Chapter II

Review of Literature

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There is limited literature on doctor-patient relationship in Indian particularly in the North East of India. Nevertheless, some books, journals, thesis, periodicals, newspaper reports that covers doctor-patient relationship could be referred and reviewed.

Doctor-Patient Relationship

Talcott Parsons was the first Social Scientist to theorize the doctor-patient relationship. In western society, Parsons (1951, 1958, 1978) began with the assumption that illness was a form of dysfunctional deviance that required reintegration with the social organism. Maintaining the social order required the development of a legitimized "sick role" to control this deviance, and make illness a transitional state back to normal role performance. The sick role enquires a commitment on the part of those who feel unwell to return to normality as soon as possible. Parsons cites four features that define the sick role: 1. Sick people are legitimately exempted from normal social responsibilities associated with work and the family. 2. Sick people cannot make themselves better – they need professional help. 3. Sick people are obliged to want to get better – being sick is only tolerated if there is a desire to return to health. 4. Sick people are therefore expected to seek professional treatment[1].

Talcott Parson, in the context of sick role, includes health in the functional needs of the individual member of the society so that from the point of view of functioning of the social system, too low a general level of health, too high an incidence of illness. It is controllable, through rational action or otherwise, it is clear that there is a functional interest of the society in its control, broadly in the minimization of illness. He further states that modern medical practice is organized about the application of scientific knowledge to the problems of illness and health, to the control of "disease". It is partly biologically and partly socially defined. Participation in the social system is always potentially relevant to the state of illness, to its etiology and to the conditions of successful therapy, as well as to other things. The role of the medical practitioner belongs to the general class of "professional" roles, a sub-class of the larger group of occupational roles. Unlike the role of the businessman, however, it is collectivity oriented not self-oriented. With regard to the pattern variable, self vs. collectivity-orientation, the physician's role clearly belongs to what, in our occupational system, is the "minority" group, strongly insisting on collectivity-orientation. The "ideology" of the profession lays great emphasis on the obligation of the physician to put the "welfare of the patient" above his personal interests, and regards "commercialism" as the most serious and insidious evil with which it has to contend. By institutional definition of the sick role, the sick person is helpless and therefore in need of help. If being sick is to be regarded as "deviant" as certainly in important respects it must, it is as we have noted distinguished from other deviant roles precisely by the fact that the sick person is not regarded as "responsible" for his condition, "he can't help it" . The doctor-patient relationship is thus focused on these pattern elements. 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[2].

Since the physician deals directly with the welfare of individuals, medicine must be recognized as a moral profession whose tools are, in part, technical. Medicine is concerned with the care of persons by persons. The focus of medicine must be the patient, not the disease. As Cassell points out, the physician's role is most critical when there is nothing that can be done about the disease and the role of medicine is the cure of the persons (patients). There must be a similar distinction between the healing and curing. If a sick person, indeed, presents two different aspects of sickness- the illness and the disease that caused it – the doctor must respond with two separate functions, no matter how closely connected they may be or how the curing function may conceal the healing function. To the doctor who does not distinguish between illness and disease, making a patient with pneumonia better means curing the pneumonia – killing the bacteria, bringing down the fever… but there are other aspects of the illness that the doctor may ignore: the patient may be frightened about what is happening in his body; he may feel cut off from his family and friends, and he may find himself painfully dependent on other people. Healing those aspects of pneumonia is also part of the doctor's job, a part of the healing function. Healing is care of the person, directed at the person and the needs and fears brought on by the illness; curing is activity directed at the disease itself than can at times seem to leave the patient feeling superfluous[3].

It is stated that the focal point of health care delivery has traditionally been the face-to-face interaction between the patient and physician. Elements of this interaction that have set it apart from all other social and business transactions include: 1. A detailed history that include many personal and private elements that necessitates confidentiality. 2. A through physical examination. 3. Discussions of disability and death that directly relate to the patient. 4. Diagnostic tests and therapeutic interventions with which the physician is directly or indirectly involved. 5. An atmosphere of respect for individual dignity, as manifest by trust, compassion, humanism, professionalism and high moral and ethical standards[4].

Generally, encounters between physicians and patients have three major goals. First, the physician must come to understand, by talking with and observing the patient, what is actually troubling the patient. What is troubling the patient may or may not be a clearly definable "medical" problem, and failure to recognize this will not only impede the physician's ability to get needed information but may also impair the physician's ability to appropriately treat the patient. For example, a woman who complains of insomnia since she lost her job may benefit far more from a supportive discussion of the stress she is under than from a prescription for a sleeping pill. Sometimes understanding what the patient really meant is not easy as it sounds. For example, patients may use medical terminology inappropriately or even name body parts incorrectly. The need to find out "what's really wrong" is especially important in cases where symptoms cannot be explained by a definable medical problem. However, discovering what the patient is most concerned about is always important, since one of the key steps in building rapport is making sure the patient feels that he or she has been heard. Without this feeling, patients are much

less likely to experience trust or to follow medical advice. Second, the physician must be able to restructure the information received from the patient so that the patient's concerns make sense within a medical framework. The facts or "raw material" elicited from the patient need to be organized and interpreted to create the "history". For example, the symptoms of crushing chest pain, sweating, and shortness of breath are rephrased in the physician's mind to "possible heart attack." Finally, the physician must "retranslate" medical knowledge into an answer or explanation that makes sense to the individual patient. This can be especially difficult in situations where the cultural background, life experiences, or education of the physician differ markedly from those of the patient[5].

John Hopkins and American Healthways dedicated the outcomes Summit of 2003 to a consensus conference to define the patient-physician relationship for the 21st century. At the conference, patients and physicians were encouraged to examine their own real-world interactions in the context of the trends, technologies and lifestyles. The participants, both patients and physicians, 200 in numbers, followed a consensus conferences process in working to establish and reconcile patient and physician expectation which led them to identify seven essential elements to the relationship. The elements are communication, Office Experience, Hospital Experience, Education, Integration, Decision-making and outcome. By Communication, they mean means of communicating; information gathering; the note of patient self-assessments and feedback; delivery of information; and adequacy of information. Office Experience includes access to care; office-patient communication; process for obtaining prescription and refills; information forms; and the care environment. Hospital experience covers expectations for personalizing

care; the physician in charge; communication among members of the health care team, patients, family and patients advocates; discharge planning and the emergency room experience. Education includes information provided by physicians to patients; addressing patients' individual situations; non-physicians sources of information; and the role of self-care. Integration covers the sharing of information among all members of the health care team; navigation of the health care system; medical records; and health plan information. Decision-making includes the patient's role; patient advocates role; the right of patients to know all evidence-based options; and non-clinical factors that impact medical decisions. Outcome covers clinical outcomes; patient-centered outcomes; and physician-centered outcomes[6].

Desired and healthy out come in the dynamics of health care can only be made only when communication between doctors and patients is strong.

Communication

German Social functional theorist Niklas Luhmann views that all social systems are based upon communication among actors as they align their respective modes of conduct. Because action systems are built from communication, Luhmann, devoting considerable attention to communication theory, stresses that human communications become reflexive and that this reflexiveness leads to self-thematisation. He says that communication occurs in terms of symbols that signal actors' lines of behavior; and such symbols constitute a code with several properties. Luhmann opines about the need to reduce the complexity of their environments in terms of their perceptions about time, their organization of actors in space, and their

use of symbols. And the processes that reduce complexity are functional mechanism which occurs through communication [7] .

Many Sociologists talk about three levels of communications essential for effective doctor-patient interaction. In the first level, termed as 'Communication on an emotional plane', doctors should listen intently to the complaints made by the patient party to establish a quick rapport. In the second level, called 'Communication on a cultural plane', doctors are suggested to be aware of the general concepts of cultural and social organization of the community of the patients concerned to help acquiring flexibility in dealings with patients. In the third level, known as 'Communication on an intellectual plane', doctors are recommended to talk in the intellectual level of the patients to avoid possible misunderstanding and gap between the illiterate masses and themselves who are sophisticated and come from well-to-do family [8] .

There is a lack of communication on the emotional, cultural and intellectual planes. This created a distance between the doctor and the patient. The result was dissatisfaction and disappointment for the patient, which affected treatment and care management, particularly in cases of chronic illness. In such situations, it is common for the patient to turn to traditional healers where he/she felt more at ease, received more attention, felt more comfortable because of social and cultural homogeneity, and because it is felt that the treatment given is more holistic[9] .

Yet many patients have difficulty understanding what physicians tell them. Even immediately after leaving their physicians' offices, patients are able to recall 50% or less of important information just given to them. Patients with inadequate

literacy skills particularly those with a poor understanding of common medical terms and written health materials probably account for a substantial portion of these patients. Indeed, the concept of poor 'health literacy' has been coined to describe patients with an inability to 'obtain, processes, and understand basic health information and services needed to make appropriate health decisions[10].

In a study, Tamblyn et al concluded that the patient-physician communication score in the Medical Council of Canada clinical skills examination was significantly predictive of patient complaints to medical regulatory bodies. A review of randomized controlled trials and analytic studies of physician-patient communication between 1983 and 1993 found evidence that the quality of communication in history taking and during discussion of the management plan influences patient health outcomes, including emotional health, symptom resolution, function, physiologic measures. It also states that patient dissatisfaction with doctors' communications is reflected in complaints and litigation. A retrospective analysis of complaints in 36 Emergency Departments in Australia between 1996 and 2001 found that nearly a third of complaints (31.6%) related to communication problems. The communication gap is not limited to patients only. Doctors too are not spared by this problem. In a study by Levinson et al, 1997, it was identified that specific communication behaviours, including use of statements of orientation and facilitation is associated with fewer malpractice claims for primary care physicians in the USA. In the UK, a survey of 227 patients and relatives taking legal action in 1992 highlighted the importance of communication [11].

In a study conducted by doctors in Sion Hospital, Mumbai, it was indicated that ill-informed patients and kin and absence of proper communication would be the possible reason for the rise of incidents of patients' family and relatives assaulting doctors in public hospitals (Times of India, 2011). On the rise of doctor-patient conflict in Manipur, the editorial, Imphal Free Press, Imphal commented that lack of skillful public relation efforts in hospitals as one of the important factors for the undesirable development[12].

On the other hand, many studies suggest that effective communication in every sphere of the interaction can help in maintaining healthy doctor-patient relationship. Good doctor-patient communication has become a core requirement thereby helping improvement in the health outcome.

Shukla et al reiterate that emphasis should be given on good doctor-patient communication citing that it improved compliance with medical treatment; improved health, functional emotional status; improved clinical satisfaction; reduces medical malpractice risk; and improved patient satisfaction. They stated that in a review of 21 randomised controlled trials and analytic studies on the effects of physician-patient communication on patient health outcomes, the quality of communication in both history taking and discussion of the management plan was found to be associated with better health outcomes[13].

Considering that doctoring usually involves interpersonal communication, and that patients have feelings, needs, and agendas pertinent to their medical problems, it stands to reason that communication skills play an important role in medical care. Research on physicians has focused on two specific skills: skill in

expressing emotions via nonverbal cues and skills in decoding or recognizing others' nonverbal expressions. These skills can be reliably measured and are enduring qualities of a person. Physicians who could read body movement cues more accurately had more effective interpersonal relationships with their patients. It further points out that ability to express emotions intentionally through nonverbal channels was also related to patient satisfaction. In particular, ability to express happy emotions seemed to be important physicians who were easily able to convey warmth, acceptance, and positive feelings toward patients seemed to be those whose patients returned a high level of regard. In this research, the physicians who were good expressers were also more dramatic, dominant, nonconforming, and playful on a battery of personality scales, and were rated as more likable in videotapes of their actual greetings with patients. Physicians who were good expressers also had more patients overall[14].

Research on doctor-patient communication has generated considerable evidence that effective communication can improve outcome measures such as patient satisfaction, adherence to treatment, and disease outcome[15].

Many studies of doctor-patient relationship communication have been carried in order to investigate which communication behaviours of the doctor (and less frequently of the patient) are significantly related to patient satisfaction. In terms of relationship factors, studies have indicated that doctors' friendliness, courteous behaviour, social conversation, encouraging and empathic behaviours, partnership building, patients' liking of the GP as a person and faith in doctors are all positively related to patient satisfaction[16].

The physician should sit down with patients, look at them when they speak, and listen carefully to what they say, without interrupting. When patients are finished speaking, the doctor should ask whether there is anything else they would like to add. Only when the patient is finished should the physician start asking more focused questions. Physicians should never ignore the last comments patients make as the visit is coming to close. Many times these comments will reveal the true reason for the visit[17].

Sushil Kumar Sharma (2012) gives emphasis on the interpersonal communication as he writes, "Effective interpersonal communication between health care provider and patient is an important element for improving patient satisfaction, treatment compliance, and health outcomes…Both patient and provider are partners in this dynamic exchange, and both contribute to successful communication." [18].

In a study that explored the effects of communication skills training on the process and outcome of care associated with patients emotional distress, improvement in physicians communication skills was shown to be associated with a reduction emotional distress in patients [13]

It was necessary to improve interpersonal communications by understanding the cultural background of the patient, creating trust, using a language easily understood by the patient and maintaining confidentiality in order to ensure positive doctor-patient relationship for healthy outcomes. A holistic care approach needed to be adopted which was patient-centered. Also, the health facility should be patient-friendly where the atmosphere should be welcoming with supportive and

sympathetic staff and where the patient does not have to waste too much time waiting to be attended to[19] .

Teaching the interpersonal interaction which must occur between physician and patients is critical to diagnosis and treatment of the diseases and conditions that initiated the encounter. This interaction requires communication and interpersonal skills which will build a trust between physicians and patients that will encourage them to accept and follow the medical advice (medical adherence) that will restore or maintain wellness[20].

Trust

The soul of medical profession be restored and preserved regardless of technological and social change in society by restoring the element of Trust in the Patient-physician Covenant[21].

Trust is considered a key component of relationships between patients and physicians. Trust exists when patients perceive their physician to be sincere, credible, honest and benevolent. Patients' trust in their physician and commitment to the relationship offer a more complete understanding of the patient-physician relationship. In addition, trust and commitment favorably influence patients' health behaviors. Patients' trust is associated with three composite physical behaviors: developing knowledge of the patient, demonstrating medical competence, and supporting patients' autonomy. Knowledge of the patient refers to patients' perceptions that their physician knows their medical history and knows them as a person. Competence is defined as the degree to which patients perceive that

physicians have the skills and knowledge required to provide for their health care needs[22].

As with Luhmann, trust is required in the modern world because we know so little about the systems with which we have to deal. Giddens defines trust as 'the vesting of confidence in persons or in abstract systems, made on the basis of a 'leap of faith' which brackets ignorance or lack of information[23].

Fostering trust is another therapeutic benefit that results from an effective medical encounter. By exhibiting patience, consistency, and unconditional positive regard, the physician can win and maintain patients' trust, even in the event of mistaken diagnoses or therapeutic mishaps. Trust in the physician allows the patient with an acute illness to agree to undergo otherwise unthinkable procedures. By fostering and maintaining the patient's trust, the physician can improve the quality of the patient's illness experience and also lessen the patient's suffering- therapeutic effects that are often difficult to achieve with medications alone[5].

Physician's involvement to patient management is fundamental in developing patient trust; which is necessary for the patient to accept that the physician is knowledgeable and reliable and can be trusted to recommend the proper therapy[24].

The vulnerability of patients and their need for care force them to trust physicians. Patients generally view trust as an interactive process, requiring care, concern and compassion, with listening as a central focus. Trust can manifest at the interpersonal level, between an individual patient and a physician, built through

repeated interactions and met expectations. This is intimately intertwined with trust at the societal level towards the medical profession; influence broadly by the media and by general social confidence in particular institutions. The level of trust in their physicians has been shown to correlate closely and independently with satisfaction with physician and adherence to treatment[21].

Patients' trust to the physician and commitment to the relationship offer a more complete understanding of the relationship. The patient-physicians relationship is built not only from physicians' medical competence, but also from their interpersonal behavioural competence. If a "good doctor" is one who positively influences health-related behaviours, then our findings support the conclusion that good doctors are both interpersonally proficient and technically proficient, not just the latter. They know the patients and work with them in a spirit of partnership (conceptualized as autonomy in this study). Both knowledge of patients and support of their autonomy are consistent with conveying respect[25].

The development of trust to physician leads to proper patient-doctor relationship and is part of the healing process. When management dictated "the rules of engagement," patient resentment increased as the patients no longer felt that they could rely on their physicians for total care. Patients began to feel that their primary care physicians were restricting their access to specialty care and in effect were rationing their care on behalf of profit- orientated managed care[26].

The Trust that is essential to the physician-patient relationship has generally been interpreted to mean that physicians should not desert patients whose care they have undertaken. The WMA's International Code of Medical Ethics implies that the

only reason for ending a physician-patient relationship is if the patient requires another physician with different skills. “A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination on treatment is beyond the physician’s capacity, he/she should consult with or refer to another physician who has the necessary ability”. Since the time of Hippocrates, confidentiality has been considered important. The Oath states “What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about”. However, other codes reject this absolutist approach to confidentiality. The WMA’s International Code of Medical Ethics states, “It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.”[27].

Patients now have more information than ever about the results of care given by individual clinical teams and clinicians. With such knowledge comes power. If knowledge is power, all these developments will transform the relationship between patients and doctors in future. Rather than regarding these developments as a threat, doctors should see their opportunities to rethink the conditions for continuing patient trust. Even today patients want to be able to trust their doctor without having to think about it. For that to happen, the basis for such trust must be absolutely sound. Naturally, patients expect continuous improvement as medical science advances, but for them generic improvement is not the same as, or a substitute for, a guarantee of their doctor’s overall professionalism at the time of a consultation. That’s where the

obligation comes in. Practitioners who had undergone the necessary training in medicine and secured registration/licensure granted by the state were presumed to be professionals by both the medical community and the public. From that point on in doctors' careers, the particulars of their future practicing styles, their competence, their attitude to patients and colleagues, their ethical principles and ethos of service were deemed to be largely a matter for the individuals themselves to decide because - well, they were professionals. This was personal professional autonomy in action. It is the conscientious commitment of individual doctors to the daily observance of optimal standards that will ultimately decide the degree of trust patients and the public invest in doctors in future[28].

Trust and respect are essential elements of an effective physician-patient relationship. Physicians may find in the course of providing services to a patient that these elements break down to the extent that the physician is no longer able to provide quality care to the patient. This may occur when there has been: patient fraud, such as for the purpose of obtaining narcrotics or other drugs; serious threat of harm to the physician, staff and/or other patients; other forms of inappropriate behavior towards the physician, staff and/or other patients; a conflict of interest that compromises the physician's duty to put the interests of his/her patients first; a communication breakdown that makes it impossible to provide quality care[29].

There were various social, cultural, economical, psychological and legal aspects which made the doctor-patient relationship more complex than ever before. Legal actions by patients against medical malpractices had further complicated this relationship[30].

Satisfaction and Dissatisfaction

Satisfaction of doctors and patients is a key determinant of quality care. Patient satisfaction is an indicator that should be indispensable to the assessment of the quality care in hospitals. But it is said that "The more one has, the more one wants, since satisfactions received only stimulate instead of filling needs" [31].

Physician's satisfaction with professional life is considered as an important determinant of a healthy doctor-patient relationship. It seems that physicians who are themselves more satisfied with their professional life may have more positive effect, which may in turn affect their communication with patients which then affect patients satisfaction[32]. Moreover, physician satisfaction can be increased by improving patient-physician communication[6]. The degree of dissatisfaction is indicated by the number of doctors who claimed that they would not enter the profession again if given the chance. Some respondents even complained that doctors employed by government are "treated shabbily", even "trod upon like dirt". There is a general feeling among doctors that there was insufficient realization on the part of the people in general that 'doctors also are human beings that they too want to enjoy creature comforts'[33]. One of the major contributing factors to growing job dissatisfaction among doctors is work related stress. It has been found that job stress impacts not only on doctor's health but also their abilities to cope with job demands. This will seriously impair the provision of quality care and the efficacy of the health service delivery[34].

The forms, patterns and directions of the relationship with the goals (of doctors, patients and general goals of the system) and the norms have to be

ascertained in relation to the functioning of the system with reference to the doctors, patients and their satisfaction in a given situation, existing in a hospital at a particular time. A study conducted by Mohan Advani in Indian government hospitals reveals that doctors had enough skill to treat patients and they always gave instructions about treatment, but at the same time, they were somewhat detached from the patients. They did not always maintain self-critical attitude, and paid little attention to the patients' social needs. The patients rated doctors high on their behavior, medical attention, interest taken, and treatment provided, but they rated them little low on Communication of diagnosis, for discharging them early from hospital, and for not making their overall stay comfortable. The OPD patients commented some discontentment on account of waiting time. The patients appeared to be dissatisfied because of the use of influence and or 'pull' by some of them and also because of shortage of medicines in hospitals. The doctors felt the need of medicine and equipment for increasing the level of patients' satisfactions[35].

Study by Madan at AIIMS, New Delhi, found out how doctors were satisfied with their work. Personal satisfaction includes the winning of the gratitude of one's patients, and the feeling of being wanted by other human beings, by alleviating pain, preventing suffering, and saving precious human lives. There are also other dimensions of this sense of personal reward, notably social status and prestige and monetary gain. It is more about human behaviour than about the etiology of diseases. One respondent expressed, "the doctor who cures the patient but does not understand him does not cure him at all" [33]

At the same time, Doctors' general information provision during consultations is positively related to patient satisfaction. In terms of relationship factors, studies have indicated that the doctor's friendliness, courteous behaviour, social conversation, encouraging and empathetic behaviour, partnership building, patient's liking of the General Practitioner as a person and faith in doctors are all positively related to patients' satisfaction[36].

In a study conducted in the outpatient division of a teaching hospital, it was shown that physician's satisfaction with their professional life was associated with greater patient trust and confidence in their primary care physicians. It seems that physicians who are themselves more satisfied with their professional life may have more positive effect, which may in turn affect their communication with patients which then affect patients satisfaction At the same time, Doctors' general information provision during consultations is positively related to patient satisfaction[36]. In terms of relationship factors, studies have indicated that the doctor's friendliness, courteous behaviour, social conversation, encouraging and empathetic behaviour, partnership building, patient's liking of the General Practitioner as a person and faith in doctors are all positively related to patients' satisfaction[33].

B.S.Akoijam and others, in their study at RIMS, Imphal, stated that majority of the patients being treated were satisfied with the treatment. They cited that most patients, 74% were satisfied with the overall Care received. 70.9% said that the Physicians always explained them about their diagnosis and treatment plans. 73.2% could always get an answer to their important questions. Around 65% felt that they

were always involved in making decisions about their care. 83.4% of the patients have trust and confidence in the doctors/nurses treating them. Doctors suggested for carrying out investigation outside the hospital in 67.7%. It was observed that younger as well as educated patients tended to have higher satisfaction scores[37].

Stress

British Medical Association report (2000) suggests that many senior doctors suffer high level of stress as a result of their work and this impairs their health and compromises their ability to provide high quality care to patients. The main sources of work related stress for consultants and General Practitioners are excessive work-loads, Health Serv. Res. organizational changes, poor management and insufficient resources dealing with patient suffering and mistakes, complaints, and litigation. Role overload is the most significant source or factor causing role stress among doctors working in the hospital'. They concluded that Role overload showed 40 percent variance which was found to be significant factor causing stress among the doctors[34].

Another important determinant for good doctor-patient relationship is adherence. Leonard and others stated that adherence is a silent issue. A meta-analysis of 63 studies assessing patient adherence and medical treatment outcomes concluded that on average, 26% more patients had a good outcome through adherence comparing with non adherence[22].

Medical and Health Care

Studying on the origin of medical profession, K. Ganesh views that origins are steep in mysticism when doctors more often than not treated their patients free of charge and with contempt. Patients considered the physician and his mundane order as God's own gospel. The nature of the profession transformed with the settlement of civilizations and the establishment of kingdoms, most Royal houses developed or encouraged their own seers or mendicants who treated the members of the royal family and also allowed their disciplines to perfect their art upon the hapless commoners. The following period to the renaissance in modern Europe in the middle of last millennium, according to him, medicine became more codified both in the process of treatment and preparations of cure where doctor then transformed into an elder society with fiduciary relationship between doctor and patient. He cites that medical profession diluted the direct role of the physician through the multilayer and nuanced administration of Medicare in the post modern era[38]

Likewise, Health care in the United States is delivered by a large number of autonomous organization and individuals. There is no central agency that coordinates, controls, and plans the various elements of the health-care system. As a result, American medicine is often marked by considerable conflict among the many groups involved. One way to understand the American Health-care system is to identity the major secondary and primary providers of health care. Popenoe states that the health-care systems in the US differ from most of other nations by saying that the US and South Africa are the industrialized nations that do not have some form of national health insurance. Sweden and Great Britain, among others, have

system in which the government runs its own national health service. In these countries, health care is financed by taxes and is provided virtually free to all citizens. Almost all physicians work for the government. The health- care systems in communist countries, including Cuba and the People's Republic of China, are also highly centralized and provide essentially "free" and comprehensive medical care. They are often criticized for being impersonal and regimented (Ucko, 1986). Other countries, such as Germany and Japan, have more decentralized national health programs, with compulsory insurance and health services that vary according to one's occupation and place of employment. Such services are typically financed by employees' and employees' contribution rather than by the government itself, which serves mainly as an administrator[39].

Health Care in India is plagued by the malaise of missing doctors at the Government run facilities. Doctors at the Government- run health facilities. Health Ministry claims that there are about 6-6.5 lakh doctors available. But India would need about 4 lakh more by 2020 to maintain the required ration of one doctor per 1,000 people[40].

Medical professionals are drawn to the cities not because of their disdain for villages, as is generally assumed, but, like other entrepreneurs, they are also guided by forces of market they operate in the cities. For understanding medical pluralism, proper statistics about the distribution of various medical recourses and human powers are essential. Moreover, it is not enough to know how many practitioners are available, but also in what capacities and institutions they are available[41] .