THE YOUNG SCHOLARS

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Transformation of models of interaction of a doctor and a patient

The problem of interaction of a doctor and a patient within the framework of medical practice since the time of becoming of medicine as a science up to the present stage of development of the patient-centered approach is considered in given article.

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Beginnings of medical knowledge go from remote ages. Since the most ancient times the vulnerability of a person in the face of nature and own feebleness led to attempts to cope with fear of illnesses and death by means of mystical ideas. The profession of a doctor was formed in ancient Egypt and neighbouring states about 3 thousand years ago. Magic was the main component of healing, and also an integral part of care and nursing of patients: mystical ceremonies, incantations, spells and suggestions formed the basis of a temple medicine. Activity of ancient doctors was confined to an increasing degree within restoration of external and visible dysfunctions of a human organism.

In the V BC Greeks managed to get up medicine from position of minister of religion up to the level of the major state discipline. Hippocrates, the great reformer of antique medicine, refused mystical, religious justifications of physical abnormalities and sufferings of a human body in many respects, laid the foundation for development of medical system which was based on the empirical-rationalistic approach. At that particular time based on naturalistic observation and practical experience, there was a forming of basic medical canons, as especially professional, as ethical-deontological ones. «The Oath of a doctor» created by Hippocrates put health and well-being of a sick person higher than personal interests of representatives of the medical occupation, and their class and status belonging. During many centuries this oath has been a starting point of a professional ethics of a doctor and has been sworn by graduates of medical educational institutions. To present day it remains an outstanding monument of humanism.

In days of Ancient Rome Galen spoke about identity of medicine and philosophy. In the Hellenistic epoch philosophizing meant a dialogue with people who were devoted into secrets of the universe and human nature. Such a dialogue with the philosopher-doctor frequently took a psychotherapeutic character: the philosopher became a confessor – a doctor of a soul. The need in such doctors was always great, as fear, anxiety and stressful states are eternal problems of mankind, accompanying

organic diseases and quite often acting as their reason.

After the decline of Roman Empire scholastic traditions of medieval medicine dominated everywhere in Europe. Doctors were only allowed to practise medicine after graduating from medical faculties. They kept control of medical knowledge, which was inaccessible to strangers, used a special terminology and Latin for writing prescriptions. A doctor vested with authority was in a higher rank and established a monopoly for medical knowledge and the right of exclusive independence of judgements, regarding patients as ignorant helpless babies.

Events of the French Revolution initiated development of an empirical science and put an end to the era of a confinement of incurable patients, and also mentally ill people. The developing medicine of the XIXth century considered separate symptoms of a disease as unique indicators of a specific pathology. Such an approach demanded from a doctor system anatomic and clinical knowledge for diagnostics of diseases, keeping a patient in a dependent condition from an expert opinion of the doctor. Such interaction supposing a leading role of a doctor and a passive role of a patient was forming a paternalistic model of relations in a dyad of doctor-patient [1].

In the beginning of the XXth century, since the time of occurrence of the first psychoanalytical theories in psychology, within the framework of various psychotherapeutic schools forming of concepts about the personality of a patient began. The major driving force of various schools of psychotherapy became the requirement to treat a patient as a personality, to recognize his/her individuality, and uniqueness. As a central determinant of effective therapy it was considered a character of «psychotherapist-patient»'s relations instead of psychotherapeutic techniques and skills of the therapist. The idea of interaction came to take the place of idea of influence of a psychotherapist on a client and was an incentive for criticism of biomedical views of leading clinicians according to which a patient was considered as an object of medical manipulations without taking into account subjective experiences. In the 50s of the XXth century M. Balint made an attempt to unite medicine and psychoanalysis. Considering an illness as a phenomenon simultaneously determined by biological and psychosocial reasons, he noted the dynamic nature of unique emotional relations in the doctor-patient system and introduced «a doctor as a medicine» concept, emphasizing a crucial importance of personal features of the doctor as the subject of the dialogue in a therapeutic process.

In the 60-70s there was a formation of bioethics – a form of medical ethics which basic moral principle is the principle of respect of rights and dignities of a person. Robert Vich, an American doctor-bioethicist, distinguished 4 models of interrelations of a doctor and a patient: technological, paternalistic, contract and collective ones. According to the technological model a doctor acts as a biotechnologist, remaining personally aloof in conformity with traditions of classical scientific character leveling subjectivity in research of any object. The paternalistic model provides an investment of a doctor with an absolute measure of responsibility and the authoritative right of decision-making concerning the health of a patient. The contract model consists in a

regulation of interrelations of a doctor and a patient with the help of a contract about mutual respect of rights and duties of each other. The collective model establishes relations of partnership and equality in the doctor-patient dyad [2].

For the last 20 years in medicine a heightened interest to the concept of «patient» has been generated – a centered approach which grows out of reorientation of public health service from the biomedical model of health to bio-psycho-social model. «The new medical paradigm» transforms a patient from a passive object of researches into an active participant of a medical process, and establishes the degree of confidence and consent between s doctor and a patient, awareness of the patient and his/her consciousness in decision-making as determinants of successful treatment and satisfaction of the patient.

The practice shows that paternalism cannot be completely excluded from the dialogue with a patient. However, a transition to market relations in medicine, which have added interrelations of a doctor and a patient with such concepts as a maker and a consumer of medical services, inevitably causes changes in the field of their social interaction. The standard of the modern doctor is not only a skilled specialist, but also a subject of the dialogue who are endowed with an aggregate of social abilities and personal characteristics, allowing their bearer to provide a high degree of individuality of the service according to requirements of the consumer.

Thus, transformation of models of interaction of a doctor and a patient demands perfecting the competence of medical staff in the sphere of communication and promotes mutual satisfaction of participants of a medical process.

References

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