PUBLIC HEALTH

DOI 10.35630/2022/12/psy.ro.1

Received 14 December 2022;
Published 6 January 2023

DOCTOR – PATIENT (ADULT OR CHILD) RELATIONSHIP IN CONTEMPORARY MEDICINE

***Vasile Valeriu Lupu*[1], *Ingrith Miron*[1], *Anamaria Ciubara*[2] ✉, *Valeriu Lupu*[3], *Iuliana Magdalena Starcea*[1], *Ana Maria Laura Buga*[1]✉, *Stefan Lucian Burlea*[4], *Alexandru Bogdan Ciubara*[2]✉, *Ancuta Lupu*[1]**

[1] Pediatrics, "Grigore T. Popa" University of Medicine and Pharmacy, Iasi, Romania
[2] Faculty of Medicine and Pharmacy, "Dunarea de Jos" University of Galati, Galati, Romania
[3] Pediatrics, Emergency County Hospital, Vaslui, Romania
[4] Faculty of Dental Medicine, "Grigore T. Popa" University of Medicine and Pharmacy, Iasi, Romania;

✉ ***anamburlea@yahoo.com*, *anamaria_bnz@yahoo.com*, *bogdan.ciubara@ugal.ro***

ABSTRACT

The article is an incursion in the history of the doctor – patient relationship, which experienced an interesting evolution from the moment when medicine has gained the status of science and most of all because of the technical progress from the last century. In this context, the technicization of medicine, the medicalization and over-medicalization of individual and social life, as well as the elusion of the basic principles of the doctor – patient relationship, have a negative impact on this relation. Is there any way, in the contemporary society, to regain what it was the nobleness of the profession and its divine and human devotion? A possible answer might be found reconsidering what over the years has given social value to the medical act. Because only here can be once more found the necessary binder for harmonizing human devotement and professional responsibility.

Keywords: doctor; patient; principles; child; adult; ethics.

The history of medical profession has always been marked by the relations that existed between the doctor, considered to be endowed with the art of healing, and the patient, as beneficiary of the medical act with the purpose of regaining his state of health. From the oldest times, the medical act has been associated with the invocation of divine powers as help in the healing process. This relation was easily to intuit because the Hippocratic vow itself invokes divinity to act as aid and warrantor in practicing medicine in its first period

(Iftimovici, 2010, pp. 65-71).

Then, it followed the charitable spirit practiced and promoted by Christians from its beginnings which embraced human suffering, for the relieve of which many health care facilities were to be built near the churches; they were known as Basiliades of Saint Basil the Great about which Saint Gregory of Nazianzus said with admiration and veneration "As soon as you get out of the city you will see a new city which is the sanctuary of piety. There the disease endured without a sound seems to be a blessed trial, there charity shines in its deeds" (Lupu, 2012, pp. 183-194).

These Christian establishments developed and spread all over the world; they were to represent the base for the development of medical practice. Hence, the relation with the church which would remain unaltered for centuries so that if at the beginning all medical facilities were built near churches, later on, hospitals would build their own chapels where both staff and patients could pray for the divine help in overcoming their sufferings.

Phrases as "**doctors treat, but only God can heal**" or "**Nihil sine Deo**" **(nothing without God)** are still present in many health care or surgical institutions as a proof of the faith in God. Each doctor with some experience knows very well that the science of healing can be learnt but the gift of healing is given and strengthened through faith and that these two aspects (science and faith) complete each other and together accomplishes the art of healing. This is the reason why, doctors using the same therapeutically protocols record different results, or with very simple therapeutically protocols obtain spectacular results. Invoke the power of God and you'll have the desired results used to say the classics of medicine (Buta, 2010; Lupu, 2012).

From the very beginning, this communion between science and faith gave birth to the doctor – priest relationship (Necula et al., 2013). Thus, it results that the collaboration between them goes way back in time because medicine and theology both have as their sole study subject man in its integrity (Damiant et al., 2013), body and soul. With those suffering both doctor and priest have the moral duty to support the patient providing him the necessary cares, advices and the necessary support because only this way the two of them will fulfill their mission (Miu, 2010, pp. 60-66).

It remains true that for a long period of time both doctor and priest were considered carriers of truth: the doctor was the carrier of the scientific truth; tangible, real, that could be proved but nonetheless relative, while the priest was considered to be the carrier of the revealed truth, the absolute truth which cannot be proved by means or human reason or logic. Referring to the latter aspect, one of the most important Romanian doctors in our history (and not only) Nicolae C. Paulescu used to tell his students: "**If you wish to be perfect, care for the ill not as a human, not as a brother, but as God itself**" (Paulescu, 1913).

There may be no other field of study in which the scientific truth manages to complete itself with the truth of faith with such harmony as it does in medicine; this because only man can embody the body – soul duality, body – material entity destined to assimilate, soul – spiritual entity destined to transcend. This is also the reason why the doctor is expected to know, to be able to do and specially to know how to be a doctor in attitude and behavior. The first two are cultivated by theoretical and practical training, while the last one is related to the individual qualities and the profession's morality, just as Iuliu Haţeganu used to mention: "**the doctor's work is neither the machine, nor the syringe, but his kind heart and soul, where there is love of men there is also love of the medical art**" (Miu, 2010).

Thus, it can be said that the professional commitment for the servants of medicine finds itself in the communion of science and belief, in the moral principles of belief and last but not least in the traditions of caring for our fellows in suffering. From this reality results the doctor – patient relationship which from the start presents itself as paternalist, supported later on by various deontological codes which succeeded each other during the years (Ioan, 2010, pp. 67-74).

A special part in this context is played by the doctor – child relation, which, in time, evolved in a special manner. Considered from the start to be an insignificant pathology in comparison to the one of the adults, the child itself being seen for a long period of time as an adult in miniature, the child's situation would change radically in the 18th century along with the new discoveries in the fields of anatomy, physiology, metabolism, embryogenesis, nutrition, childhood pathology which have managed to prove the unmistakable identity of the child with its anatomical and physiological particularities (Iftimovici, 2010, pp. 129-130). Towards the end of the 19th century pediatrics would separate itself as a distinct specialization, and the attitude towards children would change completely with the adoption of the Universal Declaration of the Rights of the Child (1991) and the UNESCO Convention on the rights of hospitalized child (2005), which foresee the child's right to consciously take part in making the decisions which concern him as a person and from here, among other, a certain type of doctor – patient relationship with the corresponding particularities (Buta, 2008, pp. 10-34; Tighici et al., 2012). In a study performed on communications skills in pediatrics the main aspects that need to be improved in the health care system in downward order are the following: hospital environment, time management, communication, transparency, and intercultural issues (Mărginean, 2017).

The evolution of human society has made many rules deriving from the tradition in which medical science encounters Christian charity, become pale in the 20th century, when the extraordinary progress of medical science seemed to place men beyond his condition, to establish the myth of self-sufficient scientific reasoning and of the logics of human thought, releasing, in the atheist materialist conception, the human being from all that was spiritual value or moral custom until then (Iloaie, 2010, pp. 163-182).

Secularization, which accompanied this process, managed to marginalize all that moral rules and historically consecrated values meant. These aspects became more intense also, because in the doctor – patient relationship a new set of social norms appeared, norms which, with the beginning of the 19th century start being present within a medical system organized according to the needs of the attended society (Rădulescu, 2002, pp. 121-127). This interposition would have negative consequences on the doctor – patient (adult or child) relationship, or medical system and collectivity, in the end affecting also the medical responsibility.

In this context, the relation doctor – patient is more and more presented as experiencing a crisis; less is told about the objective factors which lead to this state of fact. In our opinion, there have been at least three distinct elements: the excessive technicization of the medical act, medicalization and over - medicalization of individual and social life, and elusion of the basic principles in the doctor – patient relationship.

THE EXCESSIVE TECHNICIZATION OF THE MEDICAL ACT

One of the truths of the contemporary world is that scientific progress in general has led to excessive technicization of the medical field, which allowed the achievement of some truly extraordinary medical performances, defying sometimes even the natural human limits (see genetic pathology, neonatology). This evolution would transfer the focus of medical practice on its technical aspect. Consequently, the amount of time dedicated to the patient recorded significant decrease, which had negative effects on the doctor – patient relationship, the patient becoming in this case, nothing more than a number or a case. The formation of the doctor himself during the educational process is more likely a technical – scientific one and less, or almost not at all, humanistic. Also, the burnout of the medical professionals lowers their empathy level (Yuguero et al., 2017).

Consequently, the doctor – patient relationship will completely change its essence, moving from the traditional model which meant: long lasting relations with the doctor which is involved in the patient's family and social problems, to the modern system in which the doctor is the interface of a system. In addition, in health issues and not only, the doctor enjoyed a special status, miming the paternalist aspect of medical decision which hardly accepted negotiation and partnership in making decisions (Rădulescu, 2002).

There have also been periods in the past when, due to certain circumstances, ideologies or doctrines, the humanist side of medical practice has been completely neglected, canceling practically the doctor – patient relationship. This reality did not leave aside the doctor – child relationship, on the contrary, it had even more dramatic consequences, if we consider the attitude people had in antiquity and middle age towards the child with birth handicap (Iftimovici, 2010, pp. 733-742). Apart from these episodic aspects, nowadays, due to excessive technicization, the problem seems to have become extremely important as the need of reconsidering the classical asklepian (scientific) side of the medical act and the Samaritan side (compassion and charity) in medical education has become necessary from the beginning of the teaching period of the future doctor (De Fleur, 1983, pp. 10-18). Hence, the necessity of some disciplines as ethics and medical deontology, bioethics and medical sociology (some of which insufficiently represented, others completely absent) which consider men and society from a medical point of view, referring to health, disease and death.

Without ignoring these aspects, discussable no doubt, we must acknowledge that the technicization of the medical act has given doctors the possibility to increase their efficiency, has forced society to recognize and impose them as an autonomous, legitimate system with enough authority because, just as K. L. White mentioned in 1978, society concludes a symbolic contract with medicine, resulted from the importance assigned to the social consequences of disease and death (Rădulescu, 2002).

MEDICALIZATION AND OVER - MEDICALIZATION OF INDIVIDUAL AND SOCIAL LIFE

The evolution of medical sciences accompanied by the development of a true set of technical and therapeutic arsenal induces, willingly or not, the orientation of the medical act towards economic reasons, which often focuses on profit. Hence the aggressive marketing in the health care system practiced by pharmaceutical companies and medical equipment, but also by the top health care units which would implement a true informatic dumping and medical bureaucracy which considered medical assistance to be medical business.

The truly dangerous thing is that it also overbids the illness state of the society, generating false images of biologic catastrophes which are about to appear. This situation would lead to social stress and increase the population's level of dependence of the medical system, because this is how it generated new painful necessities, most often unnecessary. The society's answer, but especially the individual's answer was a disarming one, as it reduced pain tolerance, suffering tolerance and the compassion level towards those in suffering, reaching that point in which not even biological decline was accepted any more.

The results have not delayed to appear, because **one of the most disastrous effects of medicalization and over - medicalization is iatrogeny**. Nowadays iatrogeny has managed to rise above the direct and indirect effects of malpraxis.

In 1983 De Fleur presented an interesting vision on iatrogeny, classifying it in three categories (De Fleur, 1983):

- **clinical iatrogeny** which include: doctor's errors and/or treatment complications. Here, facts and speculations find themselves perfectly. It is sure that, for example, in the United States of America there are recorded 98,000 deaths due to wrong administration of medicines in emergency care. Unfortunately, this evaluation disregards that a critical condition can be fatal by itself, that the reaction to a medicine can be a paradox in critical conditions and that the essential fact is the biological background on which that particular critical condition evolves.
- **social iatrogeny**: the accent falls on the inefficiency of the medical services, when in fact, part of the morbidity is related more to the social, economic or geopolitical context, as they all bring along death and disease. We remind the Romanian reality when pediatric sections were over-dimensioned due to the numerous social cases. In the same time, the units for dystrophic children and care centers which were the responsibility of the medical system although they were populated only by social cases, which had nothing to do with the patients' state of health.
- **cultural iatrogeny**: in which the doctor and the medical system are to blame for the medicalization and the over medicalization of the individual and the society, which have led to a higher number of iatrogenic cases. In fact, it represents a true psychosis for some treatments, vaccines and unnecessary, useless and even harmful medical procedures among which we can mention: caesarean section, tonsillectomy, cosmetic plastic surgery etc. We support our statements with the same example of the United States of America where annually there are performed 2 million unnecessary operations with thousands of deaths and 1.5 million hospitalizations due to the side effects of medicines prescribed for various unnecessary medical purposes (De Fleur, 1983).

ACCIDENTAL ELUSION OF THE FUNDAMENTAL PRINCIPLES IN THE DOCTOR – PATIENT RELATIONSHIP

Of course, these realities would increase the conflict between medical system and society and implicitly between doctor and patient. In fact, this conflict would point out the abandonment of the principles which have, along the centuries, turned medicine into a humanist science. With this renunciation more or less accidental, the transformation headed towards economic efficiency, more precisely profit, which draws the attention of both medical system in relation to the society and the doctor in relation to the patient.

According to Parsons (Parsons, 1975), the abandoned principles would be:

- **universalism of medical practice**, which assumes the doctor to be at the patients' disposal, without exception, without emotional bondage or personal interests. For making this clear, let us carefully observe the system of primary care. We do not consider the doctor to be the only one to blame, but also the medical system which discourages the values of traditional practice, by imposing all sort of bureaucratic barriers.
- **functional specificity** which opposes to the first criteria by strictly limiting the doctor to his specialization, thus losing the general character of medical activity. Specializations and super specializations have dissipated medical care and have disoriented the patient (Lupu, 2007, pp. 182-191). Let us also notice here the relation between primary care and hospital care which is also influenced by bureaucratic limitations.
- **emotional neutrality**, by detaching from all that represents subjective attitude with emotional implications, consequently sympathies or antipathies, without intimate relations, but maintaining the confidentiality of the medical act. Only that often emotional neutrality has turned into indifference and insensitivity to sufferance. At the level of the relations with an ill child, the elusion of this principle can lead to dramatic aspects.
- **focusing the activity towards the community**, underlining the nobleness of the devotement towards the community. This is why the doctor should not refuse bad payers, he should not negotiate

his honorary and neither should he make publicity to himself especially on child patient.

- **professional satisfaction as well as technical performance or competence**, which once acquired they must not have negative impact on the patients, or in fact the higher the competence the limited the access and even conditioned, often with a discriminatory character in relation to children.

No doubt, these principles so generous in their strict sense and which in the past used to give honor and make noble the medical profession and its staff, are harder to find in nowadays society. And then it appears the natural question, is there any way, in the contemporary society, to regain what it was the nobleness of the profession and its divine and human devotion? A possible answer might be found reconsidering what over the years has given social value to the medical act. Because only here – we would say - can be once more found the necessary binder for harmonizing human devotement and professional responsibility.

It would also be a rediscovery of what over the centuries has consecrated medical art, which is that fortunate combination of medical science and medical humanism with its charitable side.

ACKNOWLEDGEMENTS

All authors contributed equally to this article.

REFERENCES

1. Buta, G. M. (2008). *Bioetica în Pediatrie* [Bioethics in Pediatrics]. Eikon.
2. Buta, G. M. (2010). Pentru o bioetică creştină într-o epocă postcreştină [For a Christian bioethics in a post-Christian era]. In G. M. Buta (ed.), *Medicii şi Biserica* [Doctors and the Church], vol VIII. Renaissance Publishing House.
3. Damian, S., Necula, R., Sandu, A., Iliescu, M., L., Ioan, B. (2013). Ethical evaluation model for technologies. The role of medical technology in the development of autonomy in diabetes patient. *Revista Medico-Chirurgicală a Societăţii de Medici şi Naturalişti din Iaşi, 117*(3), 722-730.
4. De Fleur, T. (1983). *Social problems in American Society*. Haughton Mifflin Co.
5. Iftimovici, R. (2010). *Istoria universală a medicinei şi farmaciei* [The universal history of medicine and pharmacy]. Romanian Academy Publishing House.
6. Iloaie, Ş. (2010). Relativismul moral al secularizării şi prezenţa lui în bioetică [The moral relativism of secularization and its presence in bioethics]. In G. M. Buta (ed.), *Medicii şi Biserica* [Doctors and the Church]. Renaissance Publishing House.
7. Ioan, B. (2010). Rolul şi locul cuvântului în relaţia medic pacient [The role and place of the word in the doctor-patient relationship]. In G. M. Buta (ed.), *Medicii şi Biserica* [Doctors and the Church], vol VIII, Renaissance Publishing House.
8. Lupu, V. (2007). Grigore T. Popa sau polivalenţa spiritului [Grigore T. Popa or the polyvalence of the spirit]. In *Reflecţii peste timp* [Reflections over time]. PIM.
9. Lupu, V. (2012). Medicul între devotamentul profesiei şi responsabilitatea profesională. In G. M. Buta (ed.), *Medicii şi Biserica* [Doctors and the Church], vol X. Renaissance Publishing House.
10. Mărginean, C. O., Meliţ, L. E., Chinceşan, M., Mureşan, S., Georgescu, A.M., Suciu, N., Pop, A., & Azamfirei, L. (2017). Communication skills in pediatrics - the relationship between pediatrician and child. *Medicine*, *96*(43), e8399. https://doi.org/10.1097/MD.0000000000008399
11. Miu, N. (2010). Teologia bolii. In G. M. Buta (ed.), *Medicii şi Biserica* [Doctors and the Church], vol VIII. Renaissance Publishing House.
12. Necula, R., Damian, S., Caras, A., Sandu, A., & Vicol, M. (2013). The role of spirituality in the construction of the autonomy and responsibility of chronic diabetic patients. An orthodox priests' perspective. *Procedia - Social and Behavioral Sciences, 92*, 617-626. https://doi.org/10.1016/j.sbspro.2013.08.727
13. Parsons, T. (1975). The sick role and the role of Physichians. *Millbank Memorial Quaterly*, *53*, 257-278.
14. Paulescu, N. C. (1913). *Spitalul* [The hospital]. Curs de deschidere [Opening course]. Bucuresti.
15. Rădulescu, M. S. (2002). *Sociologia sănătăţii şi a bolii* [Sociology of health and illness]. Nemira.
16. Tighici, E., Burlea, M., Lupu, V., & Lupu, V. V. (2012). Ethical aspects in pediatric gastroenterology. *Romanian Journal of Bioethics*, *10*(3), 116-123. https://www.umfiasi.ro/ro/academic/programe-de-studii/doctorat/Documents/Abilitare/2021-2022/Conf.%20Univ.%20Dr.%20LUPU%20Vasile%20Valeriu/10.pdf
17. Yuguero, O., Forné, C., Esquerda, M., Pifarré, J., Abadías, M. J., & Viñas, J. (2017). Empathy and

burnout of emergency professionals of a health region: A cross-sectional study. *Medicine*, *96*(37), e8030. DOI: 10.1097/MD.0000000000008030

back