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Doctor–patient relationships amid changes in contemporary society: a view from the health communication field

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ABSTRACT

Synopsis: In this article, we propose to understand the doctor–patient relationship (DPR) using a health communications perspective, as it is located in the sociohistorical framework of modernising processes. The paper analyses the academic literature about the doctor-patient relationship (DPR) during the period of 1980–2015, gathered from key words in digital collections and indexed magazines available in three electronic databases (SISBI, SciELO and DIALNET). Eighty-four articles were selected from the initial search. The results suggest three axes of thematisation of the DPR over the period analysed: patient satisfaction, models of relationship between professionals and patients, and eHealth. The latter, eHealth, demonstrates the current transformation of social and communication order and is the main axis of reflection and investigation.

Introduction

In health consultations, periodic health checks, searches for health information, treatments, diagnostics, and prevention, among others, health professionals and patients build a relationship that oscillates between two typical models: one close to paternalism and focused on the doctor's authority; and another that recognises the patient's autonomy. Although it is true that such models differ, the doctor-patient relationship (DPR) is an asymmetrical social relationship whose main points of support are the difference of knowledge (Boltansky, 1975), of language and vocabulary (Clavreul, 1978) and of power (Foucault, 1953/2001).

Interest in the link between doctors and patients, or between doctors and the sick, has a long history (Laín Entralgo, 1964) and has received extensive academic attention from a range of disciplines (History of Medicine, Medical Sciences, Social Sciences, Anthropology). The questions that guide the exploration and description of this academic attention focuses on communication: Is communication understood as a tool for the purposes of

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navigating a face-to-face individual relationship? Does it seek to understand the asymmetries of that social relationship?

Our theoretical approach to the DPR from the field of health communications understands that communication is not a mere transmission of information from a professional to a patient. It is a complex process in which other actors participate (Cuberli & Araujo, 2015; Del Pozo, Román, Alcántara, & Domínguez, 2015; Obregón & Waisbord, 2012; Petracci, 2015; Petracci & Waisbord, 2011; Rogers, 1996) in the context of contemporary social and communication changes (Bauman, 2003, 2007; Beck, 1998; Rosa, 2011).

This article has four sections: communication and health: a focus on DPR; methodology; axes of thematisation of the DPR; conclusions and discussion. The paper analyses the academic literature about the doctor-patient relationship (DPR) during the period of 1980–2015, gathered from key words in digital collections and indexed magazines available in three electronic databases (SISBI, SciELO and DIALNET).

Health communication: a focus on DPR

Health communication is (in a Bourdeausian sense) an interdisciplinary field, academically established in the United States and some European countries in the second half of the twentieth century. It is heterogeneous due to the diverse range of issues present at its intersection (Petracci & Waisbord, 2011): the disease in the individual and collective identity construction; health as an agenda and the construction of hegemony; the risk of epidemics and the need to communicate messages of prevention, the demands of rights, care and research in health as an axis of social mobility; and health–disease as news in the media, the social networks and consultation fora.

The DPR is also placed at that juncture. It is understood as a type of interaction materially and symbolically anchored that includes, on the one hand, links of dispute and relational power and, on the other, a departure from the position that reduces communication to the learning of skills on how professionals must conduct themselves with the patients, or it is guided by an 'instrumental utility' (Del Pozo et al., 2015, p. 11).

Following Rosa (2011), contemporary processes of rationalisation, differentiation, society-nature, individuation and acceleration, helps to understand the complexities of changes in the DPR from the communications field. These include the prioritising of the bureaucratic rationality of health systems over face-to-face ties and relationships; the patient's transformation into a consuming client who, in addition, can become a producer of health knowledges; the anonymity and emphasis on the provisional ties with professionals; the presence of risks in consultations linked to prevention; the crisis of the normative structures in which the relationship between health professionals and patients evolve linked with eclectic forms of care; and the increase in workload on professionals, which can generate perceptions of dissatisfaction about the duration of the consultation for patients and professionals.

Methodology

We used two methodological stages to retrieve literature for this analysis:

(1) The search for digital collections and indexed magazines available in electronic databases, and national and international sources. Three key words were used: doctor-patient relationship (DPR), eHealth, and gender. The research was conducted by the Gino Germani Research Institute's Documentation Centre.[1] The following libraries were consulted, based on the search strategies and the use of registries for each source focusing on the key words: the Faculties of Social Sciences, Medicine, and the Gino Germani Research Institute's Documentation Centre (Buenos Aires University) in SISBI (Information and Libraries System of the Buenos Aires University[2]; as well as the SciELO (Scientific Electronic Library Online); and DIALNET databases (each database is defined in Table 1). From the initial search, which was not tabulated by the type of database, we selected 98 results through consensus with the research team.

(2) Definition of inclusion criteria in the final sample required that the article presented the findings of an empirical investigation, or developed theoretical reflections, or gave practical recommendations. Fourteen publications were excluded from the initial selection during this stage. The final sample consisted of 84 publications.

Axes of thematisation of the DPR

Exploration of the retrieved articles were guided by two hypotheses. The first refers to the impact of technological changes to the DPR: eHealth displays different modalities and produces positive and negative changes in the traditional face-to-face relationship between doctors and patients (modalities such as online searches before or after the consultation, participation in online fora, sending tests results via email, and telemedicine, among others). The second hypothesis refers to the characteristics of the change process: the changes produced by eHealth coexist with previous formats, and do not substitute them. In this context, the Internet is an *a la carte* communicative medium set according to the tastes and needs of each user, ending the separation between audio-visual and printed media, popular and erudite culture and, entertainment and information (Castells, 1999; Mattelart, 1996).

The following paragraphs discuss the selected axes: patient satisfaction, models of doctor–patient relationship and eHealth.

Table 1. Description of literature databases.

Literature databases	
SISBI	A system that coordinates, promotes, and leads the cooperation between Units of Information of the Libraries' System of the University of Buenos Aires to provide excellent services and products to different users, and encourage continuous capacitation.
SciELO	Online scientific library for the cooperative electronic publications of scientific magazines in the Internet, especially developed to answer the needs of scientific communication in the developing countries, especially from Latin America and the Caribbean.
DIALNET	Library cooperation project initiated at the La Rioja University, Spain, which collects and provides access mostly to documents published in Spain in any language, published in Spanish in any country or that deal with Hispanic topics.

Source: Created by the authors.

Patient satisfaction

Patient satisfaction was selected as a theme due to its presence in the retrieved articles of our sample during the 1980s and 1990s, and for the weight assigned to the communicational dimension (understood as learning abilities) for the patient to express a greater level of satisfaction regarding the relationship with the doctor and the health system.

A trend here focussed on the factors that produce satisfaction (such as empathy, treatment and trust, continuity (or not) with a same professional) and those that would hinder it (barriers to cultural accessibility, loss of the personal dimension in the clinical model for new diagnostic and therapeutic resources) (Bianconi, 1988; Climent y Mendes Diz, 1986; Donoso-Sabando, 2014; Florenzano, 1986; Martínez Salgado y Leal, 2003; Orellana-Peña, 2008; Prece, Necchi, Adamo, & Schufer, 1988; Rodríguez, 2006; Schufer, 1983). Other topics outlined included the interaction of social determinants (Duarte Nunes, 1989; Ong, de Haes, Hoos, & Lammes, 1995) and the impact of communication on patient's satisfaction and adherence to treatments (Cófreces, Ofman, & Stefani, 2014; Moore et al., 2004).

Regarding the differences in satisfaction in relation to the gender of health professionals, Ainsworth-Vaughin (1998) uses a sociolinguistics approach. Hall, Irish, Roter, Ehrlich, and Miller (1994) analyse the relationship between doctors and patients (men and women) in terms of verbal and non-verbal communication in one-hundred medical consultations. They found different patterns, especially in non-verbal communication. The relationship between female doctors and women patients is the one that offers greater contrast than with the relationship between women doctors and male patients. The authors found that, compared to their male counterparts, women doctors often had friendlier attitudes and behaviour that built a participative scenario for the patients, which was associated with greater levels of satisfaction. Cooper-Patrick et al. (1999) argue that the studies focused on investigating the influence of gender of the patients in the medical consultation showed that the aspects that give more satisfaction (answer to the request for information and allocated time) are accentuated in female patients and professionals. Roter, Hall, and Aoki (2002) found that that more than their male counterparts, female primary care doctors displayed a communication centred on the patient.

Other retrieved articles, which linked satisfaction with the quality of attention received by patients (Donabedian, 1991), were focussed on conceptualising and measuring the levels of satisfaction. These challenged the validity of other studies given the problems that the concept of pre-existing 'expectations' presents to measurement of satisfaction, theoretically and methodologically, given that satisfaction is related to expectations (Necchi, 1998). Regarding the modernising processes of Rosa (2011), rationalisation and acceleration are also related with this axis of patient satisfaction. Although the first studies incorporated technology and standardisation of care and diagnosis processes, they also excluded components that can limit a patient's satisfaction, such as affective and direct treatment. Regarding acceleration in the organisational components that favour or disadvantage satisfaction, one can recognise a multiplicity of temporalities for patients (allocation of appointments, delivery of studies, etc.), as well as the commodification of health systems on the actors that comprise it (Donabedian, 1991; Ong et al., 1995).

Relationship models

Historically, the description and analysis of relationship models has attracted interest among studies in this field. Also, because it expresses the passage from a paternalistic model into a more autonomist one in the 'stage' of the DPR (Bohórquez, 2004).

For Lázaro and Gracia (2006, p. 7) it meant a transformation 'with scarce historical precedents'. Traditionally a passive receptor of the doctor's decisions, the patient as understood at the end of the twentieth century transformed into an agent with rights and the capacity for autonomous decision over therapeutic and diagnostic procedures. The doctor's position moved from a paternal figure to become more of a technical advisor of his/her patients, who are offered knowledge and advice but who are no longer obliged to take the doctor's decision. The emergence of other actors and greater horizontal ties joined the bipolar and vertical clinical relationship. These changes are complex and conflictive processes that were developed within a framework of the transformations and challenges of the medical profession (Llovet, 1999; Oriol Bosch & Pardell Alenta, 2004).

Like the previous axis, the retrieved articles here refered to the acquisition of abilities and formulation of communicational recommendations in the different models (Clèries Costa et al., 2003; Cordella, 2004; Fahy & Smith, 1999; García et al., 1995; Gordon & Sterling Edwards, 1995; Korsch & Harding, 1998; Ruiz Moral, Rodríguez, & Epstein, 2003; Vidal y Benito, 2002) and, unlike the previous axis of patient satisfaction, this literature represents a critical communicational approach (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Epstein, 2006; Gumucio-Dagron, 2010; Ong et al., 1995; Rodríguez Arce, 2008; Roter & Hall, 2006).

The literature on relationships also includes the assessment of patient autonomy in medical decision-making (De Benedetti Zunino, Pastor Carvajal, & Bandrés Sánchez, 2006); the participation of patients (Thompson, 2007); and reflects on the DPR and the problems of communication of the 'truth', and human rights (Gajardo Ugás, 2009; Ocampo-Martínez, 2002; Sánchez González, 2007; Skirbekk, Middelthon, Hjortdahl, & Finset, 2011) from other perspectives such as bioethics and psychology (Mucci, 2007).

Regarding the modernising processes of Rosa (2011), the individuation and differentiation are related to this axis. With regards to individualisation–a result of social fragmentation and atomization–the focus of the studies included in this axis emphasise the individual performance of doctors. On the other hand, structural and functional differentiation refers to the lack of social cohesion and, hence, the privatisation of risks, and the socialisation in provisional links including the one established between the patient with the doctor.

Ehealth: internet as support and a social actor

We chose this set of literature due to its centrality of the New Information and Communication Technologies (NICTs) for national health systems, and for the relationships between the health system's actors (such as the DPR). eHealth has been the subject of one systematic review (Pagliari et al., 2005) and it has been an ongoing presence in the literature since the year 2000.

In this literature eHealth (or health online or *telesalud*) seems to comprise consultation practices and publication of information, diffusion, interaction, and online health care. An

agreed definition, however, is subject of debate. Some authors link the DRP to the use of the New Information and Communications Technologies (NICTs) in general, and the internet in particular. The access by patients to information regarding online health is a topic of much attention early on (Barnes et al., 2003; Broom, 2005; Kivits, 2006; Lupiáñez-Villanueva, 2008; Marín-Torres et al., 2013; Nwosu & Cox, 2000; Rahmqvist & Bara, 2007; Wathen & Harris, 2007).

Andreassen, Trondsen, Kummervold, Gammon, and Hjortdahl (2006) observe that trust in online interactions between doctors and patients is built according to postmodern standards, as it is in other social relationships, and that patient's need for trust in the professionals and the health system are key to understand the use of the NTICs by patients. Jacobson (2007) uses a Medline review to analyse how the internet impact on the consultation (as a reason for discussion that challenges medical authority) and the empowering experience of patients. Using a trend analysis of three population studies carried out in Sweden in 2002, 2003 and 2005, Rahmqvist and Bara (2007) show that there was a significant increase in internet use during the period studied and that the predictors for its use as a source of information were age, sex, perceived health, area of residence and the type of medical encounter (first or repeated).

Wathen and Harris (2007) interviewed women living in rural areas of Canada regarding their experiences on the search of information and health given the major difficulties of access to health by people living far away from large urban centres. The government sought to empower patients and encourage processes of selfcare in health through online information as a way to overcome distance difficulties, and the findings demonstrate that seeking information online provides emotional sharing by allowing dialogue between people with similar experiences. Later, we observe that some authors of eHealth literature reflect about the DPR and internet in structural terms and fully addressing the functioning logics of the health system. Jung and Berthon (2009) developed a theoretical reflection regarding health care through the internet; and argue that it is a useful resource amid the growing demand for care due to the progressive ageing of the population.

Laakso, Armstrong, and Usher (2012) consider how a virtual platform that addresses health demands online should be constituted. In that same line of inquiry, Lustria, Smith, and Hinnant (2011) questioned the relationship between social inequalities and access to health services online. Armstrong, Koteyko, and Powell (2012) analysed an online forum of diabetic patients in England, which the authors propose can be an alternative for health systems that face ageing populations and the costs associated with the care of long term illnesses. This concern around the access to health information online remains current (Chiu, 2011; Stern, Cotten, & Drentea, 2012).

With the advance of technology we find retrieved articles that refer to the greater complexity in the use of the internet such as the analysis of online heath care practices (Bert, Passi, Scaioli, Gualano, & Siliquini, 2016; Kim, 2015; Rodríguez, Almeida, & Valdés, 2013; Wilkowska & Ziefle, 2012). Bert et al. (2016) analysed online applications for tablets and smartphones for pregnancies and childbirth, and found that most of the applications do not explicitly state the origin of the information or guarantee the preservation of privacy of the information required for the subscription. This concern for the handling of health information online is continuing (Kim, 2015).

In relation to Rosa's (2001) references to modernising processes and rationalizations, which are now currently characterised by flexible processes of control, this has gone hand in hand with New Information and Communication Technologies (NICTs). The third modernising process is also present and refers to the relationship of the social to nature. The author interprets the work of transforming the nature of subjects as a production of means of life and, at the same time, of themselves.

Conclusions and discussion

This section is organised to consider (1) the theoretical approach taken in the existing research; (2) the methodological design; (3) the findings from the analyses; and (4) some final cosiderations.

1. In this article, we reflect upon the DPR from the field of Health Communication. Health communication contributed to differentiate communication as a tool intended to recommend how the DPR link should be and as a theoretical approach through which to build the concept and establish practice. It is not about transforming the communicational recommendations in theoretical discoveries that forget the reality in which the DPR takes place, nor formulating a binary approach that ends up overshadowing what is sought to clarify. Instead, it formulates recommendations that, on the one hand, involve the patient-citizen with health as a right, autonomy, patient's participation in the decisions concerning his/her body and in the communication of diagnostics and treatments, interculturality, media and virtual platforms understood as social resources (Waisbord, 2015, p. 143); and, on the other hand, the challenges that modernising processes pose to the health system and its actors.

2. The initial search presented idiomatic limitations; technical (systematization difficulties), and search words. For search words, 'eHealth' and 'DPR' were the most appropriate. Nevertheless, in the case of 'eHealth', our evaluation shows that it would have been also convenient to accompany the concept with other specific types of use (consultation fora, information search, mobile-phone applications, among others).

The sample in this study is not representative. We do not seek to make generalisations of all the findings from this type of study. Despite those limitations, and in addition to the ones already pointed out regarding the search, we consider that the contribution of the readings and the analysis of the articles was to explore the initial questions from the field of communicational health.

3. Taking into account the reflective view of this article, the limitations of the search and the scope of the aforementioned literature, we believe that that our analysis reveals the transformation of the paternalistic model of DPR into another leaning towards patient autonomy. eHealth has played an important role of this process of change around DPR: positive change because it favours access to information and the autonomy of the patient, and negative change because the information can be of poor quality or outdated; because it opens a spectrum of exposure and control of personal information turned into virtual sites, as well as a technological update that involves patients, professionals and other actors of the health system.

The axes–patient's satisfaction, models of relationship between professionals and patients, and eHealth–are interrelated and do not exclude new axes derived from analyses guided by other theoretical frameworks and research experiences.

The patient's satisfaction is related to the perception of availability and empathy of the health professional, independently from the DPR model to which the physician ascribes, and of the practice and the personal or online media through which they communicate. On the other hand, the professional's satisfaction is related to changes in the DPR which, as the initial asymmetry dissipates, confront doctors with excess of information by patients, often from unreliable sources.

The DPR model seem to have gone through transformations: from paternalistic and hierarchical to one with more patient autonomy; from one that positions patients as passive ill people to a subject with agency, capacity and with rights; from a dyadic format to an institutional one in which the patient is a user of plural services in more than one institution; from a direct link to another mediated by technology and the internet; from a relationship where the doctor's word was unquestionable to another where the patient is allowed to doubt health professionals, negotiate the diagnosis and treatment, or is allowed to discuss and/or complain to government authorities, consumer associations, and lodge complaints, or lawsuits.

These changes do not replace but coexist with previous formats (although not without conflict) depending on each health situation and on the required levels of complexity. These changes also depend on the characteristics of the care system, and the degree of empowerment of the patient, among other things. The communicational dimension, in these changes, was valued regarding the secondary place assigned by the biomedical model. The articles of focus in this paper go through different, yet non-exclusive, paths where the communicational dimension is posed as an individual technical skill favouring the DPR and adherence to treatment, or is presented as an area from which social issues such as power, culture and socioeconomic differences become evident.

The 1980s literature included in our analyses describe patient passivity as a condition that is taken for granted and not questioned or analysed. It is seen to be part of the basic conditions in which biomedicine should operate in a 'normal' scenario. We noted that the focus in the literature with patient satisfaction was a seed upon which, combined with other phenomena such as advances in terms of rights, greater access to information, need for the profitability of the health service, development of the communication technology, among others, was reconfigured into greater spaces of action for patients. Patient satisfaction became relevant to medical training, among other issues, which had traditionally been monopolised by biomedical knowledge exclusively. These processes intervene in the modes of care and treatment, as well as of communication between doctors and patients. Table 2 presents a synthesis of the transformations in DPR registered in the literature reviewed in this article.

The axis eHealth has a strong presence with the spread of globalisation and the development of NICTs (Osorio, 2011). It is inseparable from the patient satisfaction since the changes in the DPR model are scenarios in which it excels. The articles in this paper show the interest that the search for online health information produces as a subject of study, the explicit or implicit presence as well as the influence of that information sought online by the patients in the traditional sense of the DPR. That this search contributes to a fluid interaction will depend on the interests and knowledge of the health system's actors. The most recent articles address the logic of operating online virtual health care platforms. They propose to develop both instances of computer and internet use learning for patients

Table 2. Synthesis of the process of transformation in the doctor-patient relationship.

Paternalistic Model	Transformations of the paternalistic model towards an autonomous model
A receiving patient is passive to medical decisions.	Based on an agent patient with defined rights and decision autonomy over the diagnostic and therapeutic procedures.
Concern for the patient's satisfaction is based on the legitimacy of the doctor's power and its hegemonic expert knowledge.	Concern for patient's satisfaction based on the legitimacy of medical power due to expert knowledge *and* the consideration of technological, communicational, and bioethical changes.
Doctor training fully biomedical	Doctor training happens with participation of patients.
Professional training based on expert knowledge to be exercised through a vertical, paternalistic, and authoritarian model.	Professional training based on the expert knowledge to be exercised from a more horizontal model, with diversity of specialised knowledge and bioethical principles.
DPRs within the framework of systems with emphasis on rational bureaucratic criteria.	DPRs in the framework of systems with an emphasis on economist criteria.
Doctor-patient relationships in the framework of consultations with longer duration.	DPRs in the framework of consultations of shorter duration based in the contemporary process of acceleration.
Greater autonomy of the doctor.	Less autonomy of doctor as result of a greater control over medical practice by the State, patient organisations, supranational institutions, and the market, among others.
Less power for the patient	Greater power for the patient as result of access to information, rights, democratic practices, mechanisms of collective organisation of patients, development of ethical and legal control of the medical practices, among others. This process generates the possibility of change and resistance to the control devises over the body of users of the health system.
	Internet. Google. eHealth
Difficult access to medical information	Easier access to medical information
Scarce search for medical information	Search for medical information in websites and consultation fora.
Very little discussion with the doctor.	Increase in the discussions and decisions negotiated with the doctor.

Source: created by the authors.

and physicians, such as learning about procedures and devices, so that the access to information and health care is efficient and reaches as many users as possible. Yet, no article we reviewed questions the current and future existence of this actor/support –eHealth–, which shows the current sociocommunicational transformations and is, currently, the main axis of reflection and research.

One limitation regarding eHealth in this search is concern about patient involvement. A recent review by Barello et al. (2016) addresses the role of eHealth in people's participation in health care by considering matters of subjectivity s (ie emotional, cognitive and behavioural), and conclude that the interventions aimed at each component individually, instead of considering the complexity of the psychological processes.

The focus on the DPR by the field of health communication in modernising processes in this review revealed that communication is understood as a tool at the service of an individual face-to-face relationship fundamentally in the patient satisfaction axis. In contrast, this view coexists with a more critical one that seeks to understand the relationship's asymmetries in the models' axis. In the last axis, eHealth, communication is placed in the technological context of contemporary society and renews the debate about patient's autonomy in the face of eHealth experiences because, although eHealth broadens possibilities for health care, it also renews mechanisms of social control and contributes to the persistence of access difficulties.

Table 3. Facilitators and obstacles of the doctor-patient relationship.

Facilitators	Obstacles
Empathy/Affectivity	Specific technical language
Information on the internet	Information on the internet
Empowerment of the patient	Power of the doctor
Organisation of patients' networks	Economic rationalism in health care
Rights of the patients	Abuse of legal litigation towards medical practice
Medical attention through the internet	Lack of legislation protecting the diffusion of patients' medical information.
Training of doctors with participation of patients.	Lack of time in the consultation
Preoccupation with patient satisfaction.	Technological mediation and impersonality

Source: created by the authors.

From the analysis of the emerging axes aspects develop which we classify due to their facilitating or obstructing character of the DPR (see Table 3). The outlined classification is not rigid and acknowledges the complexity of defining an aspect as an obstacle and/or facilitator. For instance, the collective organisation of patients help in the quality of health care. However, sometimes it conflicts with the DPR because it questions medical knowledge and practice (Armstrong et al., 2012). Accessing health information online favours the patient and permits a deeper and more fluent communication with doctors. Yet, this depends on the type of medical specialty. The facilitating character of the internet is also relative because inequity in access to technology deepens social gaps (Lustria et al., 2011). Yet, on the other hand, patients' internet use can overload the health system due to the confusion it generates (Nwosu & Cox, 2000). Social and economic gaps are influential here. According to González (2008), the relation between the size of a country's Gross Domestic Product (GDP) and the density of installed technology are directly proportional. NICTs assume equal standing in access and capacity of individual to use technology. Those without access and capacity experience further marginalisation (Castells, 1999).

4. We conclude that the communicational dimension of health–understood as a complex process–within the framework of modernising processes is a view that contributes to understanding the changes produced in the DPR, which favour or obstruct the fluidity of the relationship. eHealth establishes a trade-off for the DPR: although it distances patients from the paternalistic tutelage of doctors, it generates needs among patients for training to better exercise those practices. Furthermore, it also challenges the decision of professionals and patients, and of health systems facing health care in a context of technological changes.

Notes

1. *Centro de Documentación del Instituto de Investigaciones Gino Germani.*
2. *Sistema de Bibliotecas y de Información de la Universidad de Buenos Aires.*

Disclosure statement

No potential conflict of interest was reported by the authors.

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