ORIGINAL ARTICLE

Clinical Paternalistic Model and Problematic Situation: A Critical Evaluation of Clinical Counseling

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Abstract

Background: Many of health system services are done in clinical counseling. A patient's expectation of clinical consultation and physician office visits is to obtain diagnostic-remedial results, while such an expectation can be fulfilled only through an active relationship between the doctor and the patient. The aim of this study is to evaluate the quality of doctor- patient interaction in an educational clinic in southern Iran.

Methods: This is a conversation analysis based on critical approach. So, 33 clinical consultations were analyzed critically.

Results: Results showed that paternalistic model is the overall pattern in consultations. This leads to limitation of the patients' opportunity to participate in their diagnosis and treatment. Powers' asymmetrical relations lead to conditions in which physicians determine the clinical counseling process. Also, physicians determine the subject of consultation in the counseling period. In this situation, the patients' concerns were ignored. This ignorance leads to the patients' suppression in problematic situations. The main point is that the clinical counseling occurs in one general contract that is unwritten but has been known for the two sides of interaction.

Conclusion: Clinical counseling can be an active consultation when it included the symmetrical distribution of power and the patient has an active participation in the consultation. Therefore, the new patient-centered approaches can be an appropriate model for access to a type of consultation based on symmetrical power distribution between physician and patient.

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Introduction

On part of clinical counseling includes the conversation between physician and patient. An important part of the diagnosis and treatment occurs in this conversation. In any conversation, physician asks about the history of the disease. The patients' responses are guidelines for the diagnosis and treatment by doctor. However, clinical counseling includes other dimensions which are related to the conversation. For example, when the patients' chief complaint is about the abdominal pain, physician usually does physical examination of the abdomen area. Generally, clinical counseling is known with key words such as physician-patient interaction or doctor-patient interaction subject.

Doctor-patient interaction has been a central issue in contemporary medical sociological research, particularly since the second half of the 20th century.

Though this debate dates back to Hippocrates' Oath,[1] it has gained critical dimensions in the present-day's discussions. Two general perspectives may be introduced in relation to the subject. The first was developed in Parsons' sociological theory[2] and his definition of 'sick role'. Parsons (1951) developed this concept to denote how the pattern of variables shapes the relationship between doctor and patient.[3] This relationship was placed within broader systematic contexts which linked social systems to the systems of personality and culture to form a basis for social order. According to Parsons, 'we may distinguish the role of *patient* as the recipient of the services of a scientifically trained *professional* physician'.[2] Once the patient has called in a physician 'the attitude is clearly marked, that he [the patient] has assumed the obligation to cooperate with that physician in what is regarded as a common task.[2]

Despite Parsons' view, another approach has been developed named *critical* approach. A critical approach to and theorizing of the asymmetric interaction between doctor and patient have been among central concerns of some researchers. Foucault (1973) finds it related to the knowledge-power discourse in the history of medicine.[4-7] Herbermas (1978), too, views the power of the medical experts and institutions and its instrumental rationality as the factors formulating a dominance-dependent relationship over a patient's life world.[8-11] Generally, 'in a crucial theoretical move, the critical theorists pointed out that the ideals of objectivity, efficiency, prediction, control, and value-freedom are themselves values'.[12] According to these theoretical foundations, many researchers have taken a critical approach to doctor-patient communication.[1,13-16] For example, Mishler (1984) depicts it as the interaction of two *voices*, one of the *doctor voice* and the other of the *patient's life world*.[16]

The main concern of these studies is the unequal interaction between patients and doctors that is regulated by a dominance-oriented interaction (discourse). Such a relationship provokes doctors to employ various control strategies while interacting with patients.[13-16] On the other hand, in recent years, ethnographers have included discourse analysis as part of their investigation of doctoring, investigating patients' experiences, sensibilities, understandings, and objectives to suggest that patients' subjectivity resides, like an iceberg, mainly below the surface of talk.[17]

The goal of this study is to evaluate doctor-patient interactions, based on critical approach. So, the following research questions are posed:

1. Which model of interaction dominates over the consultations?

2. How is this model reproduced?

3. What is the current order in consultations?

4. What other orders of consultations can be explored?

Patients and Methods

This study was conducted in the second major medical training center of Shiraz city, southern Iran. The researchers consulted a number of doctors of the Medical Center about conducting the study, and introducing the purposes of the study to the doctors in question; 9 physicians accepted to participate in the study. 50 consultation meetings were digitally recorded. Throughout all of the stages from recording the conversation to preparing the paper, the researchers followed the ethical codes of American Sociological Association.[18] Thus, as ethical considerations, the names of the doctors and patients were kept confidential. The conversations were recorded in January 2014.

Purposeful sampling is used in qualitative research and particularity case studies. Because the investigator's sampling strategy ultimately depends on the study's aim,[19] these cases were purposefully selected due to their closerepresentation of the objective of the present study. So, of 50 consolations recorded, 33 were selected for the study. The main criterion for selection of 33 consultations was reaching saturation.

This is an ethnographic research. The method of analysis was Critical Conversation Analysis (CCA). The overriding goal of critical analysis was to evaluate the various dimensions of the formation of a discourse in asymmetrical relations of power. 'Critical approaches, however, go further and treat social practices, not just in terms of social relationships, but also in terms of their implications for things like status, solidarity, the distribution of social goods, and power'.[20] In the present study, we read all consultations under the study. According to interpretive approach, we try to explore what model of interaction is forming. Also, what are the contextual characteristics of this model. So, the analytical model was a combination of the following steps:

1. Marking the utterances exchanged between doctor and patient.

2. Exploring the pattern of consultation: how it starts, continues, and finishes.

3. Extracting the utterances that include power relations.

4. Analyzing the structure of power relations.

Results

The consultations under study have specific pattern. The

main features of these samples are:

1. The doctors are the ones who start the conversation.

2. The doctors are the ones who determine how much a specific topic about the patients' disease should be discussed.

3. In cases in which patients' opinion about their diseases does not correspond to doctors' opinion, doctors' tend to change the subject.

4. Doctors finish the dialogue with a mix of verbal and non-verbal interactions.

5. Doctors explicitly or implicitly suppress the consultations.

6. The frequency of words used by doctors is higher than that of patients.

7. Patients in all of the consultations show absolute obedience toward doctors (although patients may change their stance afterwards).

8. Some of the consultations are finished while patients are not sufficiently persuaded.

9. In all consultations the tone of the dialogue and the nature of words emphasize the imperative position of doctors and the subordinate position of patients.

Questions are close-ended and patients usually answer yes/no.

These characteristics of clinical consultations have the same pattern as the *paternalistic* model of Emanuel and Emanuel.[21] Emanuel and Emanuel argue that:

In this model, the physician- patient interaction ensures that patients receive the interventions that best promote their health and well-being. To this end, physicians use their skills to determine the patient medical condition and his or her stage in the disease process and to identify the medical tests and treatments most likely to restore the patient's health or ameliorate pain. Then the physician presents the patient with selected information that will encourage the patient to consent to the intervention the physician considers best. At the extreme, the physician authoritatively informs the patient when the intervention will be initiated.[21]

Generally, we can say that paternalistic model is an approach in which the interaction between doctor and patient has asymmetrical features. In this model, physicians determine all domains of consultation and any dislocation of clinic politeness controlled with them. So the patient doesn't have any role in this interaction and his/her participation declines to a minimal range because in the paternalistic model, the physician acts as the patient's guardian, articulating and implementing what is best for the patient.[21] For better evaluation, researchers evaluate the nature and content of the consultations.

How is the Paternal Model Reproduced?

Some features of consultations as mentioned show that these interactions are based on the asymmetrical and paternalistic model. From another point of view, this clime is also confirmed. When we look at the frequency of words used with physicians in on hand and patients in another, results show that the number of words used by physicians in all consultations are about 18453 words (nearly 60%) and the number of words used by patients are 7375 (nearly 40%). This confirms that verbal exchange between the two sides of the interaction is asymmetrical. The main question is that 'How is the paternal model reproduced?' Response to this question needs to over and over readings the conversations. In this reading, attention to the context is the best guide.

The first feature of context is about the *nature* of physicians' questions in the conversations. The overall pattern of conversation is that many of them include closed questions which are asked by physician. These questions have some specific characteristics as follows:

1: Physician asks very fast so that sometimes the opportunity of response is taken from patient. For example, in consultation # 1[patient with anal abscess]:

1. D. It was the part that you want to operate it now?

2. P. Yea.

3. D. Don't you have any particular problem?

4. P. Not. only …

5. D. Now, thyroid tablet?

6. P. Not

In this conversation, when patient has attempted to explain after chunk 'not. only …' but physician without attention to this incomplete sentences, asks the next question.

2: Due to closed question, the patients' responses are in the yes/no format. For example, in consultation 9 [patient with acne]:

D. How old are you Mrs……?

P. 36.

D. Recently, it has been little? but, lately it has grown?

P. Yea.

D. Is your monthly menstruation regular?

P. Yea.

D. Superfluous hair? Hair loss?

P. Not.

D. Only your face? or body? Or chest?

P. Not, in my it body is very little.

As it is clear, the nature of question leads to yes or no responses and this is the significant obstacle for active conversation. In active conversation, if the patient confronts with open ended question, s(he) would explain about his/her experience about the illness and its history. But closed questions limit any explanation about illness experience to the yes or no responses. Because questions are closed, so the patient didn't have any opportunity to explain his/her problem.

Many of consultationsfollow same processes such as consultation 7 that is done between physician and patient with hypothyroidism:

Doctor: Hey, how old are you?

Patient: 45.

Doctor: Do you experience monthly periods?

Patient: Yea.

Doctor: Is it regular?

Patient: Yea.

Doctor: Is it little, too much?

Patient: No, it's normal.

Doctor: Isn't it irregular: too later or too early?

Patient: No.

Doctor: Does your belly work well? Do you not have constipation?

Patient: No.

Doctor: Do you not feel too tired?

Patient: No.

Doctor: How's your appetite?

Patient: Good.

Doctor: Has your weight changed?

Patient: No, it's fine.

This exchange shows the one-sided relation which is observed in most of the consultations. When the physician uses the closed question, the *interactional reductionism* forms. Interactional reductionism means that one side of the interaction (in this study is physician) is active and another one is passive (in this study is patient). Although the patient is engaged in the problem, the physician determines the process of visit. So, interaction continues with theoretical framework of physician not with the patients' concept, experience and understanding. In this situation, it usually happens that concerns of the patients are ignored. So, interaction is one-dimensional and the patient is disregarded in this situation.

Another context of paternal model is dominance of paraclinical data over the consultations. These date refer to lab blood tests, different types of X-ray, Scan, MRI and results of some pathological samples. These data are an important reference in the doctor's diagnosis and treatment. Besides many functions of these data, one of their main functions is to help the physician in diagnosis and treatment. When the physician relies on data, s(he) will strengthen her/his position because the diagnosis or treatment has two criteria, i.e. physician and paraclinical data. In all consultations, this reliance was observed.

So, the results showed that the discourse governing the consultations was influenced by paraclinical data. The common chunks representing this discourse were "Where are your echo test results?", "My tests are incomplete", "As the ultrasonography test says", "Have you bought your previous test?", "Your previous test results are better than the new one", "You should go for the test and get back in a month", "I'll prescribe a re-test", "Repeat the re-test", "Just do these tests", "For the time being, get examined for these tests", "Bring the results to me later", "An endoscopy re-test might be needed", "Let me check out your blood sugar, too", "I'll add a mammography, too", "You should get scanned in two months", and so on. In such chunks, both doctors and patients were dependent upon test results and other clinical tests, which showed two general functions: first, evaluating the illness progress though data in which the consultations, rather than the history of illnesses, were more concerned with physical examinations, and other issues about test results such as changes in numbers and figures.

The third context is related to the previous contextual factor, i.e. little attention to clinical examination. When the doctor relies on data, clinical examination loses its significance. More than half of the consultations were done without any physical exam. However, in the other half, the physical exam was done in a very shallow manner. Except in three of them, in other cases, physical examination was done in less than a fraction of a minute. Physical examination, not only is effective on diagnosis and treatment, but also leads to circumstances in which the patient feels closer to the physician. This leads to the more humanistic doctor-patient interaction. But, in the case of dominant role of paraclinic data, interactional conditions take instrumental and less-human features which contributes to formation of the patriarchal model.

For example, in consultation 14 the patient's chief complaint is abdominal pain. The physician doesn't do any physical examination during the consultation and based on the conversation he prescribes the drug and recommends a return for future consultation.

However, the physical examination is the basis of medicine. If the assumption is made that the physician achieves accurate diagnosis and doesn't need examination, based on critical approach he/she can say that for better interaction, it would be better to do the physical examination.

Forth, the context is related to the overall structure of clinical counseling. This structure includes the unwritten but known framework for the physician and patient. In this framework, the rule is that physician has an inquiring position and the patient is in responsive situation. So, as a subliminal form, the paternal model reproduced and process of consultation is determined by the physician only. If the physician wishes to change the direction of consultation, s(he) can realize it.

From a different view, this is due to modern medicine. In modern medicine, the physician takes the new situation that promotes his/her position because s(he) is in the knowing position and patient is in the ignorant position in Parsons' model.[2] Physician in the paternal position is the only decision-maker of the main subjects, such as illness and sometime death and the patient uses complete cooperative chunks such as "Whatever you say, Doctor!". This chunk shows inferior position of the patient(s). When we look at the worlds and concepts which are used with patients or their accompanions and compare them with those used with physicians, it shows what the conceptual structure of the clinic means.

Order of Clinical Counseling

Another subject in the study is the output of paternalistic model in clinical counseling. One main focus of this study is the order of the dominant paternalistic model and the conditions prevailing in the consultations due to the patriarchal model.

The first order that was explored in these consultations is asymmetrical interaction. This means that interaction has included power relations discourse. When the physician determines all dimensions of the consultation, s(he) has more power than the patient. In this asymmetrical power relation, the patient is follower of the physician discourse path.

This order leads to a condition called *interactional marginalization*. Marginalization as defined in online Merriam-webester means 'to put or keep (someone) in a powerless or unimportant position within a society or group'.[22] This concept refers to some patients that were marginalized in health care system, such as PTST patients.[23] However, sometimes in the interaction between two agents, one of them ignores the concerns and worries of another. In doctor-patient interaction, when the physician disregards some patient concerns, the interactional marginalization occurs. Patient marginalized must follow the physician orders without any discussion. This characteristic of clinical counseling order is the cause of disregarding the patients' concerns and formation of problematic situation.

Despite the patients' concerns, marginalization by the physician and also clinical rule lead to ignoring the patients' expectations. According to this rule, the patient must follow the physicians' prescription and orders.

On the other hand, when we look at all the consultations, we can understand that functionalism is the main framework of all them. In this approach, interactional dimensions of clinic is reduced to just consultation so that there is no interaction between the physician and patient. It means that the physician has diagnostic and treatment role and the patient has a 'sick role' as Parsons mentioned.[2] According to Parsons, 'we may distinguish the role of *patient* as the recipient of the services of a scientifically trained *professional* physician'.[2] Once the patient has called in a physician, 'the attitude is clearly marked that he [the patient] has assumed the obligation to cooperate with that physician in what is regarded as a common task.[2] In the consultations under the study, we confronted with the same frame. Clinic is defined as a place for cure that includes linear path of interaction; physician asks and patient responses. Cure occurs in continues process of this inquiry.

Sick role in the clinic means that patient must respond to the physician's questions. If the patient confronts with any ambiguity in diagnosis or treatment, s(he) can ask but this problem solving has specific measures. Specific measures were found in verbal and non-verbal interactions.

From another point of view, this is instrumental and one-dimensional configuration of the clinic. So, the physician doesn't have any obligation to pay attention to other issues of the patient. For example, a treatment protocol may be associated with heavy costs for the patient; however, its effectiveness is limited or ambiguous. So, the physician must pay attention to other dimensions of patients' conditions.

On the other hand, medicine has four dimensions including bio/psycho/socio/spiritual. In these consultations, physicians only focus on biological and somewhat psychological aspects of the patients. Social and spiritual dimensions of the patients are ignored. This is due to one-dimensional and instrumental framework of the clinic where a patient doesn't need drug or surgical operation (s(he) isn't sick), or drug or surgery are the only modes of treatment. In this approach, many capabilities of the human body and human beings are ignored.

Paternal Model and Problematic Situations

As mentioned, in paternalistic model, the physician determines all dimensions of consultation. This reality

means that the patient must be able to attend and cooperate with the physician in the entire consultation process. So, this model leads to two main interactional problems such as disregarding the patient's concerns as mentioned above which leads to formation of a *problematic situation* when the patient is faced with uncertainty in the diagnosis or treatment.

Paternalistic model is generally the main cause of uncertainty and complexity in consultation. Asymmetrical interaction with closed questions, physician's reliance on paraclinical data, and historical discursive structure of the clinic lead to inactivity of the patient in interaction. So, it is shown that the patient is faced with complexity and uncertainty about diagnosis and treatment. In this situation, patient has usually several questions to ask. The physician tries to respond them, and when s(he) fails to understand the patients, the problematic situation forms. So, problematic situation is a complex condition that patient and his/her companion has further questions about diagnosis or treatment, and the physician doesn't understand them. If the patients' concerns are important for the patient or his/her companions, they try to achieve a conceivable response. On the other hand, if the physician can't understand them, the problematic situation occurs. The main question is, "what does the physician in problematic situation do?" or how does s(he) pass this complex situation?

When medicine discourse is dominant, physician isn't concerned about confronting with problematic situation. S(he) has control over the consultation and finishes it any time he/she wants. However, he/she winds up the consultation in a discursive order that has two main disregarding features: *explicit* and *implicit* suppression.

Explicit suppression happens when the patient insists on his concerns and the doctor is not able to convince him/her. This patient, according to Cordella, is named *challenger*.[1] When the physician confronts with a patient that emphasizes on his(her) concerns, and the physician fails to conceive him/her, based on the paternalistic discourse, he/she finishes the consultation with his/her authority. This approach is usually associated with explicit suppression. Consultation 33 is an instance of explicit suppression. In this consultation, a woman referred to the doctor because of numbness in her shoulder. In the previous session, the doctor had prescribed an operation on her spinal disc. The patient had not acted according to the recommendation and referred to the doctor again. This conversation included explicit suppression from the beginning because the patient was accused of disobeying the doctor's recommendation. In this case, the doctor suppressed the patient by accusing her. The conversation finished as follows:

D: Well, didn't the doctor prescribe physiotherapy?

P: The doctor didn't do anything for me.

D: He didn't do anything for you!

P: No! I'm not going to an orthopedist again.

D: Ok. orthopedists would prescribe surgery. Do what I tell you.

In this exchange, "Do what I tell you" suggests an explicit suppression of the patient and his attitude. This sentence includes the meaning that you are a resistant patient; as in previous chunks the physician has suppressed the patient explicitly:

D: A patient like this should undergo operation. If you say you don't want operation or even a blade to touch it, if you say you don't want operation, if you resist it….

P: [OK, I won't then

D: Listen! Resistance means you avoid the operation, and even if you do anything, even kill me, then we will have to start doing something. But if you decide to listen, you should undergo operation.

Consultation 5 is an example of explicit suppression. This is a conversation between physician and the mother of an 11.5 year-old girl who referred to the doctor because of her daughter's short stature. In the previous session, the doctor had prescribed a series of examinations to be conducted on the girl including ultrasonography. The mother was now facing another problem: the activation of her daughter's ovaries. The doctor tried to persuade the mother that through delaying the precocious puberty by injection, the problem could be solved and the patient's stature would as a result improve. But the mother asked frequent questions about the new medical protocol (hormone injection) and her daughter's short stature, and finally she left the office with hesitation.

This consultation is significant due to endless discussion between the patients' mother and physician. Chucks such as "All right?" and "get it?" and such propositions as "I'll recognize it myself", "I'll check out her growth myself", "I'm not talking about her growth at all", and "I'll prescribe" are instances of explicit suppression. The implicit meaning of such language and propositions is the doctor's message to the patient's mother that "these issues do not concern you". The pronoun "I" is full-scale show of the doctor's power which must be accepted by the patient's mother. The point is that the dialogue comes to an end with this exertion of power.

Patients' mother: What should be done for her growth?

Doctor: I'm not talking about her growth at all; this will prevent her monthly periods, I'll check out her growth myself, get it?

Mother: So after the injections she should go for sonography to see if her ovaries have stopped to grow?

Doctor: No, no, sonography is not needed, I'll recognize it myself; don't worry about that stage [mothers' gigle], when necessary I'll prescribe sonography or examination.

The last part of the conversation clearly shows the explicit suppression. So, explicit suppression forms with verbal interaction. This means that the main difference between explicit and implicit suppression is its language.

Despite explicit suppression, in implicit form, the physician interacts with non-verbal behavior. When the patient or his/her relatives do not challenge about his/her situation and concerns, the physician will implicitly disregard the patient's requests. In this strategy, the doctor, without any verbal interaction, disregards the patient or his/her relative's concerns. This suppression is milder than explicit, so that this is not a suppression, but a type of disregard or ignorance. In Consultation 18, the person accompanying the patient (who suffered from genital infection as a result of spinal cord infraction in an accident) asked the doctor to issue a certificate for Forensic Medical Department. The doctor tried, in every way possible, to evade this request. The accompanying person used different strategies to convince the doctor but he did not succeed.

D: Well, see you should do something, yea, what the process is, I don't know! But from [Justice Administration]…. But because it was during tubing, you should talk to the anesthesiologist, do you get it?

AP: Yea, that's about his tooth problem and I've got to talk to them about that, but the problem is that you should give a letter for the issues that are unfortunately happening from now on! Things like these don't usually happen to healthy people…. Because he is motionless and incapacitated, he suffers from that problem. OK, how often should we do the wound dressing? Presently, we do that every 12 hours.

In this conversation, the accompanying person was trying to convince the doctor to issue a certificate to be submitted to legal authorities. The phrase "healthy people" was an attempt to persuade the doctor to write the certificate. Seeing the doctor's reluctance to issue the certificate from his nonverbal interaction, the accompanying person decided to change the topic. The sign in the dialogue represents this *dislocation*. The accompanying person whose voice was ignored changed the topic to make the interaction flow. This change of topic, however, shows the non-cooperation in the conversation.

So, we can say that in problematic situation conversation is finished with the patients' suppression. This is due to the doctors' domination and asymmetrical power relations in consultation, the situation that is related to the paternalistic model of interaction.

Discussion

Inquiry in doctor-patient communication has been a prominent discourse in the last decades. Much of such research focuses on the nature of this communication that forms different paradigms. In this paradigm, we can confront with a range of research from non-critical to critical approaches. The main theme of critical approach is that doctor-patient communication has included the power relations. So, many practical studies have been done based on qualitative and ethnographic method.

This is an ethnographic research using critical approach, which evaluated the power relations between physician and patient in one clinic of educational hospital in Southern Iran. The model extracted from research is shown in figure 1. According to fig 1 doctor-patient interaction in these clinical consultations is performed according to patriarchal model. In this model, the path of physician-patient conversation is defined by the physician. So, patients have a passive role in the conversation and his role is limited to expression of the history of his/her disease. Physicians' dominance is so much that this presentation is done with yes/no response. Changing the conversation subjects, finishing the consultation, and disregarding the patients' concerns are the main features of consultations under the study. Also results showed that in these consultations, four interactional constructions made the context of counseling: 1. Physicians' closed questions; 2. Physician relying on paraclinical data; 3. lack of attention to physical examination; and 4. historical structure of modern medicine. In this context, the paternalistic model forms. In this model, 'the conception of patient autonomy is patient assent, either at the time or later, to the physicians determinations of what is best'.[21]

Also, these interactional constructions lead to a distance between physician and patient. So, it may form the problematic situation so that the physician and patient don't understand each others. Due to the patriarchal model, when this problematic situation occurs, and physician fails to conceive the patient, he/she uses implicit and explicit suppression.

Results of this research are in the same line with those of the studies conducted in the last decades. For example, in Mishler's classical model (1984), the consultation model was: first, a request from the doctor; second, a response from the patient; third, a post-response assessment, not always explicit, followed by a new request; and fourth, if optionally, a request for clarification or elaboration of the patient's

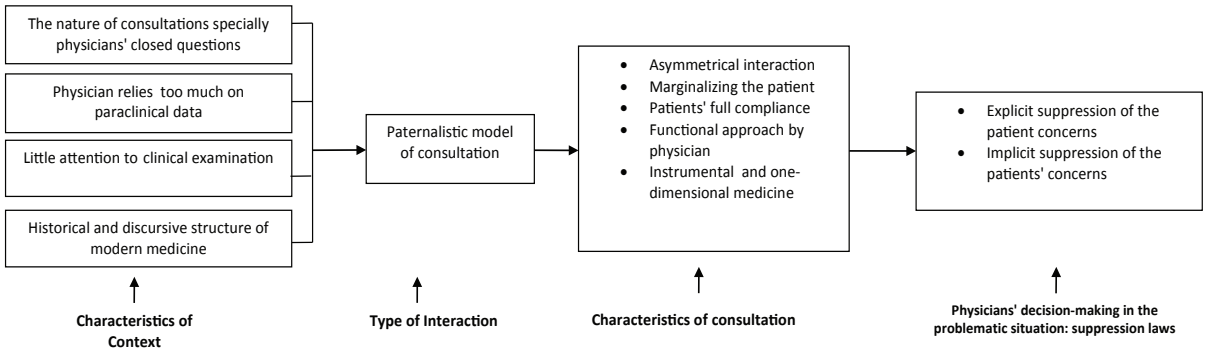

Figure 1: Paternalistic model of doctor- patient interaction and problematic situation in the clinic

response.[16] Also, our results confirm the findings of Faircloughs's study (1992) on how the doctor controls the conversation process. According to Fairclugh 'interactional control features ensure smooth interactional organization - the distribution of turns, selection and change of topics opening and closing of interactions, and so forth, interactional control is always exercised to some extent collaboratively by participants, but there may be asymmetry between participants in the degree of control'. In our study, paternalistic model as a powerful instrument was used with physicians for control of consultations.[13]

The study conducted by Barry et al. (2001) has shown that there is a four-type doctor-patient interaction, which is related to the nature of the voice used between the doctor and patient.[12] Also, Atkinsons's study (1995) has shown that the doctor has different voices.[24] Although these studies show significant results, we can say that when paternalistic model determines the doctor-patient interaction, it makes no difference that one which of voices was active. Due to paternalistic model, patients' position is suppressed, especially in problematic situations.

Results of Cordellass' study (2004) show that 'doctors are imbued with the power and authority that comes with their expertise and institutional position, but they are restricted to their roles as animators, authors and principals of medical information by protocols that do not allow for the expression of personal views per se.[1] Our study confirms her results about physicians' authority and their dominance above consultations. However, because we don't study physicians' subjectivity about interaction, the second part of her study is unknown.

The main question of this study is *'So What*?' We can answer this question from different approaches. But, if we rely on critical view, we can ask which model can be identified to improve the situation; or 'What situation is better?' Answer to these two questions is easier when we see the extensive changes that have occurred in doctor-patient interaction in recent decades.

These changes have formed paradigmatic shift in this subject so that a new window in doctor-patient interaction has opened. The new window is about what patient and his/her concerns returns to the center of medical discourse; or how the patient's marginalization can be declined.

For more than two decades, new discussions have developed in doctor-patient interaction. The main theme of these debates is that how can the patients' concerns be attended in doctor patient relationship. Except for models that were defined by Emanuel and Emanuel,[21] the other models of doctor-patient relationship include informative, interpretive, and deliberative. Unlike paternalistic model, in these models the patient has more authority and s(he) has a significant contribution to diagnosis and specially treatment. For example, despite paternalistic model, in *interpretive* model 'the aim of physician- patient interaction is to elucidate the patients' value and what he or she actually wants, and to help the patient select the available medical interventions that realize these value'.[21]

On the other hand, new debates in doctor-patient interaction have focused on the main concept called *patient-centeredness*. *Patient-centered* medicine, although not a new phenomenon, has recently attracted renewed attention. It has basically a humanistic, biopsychosocial perspective, combining ethical values on 'the ideal physician' with psychotherapeutic theories on facilitating the patients' disclosure of real worries, and negotiation theories on decision making.[25] In a patient-centered care approach, the patient is or *should be* the focus of attention.[26] The systemic patient-centered method would encourage the patients to explore feelings, meanings, and context of illness.[27] In this attention, the role of patient in his/her self care is significant.

So, doctor-patient interaction must consider the patients' concerns, understanding, and his/her other social conditions. As Watson and Frampton have mentioned, interaction is the axis of patient-centeredness in this path. Clinical care and health care practices are grounded in human communication,

human interactions, and relationships.[28] Also, Pendelton et al. also mentioned physical issues, psychological issues (ideas and belief, feelings and concerns, self regulation, narrative, expectations), and social issues. These lead to better understanding of the patient.[29] So, doctor-patient relationship needs to use new approaches such as informative and deliberative models.[30]

In the end, it can be concluded that doctor-patient relationship has another important dimension that is related to the human aspects of the interaction. From this approach, doctor and patient are defined as two human agents whose relationship must be considered as a humanistic relation. Accordingly, when a doctor, as a powerful agent, communicates with a patient, as a powerless agent, he/she should consider all the human dimensions of the patient. The patient isn't an agent with physical problems, but he/she is an agent with psycho/socio/spiritual dimensions that should be considered. So, clinical counseling and doctor-patient relationship is a multidimensional practice. As Sadati et al. (2014) mentioned, although we can't condone the paraclinical standards, clinical counseling and doctor-patient relationship need to reduce its dominance over counseling based on interpretation of human relations, paying attention to social and economical differences of people and biosocial and bio-cultural differences, and focusing on clinical examinations.[30]

So, it be said that if we expect the active clinical counseling, doctor- patient interaction must be a bilateral relationship. Due to modern structure of medicine that reproduces the physicians' power, in this direction, physicians must be proactive. Because of the inflexible structure of paternalism, there is a need to change the doctors' attitudes. These changes are related to four main subjects: 1. Patients have the right to participate in the clinical counseling; 2. Patients' participation has an important role in promoting the clinical counseling; 3. This leads to be fewer problematic situations during consultations; and 4. Because the new broadest changes in medicine, if physicians want to preserve their authority, they need to accept the new paradigm.

So, clinical counseling needs to the rotation of power distribution between physician and patient. In this direction, several issues are important to be considered. For example, in macro level, medicine needs to be developed both quantitatively and qualitatively. Expansion of medical institutions and specialist clinic and development of various medical disciplines create a competitive market in health services, and attention to health insurance is the main infrastructures of health system that need to be considered. On the other hand, Iranian medicine should focus on the content of progress and development. Extended discussions about new approaches about clinic, doctor-patient relationship, doctor and patient rights, theoretical framework in this subject, and adoption of an interdisciplinary approach are the main strategies in this path.

It should be noted that a clinic is a context and clinical changes are a time consuming process. During this time, collaboration between clinical agents (physician and patient) on one hand, and between policy-makers and clinical agents on the other hand contribute to realization of the desired changes.

Conclusion

Doctor- patient relationship is a complex interaction between two human agents. This interaction includes power relations as it is true about any other human relation. This study shows that clinical counseling includes power relations due to some causes, such as the nature of consultations specially physicians' closed questions; physicians' too much reliance on paraclinical data; little attention to physical examination; and historical and discursive structure of modern medicine. Due to this context, the paternalistic model was expressed. This model of relationship is too much asymmetrical so that the doctor determines all aspects of consultations. So, the patients' concerns are ignored and sometimes suppressed. Because of the broad social changes in the new era, this model has lost its effectiveness, and doctor patient relationship must shift toward the patient-centeredness approaches.

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References

1 Cordella M. The Dynamic Consultation A discourse analytical study of doctor–patient relation. Amsterdam: John Benjamins Publishing Company; 2004.

2 Parsons T. The Social System. England: Routledge; 1991.

3 Turner, BH. Introduction. In The Social System. England: Routledge; 1991.

4 Armstrong, D. Bodies of Knowledge/Knowledge of Bodies. In Jones, C. and Porter, R. (eds) Reassessing Foucault. Power, medicine and the body, London: Routledge;1994:17-27.

5 Driver, F. Bodies in Space: Foucault's Account of Disciplinary Power. Bodies. In Jones, C. and Porter, R. (eds) Reassessing Foucault. Power, medicine and the body. London: Routledge; 1994: 113- 131.

6 Foucault M. The Birth of the Clinic. An Archeology of Medical Perception. Sheridan AM (translate). UK: Tavistock Publications Limited; 1973.

7 McGowen, R. Power and Humanity, or Foucault Among the Historians. In Jones, C. and Porter, R. Reassessing Foucault. Power, medicine and the body. London: Routledg; 1994: 91-112.

8 Habermas, J. Theory of Communicative Action, Vol. 2. Lifeworld and System. Cambridge: Polity Press; 1978.

9 Scambler, G. Habermas and the Power of Medical Experties. In Scambler, G. (eds) Medical Sociology. Major Themes in Health and Social Welfare. USA: Routledge; 2005: 138-162.

10 Scambler, G. and Britten, N. System, lifeworld and doctor–patient interaction Issues of trust in a changing world. In Scambler, G. (eds) Habermas, critical theory and Health. London: Routledge; 2001: 45-67.

11 Powers, P. The Philosophical Foundations of Foucaultian Discourse Analysis. Critical Approaches to Discourse Analysis across Disciplines 2007; 1(2): 18-34.

12 Barry ChA, Stevenson FA, Britten N, Bradley CP. Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor–patient relation in general practice. Soc Sci Med 2001; 53: 487–505.

13 Fairclough N. Discourse and Social Changes. USA: Polity Press; 1992.

14 Králová P. Power Relations in doctor- patient relation. Kamenice: Masaryk University; 2012 [cited: 2013 Aug 21]. available from: http://is.muni.cz/th/361459/ff_b/Thesis.pdf.

15 Islam G, Zyphur M. Ways of interacting: The standardization of relation in medical training. Hum Relat 2007; 6(5): 769-92.

16 Mishler, GE. The Discourse of Medicine: dialectics of medical interviews. Norwood, New Jersey: Ablex Publishing Company; 1984.

17 Heritage and myard

18 American Sociological Association. Code of Ethics and Policies and Procedures of the ASA Committee on Professional Ethics. 1997 [updated 2008 May 10; cited: 2014 Jan 1]. Available from: http://www.asanet.org/images/asa/docs/pdf/Ethics%20Code.pdf

19 Wells K. Narrative Inquiry. USA: Oxford University Press; 2011.

20 Gee, JP. An Introduction to Discourse Analysis, Theory and Method. Third Edition. New York: Routledge; 2010.

21 Emanuel JE, Emanuel LL. Four Model of the Physician-patient relationship. Am J Med Sci 1992; 267(16): 5-13.

22 Merriam- webster online dictionary. Marginalize. [cited: 2014 22 May] Available from: http://www.merriam-webster.com/dictionary/marginalize

23 McKinney, J. PTSD Patients Marginalized by the Current Healthcare System. 2012. Available from: http://www.thomhartmann.com/users/johnmckinney/blog/2012/11/ptsd-patients-marginalized-current-healthcare-system-11122012.

24 Atkinson, P. Medical Talk and Medical Work. London: Sage pub; 1995.

25 Bensing, J. Bridging the gap. The separate worlds of Evidence-based medicine and patient-centered medicine. Patient Educ Couns 2000; 39: 17-25.

26 Forman, H. Nursing Leadership For Patient-Centered Care. Authenticity Presence Intuition Expertise. New York: Springer Publishing Company; 2011.

27 Mengel, MB. The Systemic Patient-Centered Method. Introduction to Clinical Skills : A Patient-centered Textbook. Mengel, MB, Scott, AF (eds). Plenum Press; 1997.

28 Watson, J., Frampton, SB. Human Interactions and Relationship – centered Caring. Putting Patients First. Best Practices in Patient-Centered Care. Second Edition. Editors Frampton, SB. and Charmel PA; 2009.

29 Pendleton D, Schofield Th, Tate P, Havelock P. The New Consultation Developing doctor–patient communication. New York: Oxford University press; 2003.

30 Sadati AK, Iman MT, Lankarani KB. Medical Paraclinical Standards, Political Economy of Clinic, and Patients' Clinical Dependency; A Critical Conversation Analysis of Clinical Counseling in South of Iran. IJCBNM 2014; 2(3): 157-68.