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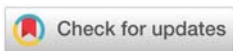
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## Review Article

# Psychology of doctor-patient relationship in general medicine

## Abstract

The transcendence of psychological factors of the doctor-patient relationship is given by the fact of its influence on results and quality of medical care, improvement in compliance, satisfaction and recall of physician information, and plays a fundamental role in the medical care process: the skills Listening and communication are fundamental parts to make the diagnosis and treatment. Some of these positive consequences arise from the fact that relationships are linked to emotions which have a physiological substrate. The different psychological behaviors of the patient and the doctor (such as verbal and nonverbal communication, affective behavior, beliefs, empathy, listening), symptom perception, shared decision, negotiation, information, persuasion, etc., give different types of relationship. In doctor-patient relationship there is a modality of psychotherapy, where the treatment is based on that relationship, in which the general practitioner and the patient work together to improve psychopathological conditions through the focus on the therapeutic relationship, which brings consequences on thoughts, emotions, and behaviors. The therapeutic function of the doctor-patient relationship can be understood in analogy to dialysis, in which the patient experience of illness passes through the clinician's compassionate equanimity for affective detoxification and cognitive clarification. Also, the work of the general practitioner can be understood as a psycho-physiological doctor-patient relationship process through which the doctor and the patient can influence the health of the other. Doctor-patient relationship evaluation has to be carried out jointly by both, doctor and patient, on the effect that both are achieving with that relationship.

*"The disease is like removing the soil where a tree is planted: the roots are exposed, and you can see how deep and strong they are."* Virginia Woolf (1882-1941; English writer).

## Introduction

The doctor-patient relationship is a "crossroads" that consists of several concepts, among which we can point out the doctor-patient communication, the participation of the patient in decision-making and patient satisfaction. The doctor-patient relationship is established in the consultation and has its central element around the clinical interview. This clinical interview is a technique or channel and place of doctor-patient communication, where the doctor-patient relationship is produced and developed. This communication and the doctor-patient relationship itself indicates to the general practitioner (GP) (such as signalling a path that shows us the direction to reach a place) the clinical environment for diagnosis and treatment [1-4].

Psychology is interested in thoughts and feelings that relate to the behaviors of human beings. The psychological approach of the doctor-patient relationship and communication is more interested in the behavior of the doctor and the patient. Thoughts, feelings and behaviors are influenced by both internal factors and external factors. The latter include the behaviors of

others (the information that gives us what we observe about the behaviors of other people), and also physical stimuli such as noise or heat. Internal factors can be psychological (for example, our memories of our memory), or physical (such as the activation of a pain receptor) [5].

The vast majority of studies on relationship and communication have focused on doctors and other professionals with patients. Every imaginable angle of these interactions has been studied, from the position of the furniture in the consultation room, to the information on the drug leaflets. When information is transmitted from one person to another, there are a number of points where errors may appear. The doctor can explain the message poorly, and the patient misunderstands it or remembers it with errors. Doctors and patients are in different worlds and speak different languages. For example, the indication of taking the medication three times a day, can be understood as three times during "the day" as opposed to the "night." There is evidence on the fact that a significant proportion of doctor-patient encounters are affected due to communication problems.

Among the factors that modify the doctor-patient communication are: 1) age; 2) gender (doctors often classify women as hypochondriacally, and take men's health issues more seriously than women's issues); 3) socio-economic status (working-class patients use physical terms such as pain, constipation, etc. more frequently, while middle-class patients use terms related to mental and psychological health such as anxiety, depression, stress, etc., in their meetings with doctors; that is, people express different symptoms and have different diseases according to their socio-economic level), 4) ethnicity (it is more than a matter of language, and differences in communication are related to culture and beliefs), 5) consultation time (more consultation time does not imply better communication or more patient satisfaction), 6) consultation style (there are controversies about the style that results in more patient satisfaction: informative- directive, persuasive, cooperative-participatory, and could depend on numerous variables including disease); etc. [6-12].

In this sense, several models of doctor-patient relationship have been described: biomedical, biopsychosocial, patient-centered, relationship-centered, negotiator, consumer-centered and systemic. Probably "one size", a single model, is not valid for all circumstances, and the attending physician must be an expert in several of these models and learn to adjust their communication style to the context in which they provide assistance. The doctor-patient relationship cannot be seen outside the context in which the interview takes place, and must be adjusted to it. And this context is multidimensional and includes verbal and nonverbal communication, individual clinic as an expression of group or relational problems, experience of the disease, beliefs, etc. [13-15].

Traditional communication models between doctors and patients have emphasized the transfer of knowledge from the expert to the common person. But, this theoretical framework involves several problems:

- A. Assumes that the healthcare professional is objective and that their own beliefs and emotions do not intervene in the relationship and communication with the patient.
- B. Assumes that patient adherence is something positive and not problematic.
- C. It does not include the beliefs and emotions of the patient [16].

And it should not be forgotten that the psychological vision of communication and doctor-patient relationship is modelled by the external world (the social context; sociological factors) [17]. Now, while they are the same social causes that are behind the doctor-patient relationship, when these social causes acting on different psychological behaviors, they give rise to the expression of different types of relationships. So, the psychological factors in the consultation act as an optical prism; they disperse the social causes that affect the doctor and the patient in a beam of different forms of the doctor-patient relationship. So, in this way, thoughts, feelings and behaviors take a great importance as intermediate mechanisms of the

social action on doctor-patient relationship in the consultation of general medicine [18].

In this scenario, this article aims to reflect, synthesize and conceptualize, based on a selected narrative review and the author's experience, on some basic elements of the psychology of the doctor-patient relationship in general medicine, and its practical implications.

## Discussion

The sociological and the psychological frameworks of the conceptualization of the doctor-patient relationship overlap. There is no psychological reality in living beings that is not inserted into a social reality. The coincidences and oppositions between both sets of data explain the diversity of individual cases and the different typologies of the doctor-patient relationship with their different ways of understanding and addressing health problems. This confusion and overlap of psychological and social factors explains the variations in the roles of the doctor and the patient [19,20].

The work of the GP includes interactions with individuals. The educator / health promoter role of the GP is not limited to interactions where there are obvious components of health education, but that any doctor-patient interaction or relationship can be more or less health promoter depending on how the process is carried out and of the degree of control and training ("empowerment") offered to the patient, client or consumer. The most significant elements of man's life and health refer to man in relation to other men and their physical environment.

In the doctor-patient relationship there is a modality of psychotherapy, where the treatment is based on that relationship, in which the GP and the patient work together to improve psychopathological conditions and functional impairment through the focus on the therapeutic relationship, which brings consequences on attitudes, thoughts, affection and behavior of the patient, as well as can be extended on the way of understanding and therefore changing, their social context. Even if the stressful environment is not modified (because it is not always possible) The world that surrounds each person, the environment of each person, is largely created by oneself because we are interpreting what surrounds us. Therefore, if the interpretation of our surroundings is varied, in a way, it is as if the environment is varied [21].

## Around the consultation

In the chronological context, the query can be seen as the interaction of some inputs or background and some results or consequences or effects. The inputs and results form a cycle of care, and are conditioned to the understanding that the doctor achieves about the patient and about his / her health / illness. The consultation will better influence the care cycle the more understanding you have about the patient's health. The roles of the physician's tasks can be identified as a problem identifier, manager, caregiver / support, prevention, and education. To define an effective consultation, we must first specify the desired goals. An effective consultation is one that achieves the desired goals [22].

## The process of building interpersonal relationships

There are some usual ways or types of building the relationship between people:

1. Reciprocity: I have the right to ask the other person for things and she has the right to ask them of me. We both have rights. Relationships are based in give and take. Sometimes I can do more things, and other times it is the other person who can do them.
2. Altercentrism: my obligation is to take care of the other person, put it first.
3. Egocentrism: my needs go first. It is an “up-down” relationship.
4. Exchange: relations are based on negotiation.

Many problems in relationships lie in misunderstandings of the perspectives of other actors. In reality, the belief about the modality of interpersonal relationship is built on a dynamic negotiation process. Each actor has his visions on the positions of the others, and these are susceptible to revision as the relational process progresses. In addition, these constructions of the relationship visions can be modified according to specific contents.

Each person has their own perspective of the relationship and the belief of what is the other's perspective (meta-perspective). It is also influenced by the content of the communication, the previous history of the relationship, and the cultural patterns. The relationships between the individuals of a system (for example, doctor-patient relationship) play an important role in maintaining its balance. In these systems the presence of the problem in one member may be a conflict marker in another member

## The medical consultation process from social psychology

Since the approach of social psychology, the medical consultation process has been extensively investigated. Human behavior has been described in terms of personality and behaviors in the consultation, both of the doctor and the patient, and the beliefs of the latter. These are factors that can modify the consultation. This approach includes verbal and nonverbal communication, and the clinical content of the dialogue [23].

Patients typically think of themselves as consumers of technical medical terms in the sense that they normally defer to health professionals' explanations of meaning. It is at the same time well documented that patients tend to think they are entitled to understand lay health terms like 'sickness' and 'illness' in ways that do not necessarily correspond to health professionals' understanding [24].

The transcendence of the doctor-patient relationship is given by the confirmed fact of its influence on the results of health care [20,25]. In fact, the quality of doctor-patient interaction and communication is a powerful indicator of the

quality of medical care and plays a fundamental role in the medical care process [26]. Some of these positive consequences for health care and health arise from the fact that relationships are linked to emotions and emotions have a physiological substrate.

To the extent that we respond emotionally to someone, we respond physiologically to that person. Consequently, people in an emotionally significant relationship share physiological responses associated with those emotions. The emotions of fear and pain that accompany patients' symptoms so often are driving them to seek relief through medical care, an important ingredient of which is the doctor's affective care. People in an empathic relationship exhibit a correlation with indicators of autonomic activity. This occurs between speakers and responsive listeners, members of a coherent group, and bonded pairs of higher social animals. Furthermore, the experience of feel cared about in a relationship reduces the secretion of stress hormones and shifts the neuroendocrine system toward homeostasis. Because the social engagement of emotions is simultaneously the social engagement of the physiologic substrate of those emotions, the process has been labelled sociophysiology. This process can influence the health of both parties in the doctor-patient relationship, and may be relevant to third parties [27].

## The ability to communicate

Communication between the patient and the providers is extremely important, especially for the treatment of patients with chronic diseases [28]. It has been found that high satisfaction with the consultation occur when the patient said that there had been good communication and doctor-patient association [29]. Evidence of improvement in compliance, satisfaction and recall of physician information has been found in patient-centered consultations [30].

The ability to communicate constitutes a fundamental requirement to succeed in collecting the patient's history satisfactorily. The information we extract, if carefully connected and assessed, can provide a correct diagnosis in more than 50% of patients and in four out of five cases in general medicine. Thus, there are studies that indicate that the final diagnosis is made by:

- Clinical history (interview-communication-anamnesis) in 75% of patients.
- Physical examination achieves diagnosis in 10% of patients.
- Laboratory tests achieve the diagnosis in another 10% [31].

In addition, the ability to communicate constitutes one of the main elements of the treatment. Almost all visits end with what can be defined as “exposure,” during which the GP exposes his case evaluation and delineates a therapeutic approach. It is therefore an interaction or “confrontation”, where there is an exchange of information related to the problem; The words said contain significant information that perhaps the patient is not yet ready to face, but which can be remembered and be

useful later [32,33]. This is of fundamental importance if the GP really intends to achieve “good” consultations [22].

The implication of understanding the therapeutic potential of making the history of the current disease is that the process of asking questions is also a process of establishing a relationship. This is analogous to the process of ritual courtship of many animals: the process is not only a test of compatibility, but also a negotiation of compatibility. Therapeutic listening can be understood in analogy to dialysis, in which the patient’s experience of illness passes through the clinician’s compassionate equanimity for affective detoxification and cognitive clarification [27].

### Know the patient’s understanding of his health to influence his behavior

The approach of social psychology allows us to see that it is possible for the doctor to know the patient’s understanding of his health in order to influence his behavior. To do this, should be done:

- Discover the beliefs, concerns and expectations of the patient about the problem or problems consulted.
- Share by the doctor the understanding of the problem with the patient in a way that is understood.
- Make a decision-making shared with the patient.
- Encourage the patient to take adequate responsibility for their own health.

#### From this perspective, the GP should pursue 2 tasks:

1. To ensure that the greatest possible amount of the patient’s disease experience is put into the dialogue, so that treatment is possible (listening has a therapeutic value).
2. Co-process that experience with an attitude of compassionate equanimity.

If the doctor understands that he is helping the patient to dialyze his anguish, he will bear better patient’s listening or the fact of not being able to cure the disease [27]. The doctor’s attention in the process of taking the medical history confirms the patient’s worth as a person who tells a story, shows interest, and lays the foundation of the therapeutic alliance [34]. It should be noted that, in general medicine, psychological problems often manifest with physical symptoms and physical illnesses have psychological consequences that need special attention. Thus, all the problems addressed need to explore the psychological elements.

It is necessary to give as much attention to the psychology of the patient as to the diagnosis in any disease if recovery is to be achieved. The psychology of the seriously ill patient puts barriers between him and the doctor’s skills. There is a feeling of hopelessness in the disease itself, especially in the serious one. There is fear of never regaining normal function again, and this produces a barrier that separates the patient from a

world of open expectations, of possible movements. There is a refusal to look like a person who only complains. There is a desire not to add more apprehension to the family, which leads to isolation of the patient. There is a conflict between the terror of loneliness and the desire to be alone. There is a lack of self-esteem that represents a manifestation of our inadequacy in the disease situation. There is fear of decisions that can be made behind our backs. There is fear of the technology that invades us, with a feeling of being a stranger between intravenous lines and devices. There is stress of being enclosed between the white walls of laboratories or hospitals and exposed to all kinds of strangers, without the warmth of human contact, without the warmth of a smile [35].

But, in addition, doctors have feelings, and these have a role in the consultation (the doctor has to identify and use their emotions during the consultation for the benefit of the patient). Specific training is necessary to produce limited but significant changes in the personality of the doctor, to be more sensitive to what goes through the patient’s mind during the consultation. The GP has a positive therapeutic role in all consultations, not only in which there is a defined pathological process [31,36].

What is the behavior that allows implementing a system of doctor-patient interactions, so that psychologically optimal consultations take place?

To ensure patient communication in general medicine, certain conditions that allow the successful exchange of beliefs, thoughts and other mental states must be met.

#### From the general point of view, three approaches can be pointed out:

1. Traditional methods focused on guidelines and directive relationships
2. Active methods, centered on the patient, where the doctor is a guide that organizes decisions and shared learning
3. Participatory method focused on reality, where the doctor is a participating driver, and considers each patient as an unconditionally accepted fact and as a being to become who is learning through his participation, which allows him to know his needs and obligations. The doctor feels engaged in this process, and participates according to the needs of the patient, giving information, facilitating the search for solutions to problems, and clarifying or releasing the psychological phenomena that block work [19].

From the point of view of social psychology, the possible functions of the professional would be; instruction, control, democratic and therapeutic strategy. But, in practice, it is possible to identify the communicative behavior of the provider that is generally perceived by many patients as positive: affective behavior (for example, asking the patient about their feelings, being sensitive to these feelings and responding to them), providing information in an understandable, proactive way; trying to understand the perceptions, expectations and

cognitive concepts of the patient. Successful communication requires certain congruence between the patient's communication preferences and the GP's behavior [28].

Patients' perspectives on the disease are shaped by their subjective horizons. The GP must maintain a holistic approach that tries to understand the meaning of patient expressions [33]. The adequacy of symptom management (such as pain) in patients seen by the GP is an important contributor to the overall treatment outcomes and positive perceptions of the disease. However, it may be subjectively predetermined by a patient's beliefs about symptom or disease (like pain control). Beliefs about symptom control significantly influence perceptions of the disease, and therefore may affect the results of treatment in general medicine. Psychological modelling of beliefs about symptom control can offer a valuable way to improve overall clinical outcomes [37].

Medical care can be understood as a mutual physiological commitment, a sociophysiological process through which the doctor and the patient can influence the health of the other for better or worse: exchange of physiology between people who participate in a meaningful interaction. In its classic or original sense, sociophysiology refers to the reciprocal physiological commitment linked to empathy; sociophysiology denotes "interpersonal physiology," based on the finding that the interpersonal relationship between the therapist and the patient is also reflected in their physiological relationship [38].

The care in the doctor-patient relationship can be expressed in several ways, including instrumental help, cognitive help and affective help. There is an added value in a positive affective commitment. Like the mother-child bond, the optimal expression of this commitment is a tuning of the caregiver with the experience of the other; its subjective indicator is "feeling felt." That feeling can be generated if patients feel that the doctor is really interested in what they have to say, so just taking a history can relieve some of the patient's distress [27].

The preferences and attitudes that patients have towards treatment are important, since they can influence the outcome of the treatment [39]. The basic idea is that the development of disease depends largely on the patient's social environment and the interrelation between the environment and the patient. A disturbed attitude on the part of the patient towards the environment and towards himself can negatively influence the development of disease. The objective of social psychotherapy is to modify such attitudes, that is, to influence the disease by psychological means [40].

A collaborative relationship is also a therapeutic alliance. In consequence, the first step is crafting the doctor-patient relationship as one in which the patient and GP are collaborative partners engaged in a common struggle against their disease. Furthermore, this collaboration can be used to create an informed partner who can make informed and shared decisions, helping the process through which the body subjected to demanding situations or stress manages to recover its stability (homeostasis) by making changes in physiological

or psychological behavior that allow you to maintain a stable balance, also considering future requirements, for both patient and doctor by increasing the patient's autonomy. A respectful collaboration is facilitated by establishing an empathic bond, which reduces the likelihood of a discordant relationship because it is harder to blame a compassionate partner than an impersonal professional. The empathic bond also facilitates a positive sociophysiological co-processing of experience.

What is extraordinary about the doctor-patient relationship is the amplification of the sociophysiological influence that results from the interaction between the patient's emotional vulnerability and the doctor's emotional availability. Conveying a compassionate equanimity may be the art of the doctor-patient relationship. It entails establishing the same kind of person-to-person attunement that is essential to the development of the newborn and that remains a vital social support throughout the life span of higher animals. But the doctor's emotional availability has limitations [27].

Finally, it should be borne in mind that the GP, after living the experience of accompanying patients in their usual task of continued care, can confirm their previous conception of chronic disease, but also discover the ways in which some patients and their families overcome their limitations. Thus, the doctor's understanding of the meaning of the disease for the patient and the family is a type of knowledge that changes the doctor-patient relationship [11,20,41].

### Evaluation or psychological measurement of the doctor-patient relationship

There is a progressive awareness among health professionals, researchers and educators about the importance of doctor-patient communication for the achievement of desired health goals: compliance, recall and understanding of advice, positive health outcomes, costs, etc., and this has resulted in a proliferation of instruments to assess communication and doctor-patient relationship (Table 1), with different approaches, various aspects of medical consultation, and various actors (doctor and / or patient) [42-46].

The ability of GPs to understand the experiences of their patients has become increasingly important, but it has been a difficult topic to investigate empirically because it involves two distinctive lines of research: interpretive phenomenological analysis and communication between the patient and the provider. While the interpretive phenomenological analysis

**Table 1:** Instruments to Evaluate Doctor-Patient Relationship.

Methods to Collect Data	Data Evaluation Instruments
1.-Data collection in real time by an observer	1.- Questionnaires with Likert scales
2.-Standardized patients	2.-Checklists
3.-Videos and / or audios of the doctor-patient interactions in real time	3.-Interactional analysis
4.-Self-communication of the patient and / or doctor	4.-Focus groups
5.-Role-play	5.-Other qualitative methods: Action research, participant observation, in-depth interview, etc.

focuses on the experiences and narratives of patients' illnesses, but not on the therapist's understanding of them, communication surveys between the patient and the provider mainly focus on effective forms of communication without addressing the real patient experiences of illness [47].

The evaluation of these instruments can rest on qualitative methods, such as observation, focus groups, or individual interviews, or on quantitative methods. Qualitative methods require specific skills, may need more time, and cannot be implemented on a large scale. On the contrary, quantitative use standardized questionnaires or instruments that seem to be more suitable for repeated or large-scale evaluations. However, these instruments may affect the accuracy of the qualifications provided, due to many methodological factors, including the quality of the instrument in terms of validity, reliability, and sensitivity to changes [48].

It could be that doctor-patient relationship evaluation has to be carried out jointly by both, doctor and patient, on the effect that both are achieving with that relationship. If this were so, the culture of evaluation of "satisfaction with my doctor" "or with my patient" could be replaced by the "joint evaluation that my doctor -or my patient- and I are making about the results of our relationship ". This would imply that the doctor and the patient could ask themselves questions like " what are we doing is useful? ", "do we know where we are going?", "what should we do?", "What do each of us have to do?" And this would close the circle of participation and training. Or rather co-participation and co-training as deeper indicators of the patient-doctor relationship.

## Conclusion

The psychological skills of the doctor-patient relationship, such as verbal and non-verbal communication, affective behavior, beliefs, empathy, listening, symptom perception, shared decision, negotiation, information, persuasion, etc., are associated with positive results in quality, improvement in compliance, satisfaction and recall of the doctor's information, and plays a fundamental role in the process of diagnosis and treatment. Some of these positive consequences arise from the fact that relationships are linked to emotions that have a physiological substrate. In the doctor-patient relationship there is a modality of psychotherapy and can be understood in analogy with dialysis: the treatment is based on that relationship, in which the general practitioner and the patient work together to improve psychopathological conditions through the focus on therapeutic relationship, which brings consequences on thoughts, emotions and behaviors, and in which the experience of the disease goes through the compassionate and cognitive equanimity of the doctor.

General medicine is defined in terms of relationships, and it has to do with the unique relationship between the doctor and each patient. In each doctor-patient relationship, the GP should be able to participate in the problems that the patient has, being accessible, trying to perceive their experience and the meaning of their feelings, knowing that they are human, fallible and privileged to be at the center of a people growth

network. The GP should not discard any form that the doctor-patient relationship takes, so that the doctor-patient dyad subsists through all the modifications of societies and contexts.

As Virginia Wolf says, "the disease is like removing the soil where a tree is planted: the roots are exposed and you can see how deep and strong they are." The psychological factors of consultation skills in the doctor-patient relationship should help care for and protect those roots.

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