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Open Access Law Journal, ISSN (O): 3049-0057

Editor-in-Chief – Prof. (Dr.) Amit Kashyap; Publisher – Reet Parihar

A Comparative Analysis Of The Doctor-Patient Relationship In India, The United States Of America, And The United Kingdom

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Published on: 9th December 2025

Abstract

This paper provides a detailed analysis of the doctor-patient relationship in India, the United States, and the United Kingdom. Through an in-depth analysis of different aspects of this relationship, such as communication patterns, cultural impacts, and healthcare infrastructure, the research seeks to identify commonalities, disparities, and key elements influencing the interaction between doctors and patients in varied settings. The relationship between a doctor and a patient is an essential component in the provision of healthcare services, as it has a significant impact on patient satisfaction, treatment adherence, and health outcomes. There is still a lack of understanding of how cultural, socioeconomic, and institutional factors influence this relationship across different countries, even though a significant amount of study has been undertaken on this subject. The purpose of this research is to fill this void by undertaking a comparative analysis to shed light on the subtleties of the doctor-patient interaction in India, the United States of America, and the United Kingdom. As a means of contributing to the development of patient-centered care practices all over the world, the purpose of this study is to shed light on the differences and similarities between the two. This paper will undertake a comparative analysis of the doctor-patient interaction in India, the United States of America, and the United Kingdom. The objective of this article is to compare and contrast these three distinct countries. It is of

the utmost importance to have a comprehensive grasp of the various differences that exist within the doctor-patient interaction, particularly in light of the growing globalization of healthcare and the numerous cultural, socioeconomic, and institutional contexts in which medical support is provided. Through an analysis of communication dynamics, cultural influences, and healthcare legislation, the purpose of this study is to shed light on the similarities, variations, and underlying variables that significantly impact the interaction between physicians and patients in these nations. In the end, the objective is to produce insights that may be used to influence strategies for improving healthcare outcomes, increasing patient-centered care practices, and developing effective doctor- patient interactions on a worldwide scale. Information for this comparative analysis will be collected from various secondary sources such as academic literature, healthcare reports, and policy documents. Through the use of qualitative and quantitative methods, the research will examine important elements of the doctor- patient relationship, including communication styles, trust building, and collaborative decision- making. Preliminary findings reveal significant variations in the doctor-patient relationship across the three countries, influenced by cultural, socio-economic, and institutional factors. While all three countries emphasize patient autonomy and informed consent, the manner in which these principles are enacted differs notably. The study also identifies gaps in research, particularly regarding marginalized populations and underserved communities, highlighting the need for further investigation in these areas. This study enhances the current literature by offering a thorough comparative analysis of the doctor-patient relationship in various healthcare settings. Through examining the distinct contextual elements influencing this connection, the research provides valuable perspectives for healthcare professionals, policymakers, and researchers aiming to improve patient-centered care on a global scale.

Keywords: doctor-patient relationship, legal framework, India, USA, UK

1.0 Introduction

In ethical principles of medicine, the "doctor–patient relationship (DPR)" is considered one of the core elements. It is regarded as the keystone of care. It is the medium in which physicians aim to gather data, diagnose, develop plans, accomplish compliance and healing, patient activation, along with providing them with the required support. Concerning highly vulnerable patients, DPR is of **relevance** for them as they tend to experience an increased reliance on the competence, reputation, and skills of the physician. In alignment with the discussed significance of DPR in medical practice, this manuscript will focus on conducting a comparative analysis of DPR in the context of developed and developing nations, wherein the emphasis will be given to the U.S., the UK, and India. The focus of the manuscript would be on analyzing the cultural and historical contexts that impact DPR in the considered nations, the elements and models related to DPR, analysis of the legal and regulatory frameworks governing DPR in the Indian context, and legal and regulatory frameworks that govern the DPR in the U.S. and the U.K.

2.0 Methods:

On the basis of specific inclusion and exclusion criteria, research papers based on which the manuscript would be developed, have been determined by the researcher. In context to the inclusion criteria, the studies that have specifically focused on DPR and associated legal frameworks governing the relationship in context to India, the U.S., and the U.K. have been specifically considered for this manuscript. Studies that have been published in English language only, have been included in this study. The year of publication of the considered studies has also been considered by the researcher, with the emphasis on studies published between 2014 - 2024 specifically, have been used in this study. The studies that addressed other aspects of ethical practice or emphasized on nurse-patient relations have been excluded from this study. The studies which have been published in languages other than English or published before 2014 have not been included in this study.

Using the keywords, the researcher has screened the studies that have been noted to be relevant to the idea of this study. Extraction of major data related to the topic has been further extracted followed by the evaluation of the title and abstract of the chosen studies. Based on the analysis,when the studies

were noted to be in alignment with the idea of the current study, the researcher has finally analyzed the full texts of the selected research papers in an in-depth manner.

The researcher has further extracted data individually from every study that has been selected for the study. Aspects, for instance, legal frameworks that govern DPR, and cultural and historical contexts that impact DPR have been analyzed by the researcher from the collected studies.

3.0 Objectives:

1.) To examine the historical and cultural contexts that influence the doctor-patient relationship in India, the United States, and the United Kingdom, emphasizing both differences and similarities.

2.) To analyze the elements and models of a doctor-patient relationship.

3.) To analyze the legal and regulatory frameworks governing the doctor-patient relationship in India.

4.) To investigate the legal and regulatory frameworks that govern the relationship between a doctor and a patient in the United States of America and the United Kingdom.

4.0 Literature Review:

4.1 Historical and Cultural Contexts of a Doctor-Patient Relationship

According to Albini, the presence of a doctor figure in human communities can be noted to be present from time immemorial[1]. Before the secularization of medicine in the 5th Century BCE, there were no specific boundaries between religion, magic, and medicine and DPR would be an extension of the "priest–supplicant, with an expected compliance from the patient" and minimal personal responsibility among doctors, who was considered to act out the "will of a god". In the study conducted by Harbishettar et al., referring to Egyptian practices, the researchers opined that between approximately 4000 BC and 1000 BC, the DPR was associated with mysticism and magical method of healing, with

[1] Albini A, 'Evolution of the doctor–patient relationship: from ancient times to the personalised medicine era' (Cancerworld, 2021) https://cancerworld.net/evolution-of-the-doctor-patient-relationship-from-ancient-times-to-the-personalised-medicine-era/ accessed 3 December 2025.

the healer or the priest having the parent figure[2]. However, it was during the 5th Century BC, the Greek method of treating developed that was based on the trial-and- error method, during when, the historic Hippocratic Oath was also developed. They rejected the effects of magic. Since the 18th century, the concept of illness began, with the supremacy of doctors established during this phase. The relationship was more "paternalistic Active-Passive" type. With the advent of time, the doctor's role associated with the decision-making process in the best of interest of the care users further evolved.[3]

However, in varying cultures, with different cultural and subjective experiences there are associated dialects to explain the subjective experiences of the illnesses of the patients, and the "therapeutic relationship" was developed on health concerns. Referring to the study conducted by Neki, the researchers opined that in the Indian context, the traditional "Guru-Chela model" can be therapeutic. The "Chela" or the follower being a disciple of the "Guru" the teacher, developed a dependent relationship based on the faith that the "Guru" has the responsibility of the best interest of the follower. In the study conducted by Tripathi et al. the researchers stated that in ancient India, the doctors were given the position of optimum respect in the society because of their activity and attitude towards the patient. They were considered to be next to God and associated with their healing power, not by previous degrees or formal courses. During the mentioned period, medical practice was viewed from the perspective of social and humanitarian. During the early and middle part of the 20th century, with the advancement of modern medicine, the majority of the practitioners were family physicians or general physicians. The patients rarely had any belief that doctors can cause harm to them and in case of undesired situations, they would consider it as God's will. The society majority had strong trust in the doctors. In the study conducted by Hellenberg et al., the significance of family physicians in the healthcare system of the nation has been highlighted[4].

In context to the cultural aspect of DPR in the U.S., according to the study conducted by Keslar, majority of "White men" who were doctors for the majority of 1st half of 20th century were instructed to demonstrate an "attitude of benevolent paternalism", which was "endorsed by Sir William Osler",

[2] Bomhof-Roordink H, Gärtner FR, Stiggelbout AM and Pieterse AH, 'Key components of shared decision making models: a systematic review' (2019) 9(12) *BMJ Open* e031763.

[3]Fernández-Ballesteros R and others, 'Paternalism vs autonomy: Are they alternative types of formal care?' (2019) 10 Frontiers in Psychology 1460.

[4] Hellenberg D, Williams FR, Kubendra M and Kaimal RS, 'Strengths and limitations of a family physician' (2018) 7(2) Journal of Family Medicine and Primary Care 284.

who is usually referred as the father of modern medicine[5]. As per "American Medical Association", under this attitude of DPR, the patients were expected to display "obedience" as the response towards the doctors. The nation developed a new order of "health care delivery" with doctors as the expert decision maker and patients being passive. However, during the 1950s, the DPR in the nation was adversely impacted by criticisms that improved drug efficacy and developments in medical technology allowed doctors "to divert attention from their patients to images, and to focus on the disease at the expense of the patient as a person". Referring to Edward Shorter the researcher stated that "Physicians had an omniscient authority, able to exert **"**a kind of medical tyranny" tolerated and even expected by the typical patient". Contrary to the conventional practice in the Indian culture, according to the study conducted by Sharma, in the U.K., the physicians treat the individual patient with an emphasis "on consultations behind closed doors", rather than treating the entire village or family[6].

4.2 Elements and Models of a Doctor-Patient Relationship

According to the study conducted by Rai, one of the elements of DPR is "duty of care", which usually exists from the doctor toward the patient once the relationship has been entered[7]. It is the legal, ethical, and professional obligation of the practitioner to safeguard and protect the health and well-being of the care user. Another mentionable element is informed consent, according to which, the doctor is required to respect the choice of the patient even if the rationale behind the choice is not medically acceptable. The third element of DPR is confidentiality, which according to the researcher is not just a legal obligation but a part of the "Hippocratic Oath" as well, under which, the professional is supposed to conceal any information about the life of the patient that he/she has known during the treatment, as sacred secrets. The 4th element is patient autonomy per which, the freedom to decide regarding the course of action, and the patient's interest in their physical, and psychiatric integrity is needed to be protected.

Regarding the theoretical models that govern the DPR, Ballesteros et al. mentioned the paternalism model[8]. According to this mode, the patient plays a passive role and the role of decision maker is being

[5]Keslar L, 'The evolution of the doctor–patient relationship' (2023) 100(10) Medical Economics Journal https://www.medicaleconomics.com/view/the-evolution-of-the-doctor-patient-relationship accessed 3 December 2025.
[6]Sharma G, 'East versus West: the great divide' (2019) 16(1) BJPsych International 22.
[7]Rai L, Doctor–Patient Relationship and Medical System: A Comparative Study with USA.
[8]Fernández-Ballesteros R and others, 'Paternalism vs autonomy: Are they alternative types of formal care?' (2019) 10 Frontiers in Psychology 1460.

taken by the doctor. This model allows the doctor to use their skills to provide the most effective treatment that has the optimum scope of reinstating the health of the patient and the care user is only provided the information that allows the doctor to receive consent. The contrary model to the discussed DPR model is the "shared decision model" in which, both parties are actively associated with the decision-making process[9]. It also emphasizes on information sharing by both the involved parties, both expressing treatment preference and both the parties to agree on the treatment. In this model both the involved parties are considered equals.

4.3 Doctor-Patient Relationship: Legal Framework in India

The DPR in all the nations are impacted by its legal frameworks and regulations governing the healthcare services. In this regard, in the study conducted by Nomani et al., the researchers mentioned about the "Consumer Protection Act of 1986", [CPA] which became effective in mid- April 1987[10]. Under Section 2(1) (0) of CPA medical practice has been included under this act. The inclusion of medical practices under the act resulted in safeguarding patients in cases of misdeeds or failures, thereby providing the provision for them to ask for relief. However, Harbishettar et al. (2019), is of the opinion that the act has imposed barriers to the development of DPR because the care users look at doctors suspiciously, which, resultantly makes the doctors defensive. The researchers believe that, followed by the implementation of the act, it seems that the doctors are required to work under fear, which may impact their confidence to treat, which may adversely impact the patients. Tripathi et al. have further opined that the implementation of the act acts as a "two-edged sword"[11]. The researchers stated that it has made the doctors more defensive and compelled them to take an "approach of evidence-based medicine", increasing the treatment cost. Referring to the instance of China, researchers also mentioned about risk of increased violence for getting repayment or actual or apparent medical negligence. Another mentionable act is the Mental Healthcare Act (2017) (MHCA), which identifies the significance of the "rights of the patients" and provides them with the right to clarify the evidence

[9].Bomhof-Roordink H, Gärtner FR, Stiggelbout AM and Pieterse AH, 'Key components of shared decision making models: a systematic review' (2019) 9(12) BMJ Open e031763.
[10]Nomani MZ, Rahman F and Alhalboosi AK, 'Consumer Protection Act, 2019 and its implications for the medical profession and health care services in India' (2019) 41(4) Journal of Indian Academy of Forensic Medicine 282.
[11]Tripathi J, Rastogi S and Jadon A, 'Changing doctor patient relationship in India: A big concern' (2019) 6 International Journal of Community Medicine and Public Health 3160.

base of the treatment offered to them. However, according to the researchers, the act has not given importance to the DPR and may be adversely impacted by various factors including increasing healthcare costs, particularly in the private sector. In context to the Indian Penal Code 1860 (IPC) and its impact on DPR, Laxmisha & Reddy also opined that it has resulted in deteriorating the relationship with an increasing number of cases against doctors[12].

4.4 Legal Framework of a Doctor-Patient Relationship in the USA and UK

In context to the U.S. one of the mentionable acts that impact the DPR is "The Health Insurance Portability and Accountability Act (HIPAA)", which safeguards care users from unauthorized disclosure and use of their data. According to the federal register (2023), the act helps the care users in developing increased "trust-based relationship" with the health care provider and establish effective communication because of the elevated privacy and confidentiality protection[13]. In the UK, patient safety and medical practice are regulated under "The General Medical Council (GMC)" which was established under "the Medical Act, of 1983". According to Rai, the NHS in the nation is bound by "clinical negligence laws" in the nation[14]. It protects the "duty of care" to the patients. Another mentionable act is the Care Act (2014), which in the opinion of Johnson & Boland, rather than safeguarding the care users, has left them unsafeguarded because of the lack of flexibility in the framework[15].

4.5 Research Gap

Based on the analysis of the existing studies, it can be noted that the majority of these studies focused on either the legal aspects or the ethical aspects of DPR. However, a holistic analysis of the DPR considering both aspects can be noted to be missing in the majority of these studies which have been addressed through this manuscript.

5.0 Conclusion and Recommendations:

[12] Laxmisha RK and Reddy BS, A Critical Study of Law Relating to Medico Legal Litigations in India (Doctoral dissertation, Alliance University 2021).
[13] Shachar C, 'HIPAA, privacy, and reproductive rights in a post-Roe era' (2022) 328(5) JAMA 417.
[14] Rai L, Doctor–Patient Relationship and Medical System: A Comparative Study with USA.
[15] Johnson K and Boland B, 'Adult safeguarding under the Care Act 2014' (2019) 43(1) BJPsych Bulletin 38.

Thus, based on the above-made discussion it can be noted that, the implementation of the existing regulations governing, DPR in all the considered nations has two diverse aspects. On one hand, it is contributing to the protection of the rights of the care users, however, it has also been reported to adversely affect the DPR. The healthcare system in the UK is primarily operated under the operation of National Health Services, which excludes the concept of medical expenses in the "medico-legal cases," which is significantly contrary to India.