternal and infant mortality of any country in the industrialized world" (Cleghorn, 2021). This discriminate and lack of care is even more pervasive for women presenting symptoms of chronic illnesses. Despite this hyperfixation with the uterus and menstruation-related syndromes, there has been a grave lack of research and support for "female complaints." The narrative of the uterus as a medical mystery has served as an excuse to not treat women's pain with the same concern or agency as men's pain, with pain and fatigue being the most common "medically unexplained symptoms" of women (Cleghorn, 2021). When the symptoms of the patient are unbeknownst to the doctor, who traditionally possesses this omniscient status, this may lead them to assume the condition is psychological, or even imagined by the patient. While the science about the mind-body connection is very real and recognized today in many countries, this also may conflate the narrative of the illegitimacy of women's pain or knowledge about their own body and experiences. Cleghorn comments on this dismissal of women's symptoms as psychosomatic, when she states that "today, women are frequently dismissed as neurotic, anxious, depressed, hypochondriac, and even hysterical when they report the early symptoms of endometriosis" (Cleghorn, 2021).

The scenario referenced earlier, taken from Louis-Courvoisier & Mauron, revealed that a woman faced ridicule and even mockery for suggesting to the doctor what type of ailment she thought she might be suffering from. They laughed at her for thinking she had the social or medical authority to present knowledge about her symptoms, what was considered physician territory. To question or infer the doctor's diagnosis or lack thereof would be to question the doctor's authority. The friction doubled from the stacking of two dominant power characteristics, as the power and social status derived from being a doctor was stacked on top of the power and social status of being a man. The reactions of these 18th century physicians suggest that there had been a feeling of infringement upon the male doctor's authority or superiority of knowledge by the questions or statements from a woman. The male physicians said she seemed too well in spirit to be sick. This further highlights the deep-rooted cultural expectations for women to be amicable and agreeable, and yet, they also cannot be *too* amicable or agreeable because then the doctor will not believe they are in pain or that something is wrong with their health (Cleghorn, 2021). The problem with this is not only social, but economical as it greatly affects health outcomes and healthcare spending. Cleghorn explains “Before our pain is taken seriously as a symptom of possible disease, it first has to be validated– and believed– by a medical professional.”

The Information Holder vs. the Information Seeker

The information holder versus the information seeker is a social dynamic that is innate and built into the patient-doctor relationship by nature of the institutionalization of medicine. The doctor, possessing knowledge, expertise, and power, is interacting directly with a person presumably in need of their knowledge, expertise, status, and power–this is under the typical assumption they are going to the doctor because they have a health problem. When one person is presumed to hold the answers while the other is presumed to need the answers, the balance of power can shovel a great divide, particularly when the patient is in pain over time. According to Louis-Courvoisier & Mauron, this chasm is widened in these particular instances. In patients who experience persistent, unexplained symptoms of some sort of chronic condition, patients experience a disintegration of their most basic human power: health. Without health as a building block for life, daily functioning in all facets is severed or more difficult. When stripped of this power, entering healthcare settings where the doctor possesses extensive power constructs an innate imbalanced power dynamic that can lead to an antagonistic experience for the patient and the doctor. The article comparing physicians and patients in the 18th and 21st centuries defines the innate aspect of individual patient experience living with pain in the body as a non-shareable reality. David Le Breton identifies the idea that “pain immerses us in a universe inaccessible to anyone else.” One study done by Katz and Shotter, illustrates a gap in “the perception of illness by the sick and the perception of the same illness by the physicians… Living the pain in one’s own body constitutes one perception; analyzing it is another matter altogether. Therefore, there is a split between the bodily experience and the intellectual explanation of that experience by somebody else.” This split leaves room for differences in understanding of the severity of the disease or the patient's perception of the doctor’s perception. This lack of lived experience in the moment may lead the patient to feel that the doctor does not take their pain seriously, along with the other social dynamics discussed.

Dynamic 2: Economic Dynamics in the Patient-Doctor Relationship

The Financial Hardships of Patients

From a global standpoint, the World Health Organization publication on the patient-doctor relationship highlights some other economic burdens patients face: “Cost of care is also seen to escalate due to over-specialization, inappropriate use of drugs and diagnostic technologies and the aggressive intrusion of pharmaceutical companies into health-care settings. ” Beyond the time spent, many patients living with chronic illnesses see an accumulation of money lost due to transportation costs, missing work, or expensive and sometimes unhelpful medications. When these economic strains meet social or knowledge-based power dynamics habituating at the doctor’s office, it can increase patient frustration, leading to increased strain on their relationship with the practitioner and potentially worse health outcomes. There is also an intersection here between poor health and lower socioeconomic freedoms. As noted by WHO, “In the case of poor patients, this interaction becomes strained further by differences in framework, the severe hardships that they have to undergo merely to physically approach allopathic providers and the paucity of money that results in breaks in treatment which may be misconstrued by doctors as defaulting or refusal to adhere to instructions about treatment and care” (WHO, 2011). Dissatisfied patients may decide to pursue a legal battle against their doctor. As healthcare practitioners recognize the growing mistrust between patient and doctor, some may prescribe unnecessary medical tests or medications to err on the side of caution that drive up the cost of healthcare for the patient and cause an even greater economic strain of having health issues (WHO, 2011).

The Importance of Listening in the Clinical Encounter

The quality of the relationship between patient and doctor can be measured by mutual knowledge, trust, loyalty, and regard. One necessary ingredient to achieve all of these measures is time. According to Donna Zulman, an MD at Stanford University School of Medicine, “a major part of what we do as physicians involves understanding what's important to the patient, how a diagnosis or treatment plan is going to affect that person's life, and being able to communicate why we think that a certain clinical decision might be the right one for our patient, and for all of these things empathy is critically important” (Hannon, 2022). Listening is at the heart of empathy, and listening requires time. According to Lloyd Minor, dean of the Stanford School of Medicine, “derivative of that is being able to place the patient's experience in a broader context to more fully understand the implications of the disease, the patient's life, their wellbeing, and the wellbeing of those around them" (Hannon, 2022). In order to truly hear, digest, and then contextualize a patients experience with disease, particularly ones of the chronic nature that affect most or all facets of their life, it is crucial for the clinical encounter not to be rushed; it is necessary that the patient has time to speak, reflect, and explain, and that the doctor has time to ask questions, listen, and disseminate knowledge rather than merely prescribing without explanation. The World Health Organization and the International Network for the Rational Use of Drugs use "average consultation length" as a quality indicator of "safe and cost-effective use of drugs" internationally. However, there are many economic constraints that may take away from the time spent with the patient, and this may have adverse health outcomes for the patient and negative impacts on the patient-provider relationship, especially for patients living with multimorbidities (Irving, et al, 2017).

Time Constraints

Both patients and physicians are dissatisfied with the amount of time allotted to a single clinical visit. "A recent survey of primary care physicians in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, the UK and the USA reported that over one-third of all primary care physicians are dissatisfied with the time available per patient" (Osborne, et al, 2015). Surveys revealed that shorter consultations with patients compromised quality of care (Mercer, et al, 2002). Less time with the patient can lead to the exclusion of necessary medical services provided, and it can drive up physician stress and burnout due to a "lack of personal accomplishment" (Irving, et al, 2017). Physician burnout could be attributed to feelings of unproductivity in disease management and care of patients with multiple or complex chronic conditions. This article provided research stating that “short consultation length was responsible for driving polypharmacy, overuse of antibiotics and poor communication with patients.” As drawn in Figure 1, Switzerland’s average consultation time for a primary care physician was around 17 minutes. Patients in Sweden and the United States had the longest time spent with PCPs, averaging around 22.5 and 21 minutes. “It is concerning that 18 countries covering ~50% of the world’s population have a latest reported mean consultation length of 5 min or less.” Countries such as Bangladesh and Pakistan had shockingly low consultation lengths of under 2 minutes per patient (Irving, et al, 2017).

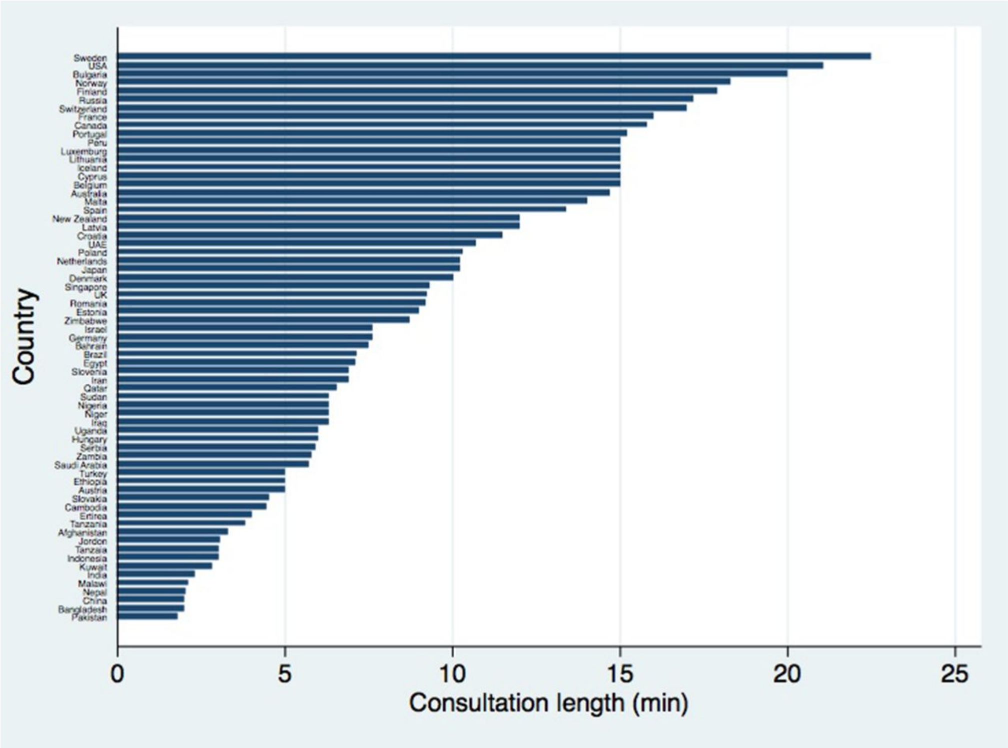

Figure 1. Average Consultation Length in Each Country Based on Recent Data (Irving, et al, 2017, *published in BMJ*)

Economic Variables

Economic factors may affect how much time a doctor can spend with their patient. Different countries will see different impacts on consultation time due to their health insurance and payment systems. Switzerland has something called the TarMed system, which labels and determines prices for medical services provided by doctors. Switzerland has a fee-for-service system, meaning that patients pay for each service provided by the doctor. In Switzerland, a patient's visit will be paid for by their insurer, with the possibility of a copay or coinsurance. In many ways, the Swiss TarMed system incentives doctors to provide patients with comprehensive clinical care; the more services provided to the patient, the more the doctor will be compensated for, regardless of whether or not the service or treatment was effective. The benefits of this practice is that doctors are willing to take tangible steps to help their patients by providing medical tests, procedures, and resources. Because of this freedom, however, doctors have a great influence over how much they are paid. By referring patients to more and more services, this leads to increasing premiums annually on a population level because insurance companies need to be able to pay for these services. So while it may benefit the doctor and the patient to provide a potential "long-shot" medical service, it also may hurt the patient later on due to increasing monthly premiums.

On the other side of the spectrum, the TarMed System can also be very restrictive for doctors who are trying to provide the highest quality care for their patients. TarMed outlines that each clinical visit should take 15 minutes of discussion plus an extra 5 minutes of physical exploration. The 15 minutes of discussion consists of 5 minutes of introductions, 5 minutes of explanation of symptoms or reason for visit, and 5 minutes of diagnosis/treatment plan. Dr. Badial explains how this system poses limitations to how much time a doctor can spend with a patient, but also is reductive in which medical services can be provided to a patient and how often (P. Diaz Badial, personal communication, November 15, 2022). He described an example of a patient with a neurological disease, a disease which affects all other body systems. If a doctor performs a full body checkup for a patient with a neurological disease in January, in order to provide comprehensive and effective care to the patient, the doctor would like to do another full body checkup in two months. However, TarMed will only pay a doctor for one full body checkup every six months. Therefore, if the doctor does perform this checkup, the doctor will not get paid (P. Diaz Badial, personal communication, November 15, 2022). A doctor can only get paid for performing an examination of three body systems twice every six months. For the case of a diabetes patient, if the doctor wants to examine the respiratory and circulatory systems, they cannot get paid for just these two systems. The doctor must meet the minimum of three body systems in order for TarMed to reimburse them, however, they can only do this twice every six months per patient (P. Diaz Badial, personal communication, November 15, 2022). This may incentivise some doctors to push back necessary medical examinations to after the expiration of the six month period, deny the patient access if they ask for another evaluation, or document what they did with their patient incorrectly in order to get compensated for the work they are doing. When TarMed does not compensate the doctor, sometimes this price may fall on the patient, which can lead to an increased economic burden for patients with chronic diseases that require frequent or extensive medical care. Due to this strain on the doctor, it may lead to doctors being more rigid in what they do for the patient in the clinical encounter, which could lead to patients feeling that the doctor is not doing enough for them (P. Diaz Badial, personal communication, November 15, 2022). To illustrate these points, consider the following example. Imagine a person is facing new, debilitating symptoms of some sort of unknown, invisible illness, and they are going to the doctor to find some answers for what is wrong. The doctor performs a full body medical exam that comes up completely negative, sends the patient home with a few recommendations for how to take care of their general health, and tells the patient to check back in a month. The patient comes back in a month, facing worsened symptoms and heightened desperation to figure out what's wrong with them. Coming into the physician's office with their symptoms and naturally heightened emotions, they explain to the doctor the problems and express their worries, and they want the doctor to perform other medical tests. However, if the doctor has already exhausted their compensatable resources or they know that they will need to perform another exam in a month or two, the doctor may be more hesitant to act on the patient now. The patient may feel abandoned, dismissed, or even that the doctor does not believe that there is anything wrong with them. Patients with chronic illnesses may already experience vigilance due to the lack of understanding from others about their invisible condition. The lack of action from their medical professional could trigger feelings of invalidity or previous medical gaslighting. This can be extremely damaging for the patient's physical and mental health and sense of self, and put a grave strain on the relationship between patient and doctor.

Dynamic 3: Knowledge and Systems-based Dynamics in the Patient-Doctor Relationship

Centuries before the medicalization of healthcare in the Western world, doctors lacked many diagnostic tools and technologies that are used in current healthcare to pinpoint the exact location or cause of illness. Patient discourse and narratives were crucial to the patient-doctor relationship because the doctor had to rely on the description of symptoms and experiences rather than these medical tests, screenings, and other technologies available today, which innately led to more holistic and patient-centered care. Despite this, one patient of Dr. Tissot's, Monsieur Gualtien wrote "I don't have any trust in our physicians; they swear by systems, to which they bend all facts; they lack the ability to observe, and their fanaticism for systems and hypotheses prevent them from seeing and studying nature" (Louis-Courvoisier & Mauron, 2002). The persistence of these feelings of dismissal and distrust despite the somewhat holistic nature of clinical encounters in the 18th century could point towards the reigning social dynamics, particularly the innate dynamic between the information holder and the information seeker. Furthermore, he asserts that while the patient was often given the opportunity to speak (or write) in detail about their symptoms or ailments, the unintended effects of humoral medicine and narrow methodological guidelines were still infringing upon effective communication with patients. The specialization of clinical care and the medicalization of wellbeing has only increased over the last three centuries.

The Decline of Feudal Society and the Shifting Focus of Western Healthcare

The view of health, illness, and death and dying have led to very different priorities and healthcare approaches across the globe. Biomedicalized, "western" countries take a hegemonic approach, placing emphasis on curative or life-saving treatment, while countries with more natural medicine, such as Traditional Chinese Medicine (TCM) place more emphasis on holistic or preventive care. These attitudes and approaches affect patient satisfaction, health outcomes, and relationship with the physician. During the late Middle Ages, before the onset of the Renaissance period, the presence of geocentric philosophy in Europe placed people in the middle of the universe, connected to earth, nature and to the divine. From the 12th to the 15th centuries, the decline in feudal societies and the rise of cities in Europe was due to disease, such as the

Bubonic Plague, and civil unrest due to war. This urbanization was then followed by the movement of populations during the Protestant Reformation. Much of this unrest and uncertainty, accompanied by the undermining of the Catholic Church during the rise of Protestantism, created a shift in medical ideology in Europe away from the church and towards science. Europeans believed “they could attain mastery in the world through their own willful efforts” (Beinfield & Korngold, 1991). In this new area of secularization of church and medicine, “the realm of Heaven existed outside of nature, apart from it, barely within human reach… the dark, sinister, mysterious forces of Earth were juxtaposed with the enlightened, righteous, and supernatural forces of Heaven.” Nature became something to outsmart, to overcome, and to conquer through science to ensure the survival of humankind against sweeping pandemics such as the Black Death. Man’s connection to Earth was replaced by a man versus nature conflict paradigm, in which man stood separate from nature and above it. In this separatist philosophy, the Earth “became an object that could be manipulated and exploited.” Beinfield and Korngold explain, “A unified reality was sacrificed for dominion over Nature; for technology, for ‘progress.’” Without this veil of divine protection from religion woven into the fabrics of medicine, sickness became feared, and “death became irreconcilable with life, rather than an inevitable transition in the cycle of existence” (Beinfield & Korngold, 1991). This led to the focus of Western healthcare being on acute intervention, such as life-saving or curative care, rather than preventive, wellbeing-oriented care. “Salvation has become the synonym of health” (Louis-Courvoisier & Mauron, 2002). However, as the prevalence of chronic illness is increasing globally, the need for chronic care and illness management alongside interventionist and curative measures is more necessary than ever. This chasm creates a disjoint relationship between

Western doctors, who have been taught to fix, and patients, who want to achieve their best quality of life as a whole person living with a chronic disease.

The Body as a Machine

In the "western", biomedicalized world, "the philosophy of science is based on the premise that humans are separate from nature, and that the world, like a machine, can be dismantled and reduced into constituent parts," that can be "measured, quantified, and analyzed" (Beinfield & Korngold, 1991). French philosopher René Descartes brought about "analytic reductive reasoning" that pervaded through medicine and became known as Cartesian principles. He visualized all things in the universe as working parts of a machine, stating "I do not recognize any difference between the machines made by craftsmen and the various bodies that nature alone composes." Noting the distinction made by the use of the word "alone," it is evident how this total and complete rejection of religion and embrace of science alone has influenced the dissection of the human body and the view of the body as a machine. In an attempt to improve health and protect from death, the body became just a body to be manipulated and tinkered with, lacking humanity, and this ideology is cemented into the foundations of modern medicine. With this objectification of the body, the distinction between human and machine are reduced. They shared the purpose of productivity, their ability to do work (Beinfield & Korngold, 1991). This ideology fosters ableism; it is exclusionary and discriminatory towards those with disabilities or severe chronic illnesses, as it fosters the capitalistic ideals that a person is only worthy based on how much they produce. Moreover, the crux of the issue comes from the positioning of the doctor if the body is a machine. The author explains "When people are like machines, doctors become like mechanics. The mechanic occasionally performs routine maintenance but mostly intervenes to execute emergency repairs. He plunges into the working parts, replacing the non-functioning elements, and puts the machine back into working order" ((Beinfield & Korngold, 1991). This historical and systematic dehumanization of the patient may be the cause of many current complaints about physicians: that they do not see them as a person but rather as a part to be fixed, that they prescribe one medication that just worsens the symptoms of another bodily system, and that they are unsupportive when the patient is not "fixed" with the doctors recommendations or treatment plans. The layering of the social dynamic of paternalistic authority with the clinical knowledge and attitude being geared towards "fixing" part of the body like it is a broken clock, reveals the potential for difficulty in patient-doctor encounters.

Overspecialization of Healthcare

The increase in technology, scientific precision, and in-depth medical knowledge has led to medicalization, which comes with strong positives such as effective treatments to medical problems and life-saving cures. However, the broken-body-machine approach that has expanded within healthcare over the past few centuries has met resistance from patients in the modern day. For patients with non-communicable diseases that require comprehensive care, overspecialization from doctors, who possess very specific, extensive, yet narrow knowledge, may leave patients with disjointed treatment and worsened symptoms of a different body system. Iatrogenic illness is a huge problem that has expanded from overspecialization. The problem with overspecialization can be explained by this quote from Beinfeld and Korngold, "The general practitioner who cared for a whole person was replaced by the cardiologist who cared for the heart; the orthopedist who ministered to the bones; the neurologist for the nerves; the oncologist for the cancer; the psychiatrist for the mind; and so on" (Beinfield & Korngold, 1991). This separation of care led to lack of continuity of care and relationship with the doctor, and there was no one who knew the patient in the "context of their environment" (Beinfield & Korngold, 1991). According to Lloyd Minor, "there has been over these past decades a rapid expansion of med knowledge, but in some cases, that knowledge and the way it has been applied and the technology accompanying it have served to distance medical providers from their patients." This overspecialization also enforces a social power dynamic of doctor omniscience that may inflame the frustration between patient and clinician within healthcare settings.

Open versus Closed Perceptions of Healthcare Practitioners

Pablo Diaz Badial, MD at a private hospital in Geneva, Hospital La Tour, has practiced medicine for over 20 years. He spoke about the correlation he has noticed within healthcare fields between specialization and ego. He explains that the more specialized a doctor is, the more details of knowledge about that specific field the doctor holds, which sometimes leads them to be more narrow-minded in their thinking and in their sense of superiority of knowledge and expertise, which may be exerted over the patient. He illustrated this phenomenon with the metaphor of the doctor who specializes in the tip of the pinky nail of the right hand. He explains that sometimes this emphasis on such a precise scope of expertise may leave the doctor with something that Louis-Courvoisier & Mauron call a "closed-perception", rather than an "'open' ordinary pattern of perception, with its mixture of knowledge and ignorance" (Louis-Courvoisier & Mauron, 2002). Hick argues that the institution of medicine is shifting towards a more "closed-perception." A closed-perception is derivative of the idea that the professional possesses "absolute knowledge" from a purely scientific viewpoint and an adherence to systems. To ensure success in the clinical encounter, Hick argues there must be an amalgamation of both closed and open patterns of perception (Louis-Courvoisier & Mauron, 2002). To maintain an open perception is to find ways outside of the systematic viewpoint of diagnostic criteria alone when it is necessary. As noted by 18th Century Swiss physician, Dr. Tissot, to a desperate patient, "if physicians were generally more observant and less systematic, you would not be, Sir, in this uncertainty" (Louis-Courvoisier & Mauron, 2002). However, according to François Laplantine, the doctor may not have access to the necessary distance required to "develop the open perception required for a successful communication with the suffering person" (Louis-Courvoisier & Mauron, 2002).

Dynamic 4: Communication and Language Dynamics in the Patient-Doctor Relationship

Current communication skills and initiatives

Doctors are taught extensively about medical problems and procedures; however, they may not have been taught communication and behavioral skills for interaction with the patient in undergraduate medical courses. WHO notes, "it could also be that {he} does not have time to communicate" (WHO, 2011). The lack of communication may feel to the patient like an apparent lack of concern and it can drive a gap between patient and practitioner. At McGill University in Montreal, Canada, faculty members Helen McNamara and J. Donald Boudreau have recognized the uses of medical humanities education for fostering "whole person care." Examples of this type of educational focus are tools such as "narrative analysis, communication skills, cultural competency, self-reflection and creative writing, and ethics-based rationing." Sociologist Arthur Frank suggests that "the act of narrating an experience humanizes the chaos of what has happened [to the patient]" (conceptualizing the patient in medical humanities, 2013). The importance of exploring and incorporating different communication styles within the clinical encounter cannot be understated as it has been shown to have significant benefits for patient and doctor satisfaction and positive health outcomes.

Clinical communication is something that experts say must transcend beyond medical school training and into clinical practice. According to an article published in Swiss Medical Weekly, in order to retain the skills necessary to understand patient perspective and build rapport, doctors must have experiential training, which includes tools such as "role playing, interaction with simulated patients, practice under supervision and observation of self and others' practice" (Perron et al, 2015). Pablo Diaz Badial, did his medical school training in Mexico, and then went on to work for Doctors Without Borders for many years before settling in Geneva. He explains that education of clinical communication was not so much institutional as it was up to the individual. According to him, the trainor on rotations was supposed to supervise the encounter with patients, but not much focus was put on clinical communication (P. Diaz Badial, personal communication, November 15, 2022). Medical educators or physician advisors are often reported as poor role models in clinical communication. According to Swiss Medical Weekly, physicians either tend to intervene only as "rescuers", rather than teachers, or they "do not feel confident enough to teach and evaluate skills that they themselves have not mastered" (Perron et al, 2015). Dr. Badial explained the need for more specific medical discourse regarding clinical empathy and intrapersonal skills, as he states that as a medical student, most of his peers and fellow students had no real understanding of the impact of disease on a person's life or how the interaction with a patient could negatively or positively affect them. A lack of faculty training in clinical communication is a strong barrier to intrapersonal communication in a clinical consultation, and widens the invisible gap of power between doctor and patient (P. Diaz Badial, personal communication, November 15, 2022).

Therefore, the power of language cannot be understated in clinical communication settings between patient and doctor. The four types of healthcare communication are verbal, non-verbal, written, and formal communication (Lee, 2021). As evidenced from the letters written to Dr. Samuel Tissot in 18th century Switzerland, written communication can be a powerful transport of information, for both the empowerment of the patient but also the attention and understanding of the doctor. Today, written communication may take place in electronic health databases, such as MyChart or Epic. Patient intake surveys are commonly incorporated in healthcare visits now, before the doctor sees the patient. As noted by Dr. Badial, patients who go to Hospital La Tour, may fill out intake forms inquiring about their symptoms, reason for the visit, and overall well being. These are used in conjunction with verbal communication to help the doctor gain a better understanding of what the patient needs. Dr. Badial is heading the initiative to manage Covid at this hospital, and he has implemented a patient file based on covid symptoms for patients to use to be screened. Patients have communicated to him that this interaction and inclusion of the patient in their own health understanding and healthcare has been really empowering for them. Patients felt like participants in their own management by sharing the information through the form (P. Diaz Badial, personal communication, November 15, 2022). Adherence to forms provides some sort of structure that gives the patient the opportunity to present the information they want without interruption. According to a study published in the Journal of General Internal Medicine, researchers found that on average, it takes only 11 seconds on average for the doctor to interrupt the patient during a clinical encounter (Philips et al, 2019).. Whether this interruption is for better understanding, to ask a question, or to insert clinical expertise is unknown, but it can sometimes make the patient less confident and less comfortable in explaining their narrative.

Verbal and Non-Verbal Communication

Effective non-verbal communication can improve patient satisfaction and trust with their doctor. Who notes that "eye communication or touch communication is important" (WHO, 2011). Verbal communication includes avoiding medical jargon, using politically correct language, using terms that indicate the presence of an intimate relationship, speaking clearly and explaining thoroughly, using affirmative sentences, and using a language interpreter when necessary. The WHO organization advises that "the doctor needs to answer the questions and even encourage him to ask questions about the treatment," but often this is not practiced as the doctor may be in a rush, not possess the skills to effectively communicate, or not believe in the importance or necessity of this practice (WHO, 2011). Who also notes that if the patient's "questions are brushed aside with annoyance or irritation, it will cause further depression" (WHO, 2011). From examples provided by patients of Dr. Tissot to present-day, patient complaints are recorded globally, which state that their doctor exhibits coldness or lack of sympathy, and often do not take the time to explain things to them. Word choice is also important, as discussed in my interview with Markus Schefer. It is important that doctors use vocabulary and jargon that are easy for the patient to understand yet also empower the patient. Persons with disabilities or chronic conditions must not be infantilized or sidelined in the participation of their own healthcare, yet their treatment must also be approached from a stance of equity rather than equality, as they often face different barriers in healthcare and other institutional settings (M Schefer, personal communication, November 1, 2022).

Cross-Cultural Encounters

According to Dr. Eytan, every clinical encounter is a cross-cultural encounter. It is important as a clinician in both verbal and non-verbal communication to understand the cultural background of not only the patient, but of oneself and the biases that accompany them. Often, patients cannot even have a relationship with their healthcare practitioner at all due to language barriers and the lack of provision of a translator. This prevents effective communication between patient and doctor, which can cause miscommunications, incorrect diagnoses, negative health outcomes, frustration, and even perpetuate ignorance or racism (Eytan, personal communication, October 27, 2022). It is important to provide patients and physicians with the tools they need to understand each other, and that physicians maintain awareness of cultural sensitivities and nuances. Cultural influences that can create differences in understanding between physician and patients are tolerance thresholds, categories of complaints, wording, understandings of causes of the problem, communication styles, perceptions of severity of prognosis or illness, attitudes and expectations, and knowledge. In psychiatry, some clinicians use Cultural Formulation Interviews, a structured set of 16 questions aimed at understanding the patient when there is difficulty due to cultural or language barriers (Eytan, personal communication, October 27, 2022). These modules could perhaps be implemented into physical healthcare and standard checkups as well to improve communication and patient-doctor relationship.

Future Recommendation Guidelines of the WHO

The World Health Organization provided three guidelines for improving patient-doctor relations: improving the curriculum of undergraduate medical courses to create more compassionate clinicians, give medical students more time to broaden their perspectives about human suffering and behavior before diving strictly into paraclinical and clinical data, and providing a "4-month elective module" focusing on the field of sociology where the student could work in a different setting (WHO, 2011). In providing more time before strict and exhausting medical training, WHO recommends a preceding period of time to attend lectures about "communication, leadership, ethics, history, philosophy and even music relating to the process of healing", as well as other countries approaches to medicine based on their cultural differences (WHO, 2011). Communication courses must provide lectures about verbal and nonverbal communication skills, such as delivering bad news, using sensitive language, maintaining a sense of trust, building empathy, and protecting against physician burnout. Doctors must also understand the power dynamics at play and work to mitigate the divide between patient and physician in a humble and proactive manner. Approaching the role of a doctor after understanding sociological ideas and perspectives would "create in him [the doctor] respect for the patient and inculcate a spirit of equality in his relationship with the patient" (WHO, 2011). Who notes that these skills must be taught interactively and in real-world contexts, not simply by discourse during in class lectures or seminars.

Conclusion

The research examined the historical and cultural power dynamics that exist within the patient-provider relationship in Switzerland and other biomedicalized countries. The dynamics identified were social, economic, knowledge, and communication. Reigning social dynamics of paternalism and authority, the overspecialization of healthcare over the last few centuries, the innate nature of a systematic and technical field in a situation of humanity, and lack of clinical communication skills all lead to a strained and oppressive relationship. These findings highlight the need for more holistic, comprehensive, and compassionate care in which doctors are cognisant of asymmetrical power relationships and work to bridge this gap through empathy, understanding, and effective communication. In doing so, doctors create more comfortable environments for their patients, build trust and continuity of care, and dismantle bureaucratic systems and power structures that reinforce oppression of minorities. These will lead to more humane and effective patient-doctor relationships, which affect all people from all communities who see a healthcare practitioner and is a positive step towards improving health outcomes. There are some limitations to this research study. There is a lack of sociological research about the implementation of medical humanities education for medical students today as most of the available preliminary research is focused on the problems rather than solutions. Considering how the age, gender, and race of the doctor may lead to varying trends in relationships should be noted but was not accounted for in this study. Finally, more research should be done about how these results vary across different countries from a more comparative methodological approach. These results support the recommendations of the World Health Organization for future implementation of solutions and recognize the need for more research concerning medical undergraduate curriculum and teaching practices. Future research directions should take the lead on implementing various communication styles and sociological approaches into medical school curriculum for future doctors and track how that improves or decreases the quality of patient-doctor relationships moving forward.

Abbreviations List

WHO: World Health Organization

UNIGE: University of Geneva

UNAIDS: United Nations AIDS

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