Chapter I

Introduction

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One of the most important factors that serves as a cornerstone of health care delivery is the doctor-patient relationship. The significance of good relationship between doctor and patient in bringing effective treatment outcome is sociologically reiterated. Many view doctor-patient relationship from the basic idealism of medicine that "Medicine is fundamentally a human activity aimed at helping the sick and disabled, through healing, alleviating of suffering, and caring for people with respect and dignity"[1]. And the basic premise reads as, "Nothing is more satisfying than to 'help' an individual patient and received their heartfelt thanks"[2]. Generally, the relationship between doctors and patients is constructed in such a manner that patients assumed the role of 'the sick' and doctor assumed the role of 'the healer'[3]. The patient has a need for technical services because he doesn't—nor do his lay associates, family members, etc.—"know" what is the matter or what to do about it, nor does he control the necessary facilities. The physician is a technical expert who by special training and experience, and by an institutionally validated status, is qualified to "help" the patient in a situation institutionally defined as legitimate in a relative sense but as needing help [4]. The relationship is often viewed by both patients and doctors as 'long term personal relationship'. Regardless of a society's level of medical knowledge and technology, the structure of medical science still functions within the context of values, attitudes and beliefs of the people comprising

the society. “Both patients and doctors differ in their beliefs, attitudes and hopes”[5]. This implied a great deal of expectations which set up patterns of social conduct. The social conduct by its very nature is interactive[3]. Interaction between doctor and patient is generally a straight forward encounter both striving for quality results. But the quality care is ascertained in many ways from different perspectives since both the parties come from different social backgrounds. ‘Doctor may count it on the number of remissions or successful treatment. And for the patient, it is probably efficiency, affordability, punctuality, promptness, equitable care, positive interpersonal relationship with doctors’. And the dynamics of interaction involves both the two parties - the physician (his professional system and organizational settings) and the patient (his family, community and social setting). It is through this interaction the basic component of medical care like diagnosis, prognosis, and the therapeutics get accomplished. Any society to exist must have a structure before it can deliver any function. “Theoretically, the structures and functions of society can be separated but in reality, they are inseparable”[6].

The functioning of a hospital is based on the mutual cooperation of a large and heterogeneous group of independent professional and semi-professional personnel who represent different values and orientations, but who constantly deal with human problem. Hence, the conceptions, expectations, perceptions and interactions form the basis for viewing their role performance and relationship. The relationship at the beginning, though not very advanced, was said to be very healthy with doctor being considered equal to ‘god’ and highly esteemed. But the nature of relationship deteriorates with the complexities of human behaviour and

advancement of knowledge making the unique relation a constraint based relationship. Conflict rather than collaboration and support disturb the important elements like trust, confidence, integrity, comfort, reliability and honour making both the parties suspicious, angry, betrayed, frustrated and sad. It is, therefore, important to understand and study what elements comprise the relationship and how to maintain it.

(a) Statement of the problem

The decline of the doctor-patient relationship, in recent times could be felt by professionals and public alike all over the world. In a survey conducted by Doctor Patient Medical Association Foundation, 2012, involving 699 doctors from 45 states in America found out that 85% of the total respondents think the patient-doctor relationship is declining where 10% commented that it is at least holding steady. In the report on Doctors' attitude on the future of Medicine revealed the view of 85% of the respondents that patient-physician relationship was in a tailspin[7]. A newspaper report cites that Beijing is struggling to deal with an increasingly violent flashpoint of social unrest in its healthcare system[8].

Unfortunately, unhealthy relationship between doctors and patients in the form of conflicts is in rise in India too. Since May, 2012 till date, more than one hundred reports on conflict between doctors and patients have been published in both national and local newspapers. Some of the incidents given below are indexical for the prevailing conflicts between doctors and patients in India. Angry villagers burnt down a hospital in Sitamarti district Bihar over the death of a woman after

delivery alleging doctors for negligence. The woman after delivery was discharged. As bleeding occurred she rechecked in the hospital but died later in the night. The fire spread to the ICU, leading to death of three other patients [9]. Relatives and family members of a patient who died of chronic jaundice stormed into the Kalina sub-divisional hospital in Burdwan and beat up physicians and health staff alleging negligence [10]. Relatives ransacked a private nursing home after the death of a patient. The relatives said that the patient died due to non-treatment. The patient who had an accident, was admitted at the nursing home by the local people on 24th October. On 26 October, doctors operated on him and his condition was stated to be stable but died two days later. The wife of the patient said that the deceased was shifted to general bed, from which he fell, but the doctors did not come to his aid. Local people, along with patient's kin demonstrated in front of the nursing home and broke the windows and chairs of the nursing home. Later, Barasat police brought the situation under control. Police have arrested five persons[11]. An ENT specialist in Durgapur was caught while he was beating up a patient. The reason being the blood oozing out of the man's nose stained the doctor's shirt[12]. An irate mob of about 40 people ransacked and vandalised the radiology department of Silchar Medical College and Hospital in Ghoonger. The trigger for the incident was the death of a seriously injured person who was admitted to the hospital. Four interns who were on duty were also injured in the mayhem. They were later treated in the hospital and said to be traumatised[13].

Family members and locals stormed a government hospital in Manipur decrying alleged negligence of the attending doctors in the delivery case of a woman

which resulted to death of both the mother and the child, [14]. Locals stormed a government hospital in Manipur demanding for reimbursement of the treatment expenses over the dead of a patient. They charged that the patient died due to negligence of the government hospital doctors and also demanded an enquiry over the issue. Doctors reported that the patient faced kidney failure but locals claimed otherwise, "The patient died of infection due to negligence of doctors, not of kidney failure"[15]. One of the ugliest protests was seen in Manipur where a dead body was deposited at doctor's residence. A woman passed away after delivering a baby at a government hospital. Soon after the post mortem examination, the agitated Joint Action Committee (JAC- formed in almost every unnatural casualty and assault in Manipur) and the family members took the body in a truck and went straight to the house of the doctor and deposited the body in the courtyard of the later. The agitators shouted slogan asking the family members of the doctor to come out of the house and take the custody of the lifeless body. However none of the family members dared to come out of the house and all doors and windows remained closed. Neighbours remained silent and amazed at the situation. The agitators and the family members went away leaving the body unattended at the courtyard[16].

In Manipur, agreements are made between the two parties as reported in the local dailies but not through conventional court. If any conflict arises, Joint Action Committee will be formed initiating both the agitation and the negotiation as in the case of dead body being kept at the residence of a doctor. In the same news item cited above, it was clearly written at the end that, "Meanwhile, reports received late in the evening informed that the family members have accepted the body after an

understanding was brought about between the JAC and authorities of the hospital where the MLA also took part making all agitations called off" [16].

India's poor health care system may also help to ignite conflict with want of more professionalism and facilities. Union Health Minister submits the poor health status of India's Public Health. Union Rural Health Development Minister Jairam Ramesh said Public health system in the country had 'collapsed', noting that even poorer countries like Bangladesh and Kenya have superior health indicators. He said, "Today, the single most important reason for rural area indebtedness is expenditure on health. We all know that the health system in India has collapsed. India is a unique country in the world where 70 percent of the health expenditure is private expenditure. Public health system simply does not exist in many parts of India" [17].

The Planning Commission's own analysis of the state of the country's healthcare system revealed the rot within. The rural health statistics 2011 show a shocking shortfall in human resources. According to planning Commission's draft, the government-run health care system is hamstrung because of the number of doctors is short of the target by a jaw-dropping 76% (actual 26,329, when the target is 1,09,484), there are 53% fewer nurses, specialist doctors are short by 88%, radiographers by 85% and laboratory technicians by 80% [18].

On the other hand, unethical public are also responsible for the unhealthy development. Intoxication, uncalled political influences and highhandedness are the common nuisance the patient party make to bring up to ugly scenes.

A doctor of Sagar Dutta hospital and a group D employee were beaten up by some drunken youths in the hospital premises. Belgharia police later arrested three youths. Five youths came to the hospital claiming they had received injuries in road accident. The doctor checked them and prescribed some medicine, but the youths demanded they be admitted to the hospital. When the doctor refused to do so, the youths went to a group D staff and asked him to admit them. When he also refused, the youths beat him up. When the doctor stepped forward to help him, the youths allegedly beat him up too[19.]

A physician was punched in the face by the son of a patient and taken to Bishnupur sub divisional hospital (Bankura, Wet Bengal) with blood oozing from his mouth. The doctor was attending patients at the OPD of Joypur block hospital in Bankura. Patients had queued up in front of the chamber. A local resident, a youth leader of a political party took his sick father and asked the physician to check him immediately. The doctor refused to give him priority, which led to alteration. The youth leader flared up and smashed his fist into the physician's mouth. The physician fell to the floor, and other patients moved in to help him. Police arrived quickly, but did not book the youth, which irked the other patients and their kin[20]. A Government Hospital in Imphal has been closed as doctors and staff resorted to cease work strike to protest alleged threat by some armed security personnel and a patient party. It said some armed security personnel, including a patient party has bullied the doctor and staff at Ante-natal Ward of the hospital[21].

Incidents of doctor-patient conflicts had become regular resulting destruction of hospital properties and doctors going on strike where public face the brunt. As the

crisis of violence became out of proportion, the Assam Government passed a bill called ‘the Assam Medicine Service Persons and Medicare Service Institutions’ (Prevention of Violence and Damage of Property) Bill, 2011. The bill empowers the state Government to make punishable action with imprisonment for a term which may be extended to three years and with fine that may be extended to Rupees fifty thousand for involvement in violence against any Medical Service Person and damage to any property of the Medicare Service Institutions or to any Medicare Service Person ” [33]

Meanwhile a doctor was nabbed for patient’s death when a bill on protection of Medicare Service was passed by the Assam Government Assembly. Police in Dibrugarh apprehended caretaker of a private home following allegation of gross medical negligence that led the death of a 26-year-old youth. An Orthopedic was apprehended after family members of the youth filed an FIR[34]. Similarly, a doctor in Agartala, after an operation of a woman’s abdomen, left behind an eight-inch corrugated drain tube inside her body. While hearing the case, High Court Chief Justice Deepak Gupta observed that it was a case of medical negligence and could be termed criminal offence[35] .

The trend of seeking knowledge and information through internet is fast prevailing in nooks and corners of the globalised world. In Manipur too, avid internet users queue their decision and knowledge from the World Website Web. Sometimes, it is misleading because views of mediocre are flooding the pages which can disturb the patient-doctor relationship. But the youths trust the internet better losing trust on the local physicians. At the same time physicians are also blamed for

being dormant as they could not change their behavior and treatment style in spite of drastic change and development in information technology. It fuels conflicts and patients become more resenting. But this attitudinal transformation is seen among the younger generation; older generation still respect local experts and physicians though trust of some of them in the treatment procedure is still debatable.

Concerning the various factors disturbing the serene relationship, both the parties are equally responsible for the development. The trust between the two is blurring each passing day especially in government hospitals. "Generally, patients remain in relation with doctors in government hospital either by choice or by the perception of no alternative" [22]. Patients' choice of government hospital belongs to the latter category where the relationship between the doctors and the patients become constraint-based relationship. In such situations, commitments of both parties are normally weak. Though rapid advancement is occurring in the medical profession, little attention has been paid to social aspects affecting the technical performance of doctors and their relationship with patients. As a result of lack of motivation or job satisfaction, prevailing unfavourable conditions in the society, heavy workload and other factors, doctors may not be fulfilling the expectations of the patients. It is important to study how doctors evaluate various dimensions of the hospital social system which may affect their role performance. Many times, we listen to doctors being annoyed with patients. Some patients are seen as problem patients. This is a newer area to be explored. The expectation of patients needs identification. Though patients may be expecting sympathetic attitude, clear instructions for treatment and diet and other preventive measures, doctors may not be able to devote attention on all these areas and spend sufficient time in fulfilling

the various needs of the patients. These are the areas to analyse with regard to doctor-patient interactions. The analysis of doctor-patient relationship will also indicate how patients and doctors view each other and check their behavioural dimensions and effective meaning system. Continued research on what contributes to and detracts from healthy patient-physician relationship should help clinicians craft improved practice strategies and lead to healthier patients. The present study intends to find out factors that contribute to the problem of doctor patient relationship with reference to Government Hospitals in Manipur and also provides suggestions for improvement.

(b) *Conceptual and theoretical framework*

The study has borrowed conceptual model identified by American physician Mark Siegler. Siegler acknowledges the existence of broadly two models of doctor-patient relationship which he terms as unilateral, static notions of physician dominated paternalistic and patient dominated consumerist libertarian model of medicine. He views that the traditional paternal model of medicine was premised on trust in the physician's technical competence and moral sensitivity and was characterized by patient dependency and physician control. Such model is gradually replaced by one in which patients are increasingly involved in decision-making concerning their own medical care. The rise of consumerism in medicine has encouraged some individual to view medicine as "serving" profession and to regard themselves as "medical consumers" making physician a passive agent, a hired

technician who practices under the direction and control of his “client”. He claims that both the physician-dominated paternalism and the new patient-dominated consumerism are unilateral models in which one or the other party in the relationship is seen as dominant. In his words, “The physician-patient accommodation is a bilateral one in which the moral and technical arrangements of a medical encounter are determined mutually, voluntarily, and autonomously by both patient and physician” [23]. Siegler M, studies doctor patient relationship in three periods: the age of paternalism, which was the age of the doctor; the age of autonomy, which was the age of the patient; and the age of bureaucracy, which is the age of the payer. Siegler views that the age of paternalism lasted for more than a thousand years, from about 500 BC to 1965. The physician was in charge, and the patient trusted the physician’s technical skill, morals, and ethics, this was characterized by patient dependency and physician control. Medicine provided symptomatic care rather than cure during most of this period, but it satisfied many basic human needs for most patients. This is an important point to make in the changing scenario of doctor-patient relationship. He terms next forty-fifty years till 1990s as the age of autonomy (Patient), because it was the period of extraordinary advances in the understanding of disease and development of treatments. Though expensive, the emphasis was given on treatment and cure rather than prevention and care. Doctor-patient relationship was based on patient rights and informed consent. In the age of bureaucracy, wishes of both patients and physicians became subservient to the wishes of administration and bureaucrats where cost containment and cost- efficiency are based on societal risk-benefit analysis. This age of external control over the patient-doctor relationship is

basically defined by the cost of care, which is easy to quantify, rather than by the quality of care[24].

Thomas Szasz and Marc Hollender, described three models for the doctor-patient relationship in their own terms. Though they called the first model, "activity–passivity", it is almost the same as the paternalistic model that has an entirely passive patient receiving care from the physician, who is also the sole decision taker. They said this strong version of the paternalistic model was a common model of care in emergency settings and paediatrics practice. They called the second model, "guidance-cooperation" where patient willingly concedes power to the physician and cooperates with the physician's treatment which is a weak paternalism. Though patient chooses to follow the physician based upon the knowledge possessed by the physician, the model is common particularly for hospitalized patients who were struggling with significant illness. Stating the third model as "mutual participation", they claim that the model is, philosophically, predicated to the postulate that equality among human beings is desirable. Psychologically, mutuality rests on complex process of identification – which facilitates conceiving of others in terms of oneself-together with maintaining and tolerating the discrete individuality of the observer and the observed. Szaz and Hollender described the third model as one model of care and the other models should not be judged inferior because patient choice and decision-making ability were more curtailed. But the model of care cannot remain static, ever with the same patient overtime[25].

Emanuel EJ and Emanuel Linda add one more model describing the four models as The Paternalistic Model, The Informative Model, The Interpretive Model

and The Deliberative Model. In the paternalistic model, also called the parental or priestly model, according to Emanuel and Emanuel, the physician-patient interaction ensures that patients receive the interventions that best promote their health and well-being. In this model, the physician acts as the patient's guardian, articulating and implementing what is best for patient. As such, the physician has obligation, including that of placing the patient's interest above his or her own and soliciting the views of others when lacking adequate knowledge. The concept of patient autonomy is patient assent, either at the time or later, to the physician's determinations of what is best. The Informative model or scientific or engineering or consumer model has an objective of the physician-patient interaction for the physician to provide the patient with all relevant information, for the patient to select the medical interventions he or she wants, and for the physician to execute the selected interventions. The informative model assumes a fairly clear distinction between facts and values. The patient's values are well defined and known; what the patient's obligation to provide all the available facts and patient's values that determine what treatments are to be given. In the informative model, the physician is purveyor of technical expertise, providing the patient with the means to exercise control. As technical experts, physicians have important obligations to provide truthful information, to maintain competence in their area of expertise, and to consult others when their knowledge or skills are lacking. The conception of patient autonomy is patient control over medical decision making. In the Interpretive Model, the aim of the physician-patient interaction is to elucidate the patient's values and what he or she actually wants and to help the patient select the available medical interventions that realize these values. Like the informative physician, the interpretive physician

provides the patient with information on the nature of the condition and the risks and benefits of possible interventions. In this model, the physician is a counsellor, analogous to a cabinet minister's advisory role to a head of state, supplying relevant information, helping to elucidate values and suggesting what medical interventions realize these values. Thus, the physician's obligations include those enumerated in the informative model but also require engaging the patient in a joint process of undertaking. Accordingly, the conception of patient autonomy is self-understanding; the patient comes to know more clearly who he or she is and how the various medical options bear on his or her identity. In the deliberative model, the aim of the physician-patient interaction is to help the patient determine and choose the best health-related values that can be realized in the clinical situation. In this model, the physician acts as a teacher or friend, engaging the patient in dialogue on what course of action would be best. Not only does the physician indicate what the patient could do, but, knowing the patient and wishing what is best, the physician indicates what the patient should do what decision regarding medical therapy would be admirable. The conception of patient autonomy is moral self-development; patient is empowered not simply to follow unexamined preferences on examined values, but to consider, through dialogue, alternative health-related values, their worthiness and their implications for treatment. They also state that the four models are not exhaustive and there might be one more addition termed as the Instrumental Model. Here, the patient's values are irrelevant; the physician aims for some goal independent of the patient, such as the good of society or furtherance of scientific knowledge[26].

The Paternalistic model of “detached concern” is replaced by Veatch with a model of total detachment, as expressed in the book by the title, “Patient, Heal Thyself”. He takes more radical step of suggesting that the doctor-patient relationship should, in a sense, be a non-relation. Non-relation can be linked to Autonomy where Patient rights in treatment are obliged[25]. In the autonomy model, Mark Siegler referred Beauchand and Childress to define Autonomy as a form of personal liberty of action in which individuals determine their own course of action in accordance with their own life plans. He responds that though the principle of respect for autonomy surely recognizes that different autonomous individuals will wish to be treated indifferent ways by health professionals, an adequate understanding of autonomy would also include possibility that individuals within a relationship might voluntarily and autonomously choose to relinquish or to waive a degree of independence to pursue other immediate interests. The critical question to be faced by both patient and physician is how independent is a patient willing or eager a therapeutic relationship with a health professional[23].

Theoretically, doctor–patient relationship is broadly analysed by six traditions which include Parsonsian Functionalism, Conflict Perspective, Marxist Thoery, Feminist Theory, Symbolic Interactionism and Foucauldian Theory. The present study incorporates Parsonsian Functionalism and Symbolic Interactionism perspectives though other perspectives contribute equal importance in the analysis of doctor-patient relationship.

Functionalist Perspective emphasizes the way in which each part of a society contributes to the whole so as to maintain social stability. According to this

perspective, society is much like the human body or any other living organism. Like the parts of the body, the parts of society work together in a systematic way that is usually good for the whole. Each part helps to maintain the state of balance that is needed for the system to operate smoothly[27]. Parsonsian Functionalism looks at the role the sick person plays in society. The focus is on how being ill is given a specific form in human societies so that the social system's stability and cohesion can be maintained. Parsons' theory of 'Social System' (1951) aims to achieve stability, equilibrium and a durable consensus of people which according to him would promote new values as it would protect the old ones. In his words, social system consists in a plurality of individual actors interacting with each other in a situation which has a physical and environmental aspects, and actors who are motivated in terms of a tendency to the optimization of gratification and whose relation to their situations including each other is defined and mediated in terms of a system of culturally structured and shared symbols. Parsons' social system incorporates within it the framework of a 'structured-functional' form. It is the by-product of the social system. There is no place of individualism in Parsons social system but has a place for all individuals who would play their parts and contribute in building a society. Parsons' social system depends on certain pre-requisites. Together, they are called the AGIL, in other words; Adaptation, Goal attainment, Integration and Latency-pattern maintenance. To Parsons, equilibrium in society is achievable if all the pre-requisites can function fully and efficiently and in co-operation with one another in order to deliver the objectives[6].

Many other sociologists including Luhmann criticized Parsons' system. "It is not a Parsonsian functional system, with parts working together as they do in art organism. It consists of numerous relatively independent systems-religious, political, economic, educational, and so on- and of people who think about themselves and their actions", Luhmann[28].

Parsons also talks about doctor-patient relationship. Modern medical practice is organized about the application of scientific knowledge to the problems of illness and health, to the control of "disease". The doctor-patient relationship is thus focused on these pattern elements[4].

Parsons has made a bold attempt to analyze the transition from traditional to modern society through his 'pattern variables'. In traditional society, people treat each other in a more personal way than in a modern society whose relationship is businesslike and impersonal. In traditional society, affectivity is important which allows members to feel the satisfaction of expression of emotions such as punishing a criminal in front of them to see that the perpetrator is dealt forth with. But in modern society, affectivity is neutralized by the judicial system where the criminal will be tried in the courtroom which might take long time to get the sentence passed even though the matter is very serious and dreadful. In traditional society, shared interests are most common which is important to them, for example sharing interests with family and the community, whereas, in modern society, the interest is self-centered. The individual prefers to pursue on a course of personal success even if that means distancing himself or herself from the family, friends and community. This diffusion of society in the form of pattern variables as presented by Talcott

Parsons replicate the Tonnies and Durkheim's typology. Parsons argues, in the modern society relationship between people is partial and rational, and people still communicate with one another to maintain normal relationship. This is an 'expressive element' people exercise as a requirement of functional imperatives[6].

German Social theorist Niklas Luhmann critically states that "all social systems exist in multidimensional environments, which pose potentially endless complexity with which a system must deal. To exist in a complex environment, therefore, a social system must develop mechanisms for reducing complexity, lest the system simply merge with its environment. These mechanisms involve selecting ways and means for reducing complexity. Such selection creates a boundary between a system and its environment, thereby allowing it to sustain patterns of interrelated actions. A social system exists any time the sections of individual are 'meaningfully interrelated and interconnected,' thereby setting them off from the temporal, material, and symbolic environment by virtue of the selection of functional mechanisms[29].

Conflict Perspective emphasizes struggle over limited resources, power, and prestige as a permanent aspect of societies and a major source of social change. This perspective is based on the assumption that the parts of society, far from being smoothly functioning units of a whole, actually are in conflict with one another. This is not to say that society is never orderly – conflict theories do not deny that there is much order in the world – but rather that order is only one possible outcome of the ongoing conflict among society's parts and that it is not necessarily the natural state of things. Conflict theories trace their roots back to Marx. They stress the dynamic,

ever-changing nature of society. To them, society is always in a fragile balance. More often than not, social order stems from the domination of some parts of society over other parts rather than from natural cooperation among those parts. Order is the product of force and constraint – domination – of the strong over the weak, the rich over the poor[27].

Marxist theory is concerned with the relationship between health and illness and capitalist social organization. In the Marxist analysis, the American doctor-patient relationship is conditioned by the "medical-industrial complex" (Ehrenreich and Ehrenreich, 1970; Waitzkin and Waterman, 1976; Mc Kinlay, 1978; Waitzkin, 1986) where profit-maximization drives the innovation of technologies and drugs and constrains physician decision-making. Vincente Navarro (1974, 1986, 1987), rejects the analyses of those such as Illich (1975), Freidson and Starr who see professional power as having some autonomy form, and sometimes being in direct conflict with, capitalism and corporate prerogatives. For Navarro, physicians are both agents and victims of capitalist exploitation, engineers required to fix up the workers and send them back into community and work environments made dangerous and toxic by capitalism. But the professions are anomalous for traditional Marxist theory; only those who own the means of production are supposed to accrue occupational autonomy and great wealth. This anomaly has led Marxist medical sociologists to propose the thesis of physician proletarianization (Mc Kinlay & Arches, 1985). Theorists of physician proletarianization point to the rising numbers of salaried physicians, the deskilling of some medical tasks, and the shifting of some tasks from physicians to less skilled technical personnel. Parallel to, and often included in the Marxist account, has been the growing feminist literature on

medicine. Feminists have focused on the patriarchal nature of the male physician-female patient relationship, documenting the history of medical pseudo-science that has portrayed women as congenitally weak and in need of dubious treatments (Ehrenreich and English, 1972, 1973, 1978; Arms, 1975; Scully, 1980; Mendelsohn, 1981; Shorter, 1983; Corea, 1984; Fisher, 1986; Martin, 1987; Todd, 1989). There is also extensive work done on the history of exclusion of women from medicine (Walsh, 1977; Levitt, 1977; Achterberg, 1991), and the effects of the growing number of female doctors on the doctor-patient relationship. Women physicians tend to choose poorly paid primary care fields over the more lucrative, male-oriented surgical specialties, are more likely to be employed as opposed to in private practice, and are less likely to be in positions of authority. But women providers are also better communicators[30].

Interactionist Perspective focuses on how people interact in their everyday lives and how they make sense of this interaction. Interactionists do not see society as a controlling force, but stress that people are in the process of creating and changing their social worlds. Moreover, they are as interested in what people think and feel as in how they act. Interactionists explore people's motive, their purposes and goals, and the ways they perceive the world[27]. Blumer stressed the creative, constructed, and changeable nature of interaction. Rather than constituting the mere vehicle through which pre existing psychological, social, and cultural structures inexorably shape behaviour, the symbolic nature of interaction assure that social, cultural and psychological structures will be altered and changed through shifting the definition and behaviour of humans. In contrast to Blumer's scheme, Kuhn

stressed the power of the core self and good contacts to constraint interaction. Much interaction is released rather than constructed, as interacting individuals follow the dictates of the self attitude and expectations of their respective roles[29].

The Functionalist and Conflict theoretical perspective share a “structuralist” view of human society and behaviour. The premises of the structuralist view that (1) the social structures should be treated and studied as social facts that are external to, and exert control over, individuals; and (2) that individual behavior is mainly the product of social structures and coercive power of society over human thought and action, perspectives such as these minimize the importance of free will and individual autonomy. It should be stressed that the differences revealed by these three perspectives typically do not stem from contradiction or antagonism but from complementary[27].

Symbolic Interactionism is concerned with examining the interaction between the different role players in the health and illness drama. The focus is on how illness and the subjective experience of being sick are constructed through the doctor-patient exchange. The argument here is that illness is a social accomplishment among actors rather than just a matter of physiological malfunction. According to the Symbolic Interactionism thesis, identity is created through interaction with others. Learning to become a social being means learning to achieve control over this process by managing the impressions others have of us. This creative capacity is evident when we play the role of patient in our encounters with health-care practitioners. Given this interpretive elements of the social encounters, doctor-patient interactions do not follow the script laid out by Parsons. Foucauldian

theory concentrates on the dominant medical discourse, which has constructed definitions of normality (health) and deviance (sickness). This discourse provides subjects in modern societies with the vocabulary through which their medical needs and remedies are defined. The source and beneficiary of this discourse is the medical profession. Foucauldian theorists also argue that medical discourse plays an important role in the management of individual bodies (what Foucault called 'anatomo-politics') and bodies en masse (bio-politics), Medicine is not just about medicine as it is conventionally understood, but also about wider structures of power and control[31].

Hence it is important to analyse all the perspectives simultaneously as each perspective compliments the others. To study one in absence of the other is to be missing something real and important.

Considering the seriousness of the situation, the present study tries to explore whether the social environment of a hospital affect the performance of doctors. Since conflict is a two party affair, the study explores area of satisfaction and dissatisfaction of both parties related to doctor-patient relationship. It is a general perception that poor and needy people mainly visit government hospitals. In order to explore this possibility, socio-economic background of patients as well as doctors in government hospitals are studied. The behaviour of doctors and patients may influence each other. This can be analysed by the views and opinions of each other's role. Finally, doctors were asked to offer suggestions for improvement in government hospitals so that it can help creating a healthier doctor-patient relationship.

(c) Objectives of the study and research questions

The following are the objectives of the study:

1. To study the functioning of hospital as a social system and its effect on doctors.
2. To explore area of satisfaction and dissatisfaction related to doctor-patient relationship.
3. To study socio-economic background of patients and doctors in government hospitals.
4. To study how doctors and patients view and evaluate each other's role.
5. To identify area of improvement in government hospitals with special reference to doctor-patient relationship.

The following Research Questions were formulated for analysing the doctor-patient relationship in Government Hospitals in Manipur:

1. Does social environment of a hospital affect the performance of doctors?
2. Does the extent of expectation of patient and doctor determine the level of satisfaction and dissatisfaction?
3. Does the choice of hospital indicate the socio-economic background of patients?
4. Does the behaviour of doctors and patients influence each other?
5. Does the nature of doctor-patient relationship determine the status of a hospital?

(d) Operational Definition

Doctor-patient relationship can be defined as a reciprocal social interaction based on mutual trust and respect, honesty, co-operation, and mental desire with strong support of adequate resources to improve health outcomes in a hospital set up.

Summary

Doctor-patient relationship is fundamental for health care delivery where patients assume the role of the sick and doctors assume the role of the healer. As patients and doctors come from different social background, quality care is ascertained from different perspectives which affect the relationship. With the advancement of technology, increase in human knowledge and complexities of human behaviour, conflict rather than collaboration disturb the relationship. Conflict between the two parties is in the rise all over the globe. In India, more than one hundred reports on conflict between the two parties have been found in national and local papers since 2012.

The study try to find out what element comprise the relationship and how to maintain it. It also intends to find out factors that contribute to the problem with reference to Government Hospitals in Manipur and also provides suggestions for improvement. As a conceptual framework, the study borrowed Siegler's two models of doctor-patient relationship, physician dominated paternalistic and patient dominated consumerist libertarian model of medicine. And theoretically, the present study incorporates Parsonsian Functionalism and Symbolic Interactionism

perspectives though other perspectives Conflict Perspective, Marxist thoery, Feminist theory and Foucauldian theory contribute equal importance in the analysis of doctor-patient relationship.