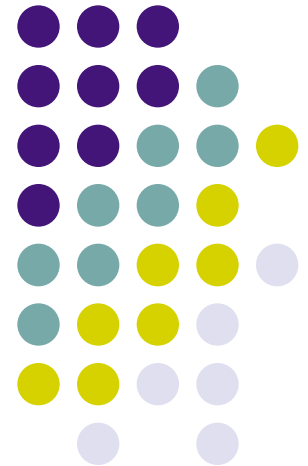
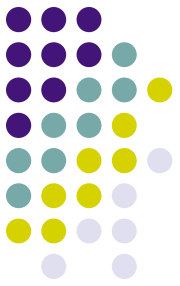


# DOCTOR – PATIENT RELATIONSHIP

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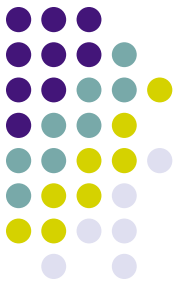


# Concept



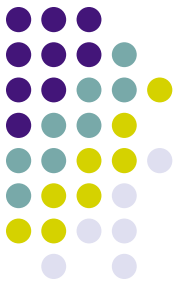
- The doctor-patient relationship is the frame in which the medical practice takes place.
- It can be considered as:
  - Social
  - Psychological
  - Cultural
- It is uneven

# The doctor's status



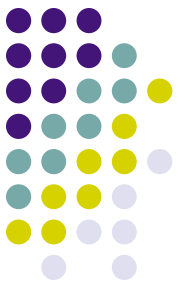
- The doctor emerges in a triple stance:
  - Comforts, understands suffering
  - Cures disease
  - (Sometimes) saves the patient's life
- Qualities required from the doctor:
  - Intellectual:
    - Professional knowledge,
    - Immediate diagnosis,
    - Flair, etc.
  - Moral:
    - Professional knowledge
    - Commitment
    - Altruism
  - Interpersonal:
    - Sincerity
    - Cordiality
    - Authority
    - Time for the patients

# The doctor's status



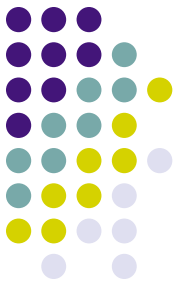
- Defining features of the doctor status:
  - Technical competence
  - Universalism in providing medical care
  - Functional specificity
  - Affective neutrality
  - Altruism
  - The obligation to get the patient's consent

# The doctor's status



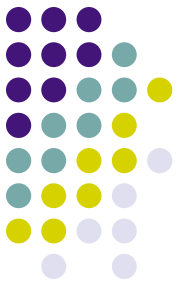
- The doctor role is embodied through:
  - Respecting the rights and obligations entailed by the doctor status
  - The willingness to communicate with the patient
    - Patience
    - Using words the patient can understand
    - Interest in taking a comprehensive patient history
    - Facilitating attitude adjustment according to the patient's personality: “authoritarian tutor”, “menthor”, “aloof scientist”, “protective parent”, “the advocate of truth”, “therapeutic mirror”
  - Professional and social notoriety/ prestige of the doctor

# Role conflicts in the doctor/patient relationship

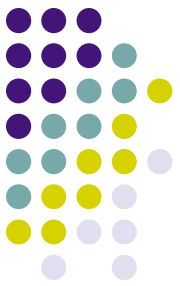


- Psychological resistance of some patients to the doctor's authority
  - Affective ambivalence of the patient
  - Refusal or inability to communicate of certain patients

# Models of the doctor – patient relationship

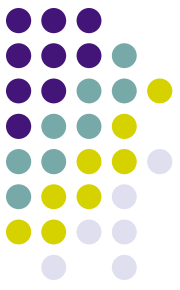


- Paternalistic model
- Informative model
- Interpretative model
- Deliberative model



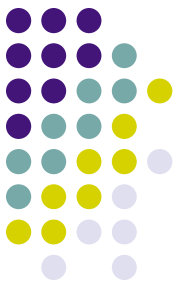
# The paternalistic model

- The doctor decides what is in the patient's best interest, based on the medical data at hand and on the clinical judgment.
- The shortcoming of this model is the fact that the doctor and the patient can have distinctive value systems.
- It is reserved for emergency medicine.



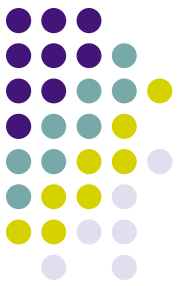
# The informative model

- The doctor provides the patient all the relevant information about the illness and treatment options, without taking into account the patient's history, personality or value system
- It can generate anxiety, stress.
- It lacks compassion.
- It erroneously assumes that the patient is fully autonomous.
- It is appropriate for outpatient assessment for minor illnesses



# The interpretative model

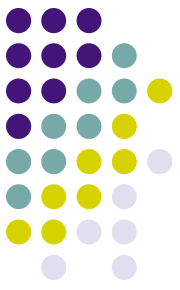
- The doctor emerges as an “advisor” of the patient, helping the patient make a decision that will take into account both information and medical judgment, and the patient’s personal value system.
- It entails the doctor’s understanding of the patient’s needs and wishes, which is not always possible.
- It is appropriate for situations in which the patient is followed up for illnesses with a long evolution



# The deliberative model

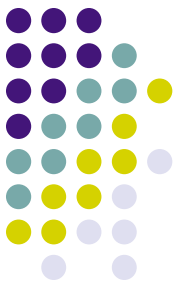
- The doctor behaves as a teacher or friend of the patient and tries to persuade the patient to make “the best” choice, taking into account both information and clinical judgment, and the patient’s personal value system.
- Mostly used in institution with a public health profile.

# Specific types of doctor – patient relationship



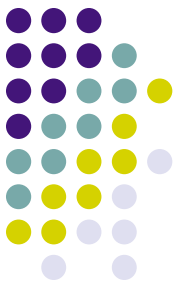
- **Anxious, phobic:** they need an authority figure, their need for dependence is satisfied by a directive, comforting attitude
- **Obsessive:** demands detailed explanations due to the intellectual need for reassurance through thorough reasoning
- **Paranoid:** needs a relationship of trust and honesty
- **Depressive:** experiences temporary comfort if allowed to verbalize her/his suffering, because he/she experiences self-blame, because of which he/she perceives any intervention from others as a punishment.
- **Demonstrative:** also requires freedom in exposing emotions, but without allowing excesses

# Types of errors most frequently encountered during the establishment and development of doctor-patient relationship



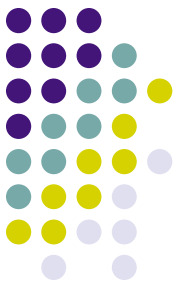
- Inappropriate attitude features of the doctor: rush, impatience, fatigue, boredom, aloofness, raised voice
- Acceptance of insufficient communication with the patient
- Excess of or lack of authority with the patient
- Engaging in conflict situations
- Underestimating difficult patients, with increased psychogenic tendencies
- Polimedication as an expression of the doctor's submission to patient's insistence

# Deficiencies in doctor-patient communication



- Failure to appropriately greet the patient, introducing oneself and explaining one's actions
- Failure to get easily accessible information, mainly due to fears and expectations
- Accepting imprecise information, failure in seeking clarifications
- Failure to verify with the patient what the doctor understood from the situation
- Failure to elicit questions or to appropriately answer to questions
- Neglecting obvious clues or clues not provided verbally or in a different manner by the patient
- Avoiding information concerning the patient's personal, family, social status, including problems in these areas

# Deficiencies in doctor-patient communication



- Failure to elicit information about the patient's feelings and the perception of the illness
- Directive style with closed questions, frequent interruptions and failure to make the patient speak freely
- Rushed focusing without testing theories
- Failure to provide appropriate information concerning the diagnosis, treatment, side effects or prognosis, or in verifying the patient's understanding of these issues
- Failure to understand the patient's viewpoint
- Poor comforting