5. The doctor-patient relationship
Levels of the doctor-patient relationship

1. Intellectual (cognitive)

Comprises the exchange of information between the doctor and the patient;
- the doctor is often perceived as an expert (“Parent”);
- the patient is subordinated (“Child”).

→ asymmetric relationship:
  the patient has no emotional catharsis →
  ↓ therapeutic adherence.
2. Emotional
= “an exchange of emotions”.

*Transference* = emotions, feelings that the patient develops towards the doctor;

*Counter-transference* = the doctor’s response to patient’s emotions;

*Empathy* = understanding the feelings of other person;
- the doctor’s endeavour to put him/herself in the situation of the patient;
- the doctor’s ability to show it.
3. Ethical

- professional competence;
- informed consent;
- universalism;
- confidentiality;
- functional specificity;
- affective neutrality;
- telling the truth.
The social role of the patient

- relief from responsibilities, depending on the nature and the severity of the illness;

- getting support from the medical staff;

- the undesirable character of the illness itself – the patient must want to get well;

- the patient’s obligation to seek competent support and to co-operate with professionals in the field of health.
Communication

Verbal:
- content of speech;
- voice tone & volume, speech rate;
- types of questions (open, closed).

Non-verbal:
- outfit, hairstyle;
- body language - facial expressions, gestures, postures;

Characteristics:
- largely unconscious;
- more authentic than verbal;
- culturally determined;
- important in communicating feelings.
Communication between the physician and the patient

Accordance between the verbal and non-verbal communication;

Attention to the non-verbal messages given by the patient;

Active listening (expressed both verbally and non-verbally);

Verbal communication:
strategies used during the interview (summarizing, paraphrases, approval of the patient, expressing interest, allowing permission for patient’s verbal expression);

Style of anamnesis:
- “technical” (directive);
- psychoanalytical (non-directive).
<table>
<thead>
<tr>
<th><strong>“Technical” anamnesis</strong></th>
<th><strong>Psycho-analytical anamnesis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Used mostly in well-localized, acute illnesses or in emergency situations; Uses precise, closed type of questions; The dialogue is focused exclusively on patient’s signs and somatic symptoms; Suppresses the patient’s catharsis. Advantage: effective in terms of time spent for diagnosis; Disadvantage: does not allow the building of trust, a key element for positive transference and compliance.</td>
<td>Open-ended questions, giving the patient the opportunity to express himself / herself; The physician lets the patient to expose his / her suffering with detail; The dialogue may focus on psychological symptoms or on the psychosocial context. Advantages: - allows the emotional catharsis; - favors the positive transference; - increases the treatment adherence. Disadvantage: time-consuming.</td>
</tr>
</tbody>
</table>
# Doctor-patient relationship

<table>
<thead>
<tr>
<th>Asymmetric</th>
<th>Symmetric</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The doctor:</strong></td>
<td><strong>The doctor:</strong></td>
</tr>
<tr>
<td>- dominant position (power and authority);</td>
<td>- medical care provider;</td>
</tr>
<tr>
<td>- Adult-Child type of relationship.</td>
<td>- encourages a partnership with the patient.</td>
</tr>
<tr>
<td><strong>The patient:</strong></td>
<td><strong>The patient:</strong></td>
</tr>
<tr>
<td>- subordinate, dependent person;</td>
<td>- more informed, wants to decide more regarding own health;</td>
</tr>
<tr>
<td>- can display affective/behavioral regression;</td>
<td>- active involvement;</td>
</tr>
<tr>
<td>Is often met in surgical specialties.</td>
<td>- favors patient’s self-perceived responsibility and adherence.</td>
</tr>
</tbody>
</table>
Asymmetrical relationship

Symmetrical relationship

Paternalistic Approach

Patient-Centered Approach

VS

75% of physicians are still “physician-directed” in how they communicate

PCMHS, ACOs, Value-Based Care & Triple Aims assume “patient-centered” communication skills physicians don’t have.

Physician-Directed

Patient-Centered

Communication style
Communicating with patients with personality disorders

INTERPERSONAL STYLES ASSOCIATED WITH PERSONALITY DISORDERS

Adapted from "Evidence-based Treatment of Personality Disorders: Principles, Methods, and Processes" by J. Magnavita
## Paranoid personality type

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>As a patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mistrust: suspicious, hypervigilant, hostile;</td>
<td>Tends to require special attention from the physician;</td>
</tr>
<tr>
<td>Overestimation: scornful attitude, excessive self-pride, authoritative behavior,</td>
<td>Wants to be confirmed in his/her hypothesis concerning the diagnostic;</td>
</tr>
<tr>
<td>does not accept criticism;</td>
<td>Tends to display an attitude of superiority over the physician;</td>
</tr>
<tr>
<td>Rigidity: does not give up previous judgments, despite new evidence;</td>
<td>Prone to non-compliance;</td>
</tr>
<tr>
<td>The Manichaeism in judgments and ways of reasoning (assesses the situations as</td>
<td>Suspicious with regard to the methods of establishing the diagnosis and the treatment.</td>
</tr>
<tr>
<td>being “white” and “black” and the people as being “good” or “bad”).</td>
<td></td>
</tr>
</tbody>
</table>
## Hysterical personality type

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>As a patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatrical attitude: the desire to be pleased, convincing, admired or pitied;</td>
<td>Asks the physician to give him/her an increased attention;</td>
</tr>
<tr>
<td>Lack of authenticity;</td>
<td>Has an exaggerated transference;</td>
</tr>
<tr>
<td>Emphasizing the erotic character of the social relationships: “seductive behavior”</td>
<td>Considers him/herself a special case (“exaltation of the Ego”);</td>
</tr>
<tr>
<td>Easily influenced (suggestive proneness);</td>
<td>May escape social responsibilities, by using the disease (“evasion”);</td>
</tr>
<tr>
<td>Can influence others, through his/her spectacular behavior (can be a source of</td>
<td>May display atypical symptoms;</td>
</tr>
<tr>
<td>information contagion).</td>
<td>May often contact the physician and may recklessly abuse medical services.</td>
</tr>
</tbody>
</table>
## Obsessive-compulsive personality type

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>As a patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeks for perfection every time / everywhere;</td>
<td>May early abandon the treatment or appeal to more than one physician or to</td>
</tr>
<tr>
<td>Meticulous;</td>
<td>non-conventional therapies;</td>
</tr>
<tr>
<td>Obsessed with order;</td>
<td>Unsure about the outcome of the treatment, despite evidence;</td>
</tr>
<tr>
<td>High consideration for norms, laws and rules;</td>
<td>Has own scenarios about the diagnosis and the treatment;</td>
</tr>
<tr>
<td>May be terrorized by own rules and by the need to obey them;</td>
<td>Tends to approach the physician at the smallest symptoms or incidents during</td>
</tr>
<tr>
<td>Indecision (especially in situations that require spontaneity);</td>
<td>therapy.</td>
</tr>
<tr>
<td>Low self-confidence.</td>
<td></td>
</tr>
</tbody>
</table>
## Schizoid personality type

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>As a patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incapacity to form and maintain social relationships; Lack of interest and consideration for others’ problems, but also for his/her own social image; Indifference to social sanctions or rewards; Isolation; Reduced affectivity: incapacity to express feelings, poor development of emotions, lack of desire and ability to build a family.</td>
<td>Comes to the physician only if it is strictly necessary; May unexpectedly vanish from the hospital, immediately after the critical phase is over; Has low to absent transference and cold relationships with the physician and with other patients; Is vulnerable to the hostility and antipathy of other patients; Can trigger negative counter-transference.</td>
</tr>
</tbody>
</table>
## Dependent personality type

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>As a patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulties in taking decisions; Unwillingness to take responsibilities; Hypersensitivity to criticism; Conforming to others‘ opinions; Willing to make sacrifices, in order to avoid losing social support; Fear of abandonment; Easy manipulated by others, on the condition that they offer care or support.</td>
<td>Often comes to the physician together with a family member; During therapy, displays feelings of anxiety, impotence, helplessness; Predisposed to information contagion; May develop high transference (possibly replacing an old dependence with the dependence to the physician (or to the physician‘s services)).</td>
</tr>
</tbody>
</table>
Delivering bad news
The SPIKES acronym

• **SETTING UP** the proper conditions for the interview;
• **PERCEPTION** (assessing the patient's perceptions):
  - “before you tell, ask”;
  - use open-ended questions, to find how the patient perceives his / her medical situation;
• **INVITATION**
  - while a majority of patients express a desire for full information and details about their illness, some other patients do not;
• **KNOWLEDGE**
  - warning the patient about the bad news may lessen the shock and may facilitate information processing;
• **EMOTIONS** - address the patient's emotions with empathic responses;
• **STRATEGY and SUMMARY** - provide key messages.
Burnout syndrome at doctors

**Prevalence**

25% to 76%, depending on the working conditions and medical specialty

Examples:
- surgeons: 27-40%;
- psychiatrists: 26-33%;
- medical oncologists: 28-68%;
- general practitioners: 22-32%.
Components

_**Emotional exhaustion**_ = the sensation of both mental and physical wasting, a feeling of not being able to spare any type of energy and “reaching the limit”;

_**Depersonalization**_ = is manifested mostly as an alteration of professional’s ability to communicate with the patient and / or his family. Common manifestations include behaviors, such as cold and impersonal attitudes, cynicism, irony and indifference to patient’s emotional needs;

A sense of _**diminished personal accomplishment**_ = manifested as a decrease of personal satisfaction at work, with concomitant feelings of insufficiency, low self-esteem, professional failure and lack of motivation.
## Predisposing factors

**Individual**
- perfectionism;
- the "good Samaritan" syndrome (over-involvement);
- history of own confrontations, followed by exhaustion;
- difficulties in establishing / maintaining relationships;
- high vulnerability to failure/ loss;
- substance abuse.

**Socio-cultural**
- stressful working climate;
- conflicts between professional effort and social recognition (♂);
- conflicts between career and family demands (♀);
- economic difficulties;
- "stress-illness" stereotype (stress → exhaustion);
- "age-illness" stereotype (old age is associated with exhaustion and illness).
Solutions

Prevention (lifestyle changes)

Individual psychological assistance
(e.g. relaxation techniques, cognitive-behavioral therapy)

Group therapy (e.g. Balint groups)