

# The Doctor-Patient Relationship and Self-Stigma\*

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The text is an analysis of the relational complex in a therapeutic space. Analysis started from the need to perform a medical act depending also on understanding these aspects. In the therapeutic process, diagnosis and treatment in their classical sense are just two of the aspects of a relational type interpersonal reality, which is much more complex. In fact, doctor-patient relationship is part of a relational system including the patient, his family, the physician and society. The four factors interact with each other, and the final result, the result that has a therapeutic effect on the patient, is a synthesis of all these interactions. Stigma is a pathological psychological product affecting all relations. Stigma is usually part of the collective mind, but also part of individual psychology. When stigma affects a patient's mind, its effect is profoundly anti-therapeutic. In psychiatry these relations are more important than in any other medical field. The brief analysis of these relations, in the therapeutic context of a patient, is the subject of the following text. Understanding all these aspects has a direct effect on the quality and performance of the medical act.

*Keywords:* Doctor; Patient; Therapeutic Relationship System; Stigma; Therapeutic Effect

## Introduction

“Saluti et solatio aegrorum”. This is the slogan written on the entrance lobby of the Psychiatric Clinic in Oradea. It means “sooth and assist the suffering”. Outside this motto there can be no human medicine, nor veterinary medicine, but perhaps some cold and inhumane robots.

Therefore, the basis of any medicine is the empathetic relationship between people and their knowledge. Only then, on this basis, comes therapy, with its spectacular evolution to date. Conservatori temporibus. The things succeed one another but the first ones give the definitive tone.

Second of all, as Aristotle proves in his “Politics”, “any society is built with a view to achieve something good”, and the members of a society pair up in the leader-subject type of relationships, in inseparable pairs. One without the other makes no sense. The physician and his patient form such a pair (Aristotle, 2005). One without the other is meaningless.

The patient is, therefore, a constitutive part of our definition as physicians. Consequently, we have to approach him as we approach ourselves, with the same warmth, understanding and scrupulousness.

Third of all, after thousands of years of medical practice, man has discovered that complete health is possible only if the person is happy. Happiness is part of the definition of health. If health is the only positive diagnosis, then this diagnosis cannot be given without assessing the level of happiness. And if getting healthy is not the ultimate goal, then medicine becomes a series of patches. So, the discussion about happiness cannot

be avoided. This is a very unexpected and extremely delicate consequence. If anybody would try to explain that it is possible to draft a happiness scale, they would be considered, ab initio, mindless persons regardless their academic status. Untamed reason often runs wild. It would be as if somebody would state that they can measure the intensity of a kiss with a ruler, according to the size of the mouth.

In conclusion, three out of the five most fundamental reasons of the medical act seem impossible to assess with the same means as giving a diagnosis or treating a disease. If people limit themselves to diagnosis and cure, without considering the other fundamentals, then they are Procrust-like, cutting their most humane essence from their dimensions.

That is the reason why current methods of diagnosis and treatment or the current state of profession cannot possibly be satisfying for people as humans or as professionals. People must not forget that before being doctors they are human beings. And every human being has a story. The ICD or the DSM or other scales used are Procrustian tools which shape a dismantling, non-unitary and incoherent person. It cannot possibly be denied their huge help when organizing the workplace and as a work tool station, but they are not the house in which human beings live, wanting to re-give to their own self in their full well-being.

The scales expose the patient statically. The static approach is for things, not for phenomena. The normal or the pathological psyche, the human being in general, is a continuously evolving phenomenon. A patient is a different person after his medical history has been taken. A well-done, tactful and professional anamnesis restructures the thoughts and feelings about the disease, about the own self and about the others. These things must be acknowledged so that static objects are not confused

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with phenomena and realities in general.

Naturally, nature sciences (of a series) require quantifications. These quantifications are impossible in the sciences of singularities (for instance, history). The psyche, besides the aspects of its generalities, is also a singularity. The generalities are derived from and consequences of its biological under-layer and are quantifiable. The singularity of the psyche derives from heredity and its ontogeny; that is why each phenotype is unique. It may be compared to the light which is both quant and wave at the same time. To regard the psyche only through its generality (quant) would be a pitiful reduction and it would lead to errors of approach and understanding.

So far, psychology (the science of the healthy mind) and psychiatry (the science of the ill mind) have approached the psyche either in its generality or in its singularity. There is a need for a synthesis which would give unity to the two aspects of the psyche. This is not possible unless the genetic heritage and the ontogeny are systemically integrated. For the time being, this is only possible at the level of sums. The synthetic unity remains a dream, but, at least, one more step is taken towards fulfilling it.

Every generation restated, sometimes loudly, that the moment had arrived for a quality leap, for a synthesis which would use all good discoveries of the minds and hearts of the previous generations of physicists, and then, step by step, all was abandoned in the exclusive favor of novelty. A state of accumulation has been reached which should enable people to become wise.

### **Historical Data about Reflection These Principles in the Medical Practice**

There is a tendency for the current generation to proudly and stupidly pretend that they have an undeniable superiority in thinking compared to other generations. This pride has its origins in ignorance, partly. But if one examines carefully the older or the ancient, one may have surprises which warn us to be modest. Thus, 2049 years ago (Ösler, 1921), Varro in *De Re Rustica* was talking about “tiny organisms which cannot be perceived by the naked eye and which get inside the body and cause diseases”. Or, in 16th century Venice, Fracastorius was talking about “contagious germs passing from one person to another”. Of course, the techno-scientific complex of the time could not capitalize such thoughts, but the performance of thinking in a sector of (series) nature allows people to trust the performance of the thinking back then, especially when it referred to singularities.

In this context, R. Iftimovici (2009), remarks that, before medicine, the shamans based their therapeutic exercise on the valence of uniqueness. Their discourse, addressed to Sprits or Secluded or Malefic Forces, was often imploring: “Help him”, “Make him stronger” etc. or imperative: “Go away!” or “Get out” etc.

Of course, the extra religious awareness must not be attributed to the shaman act, but the intuition of the role of the valence of uniqueness must be noted.

In a papyrus dating from Ramses I times (1314 BC), it is said that “the incantations are excellent in boosting the effect of the medicine, and the medicine does the same for the incantations” (Iftimovici, 2009).

Approximately one thousand years later, in the Hippocratic Corpus, in the book about proper behavior (*ibidem*), there is the

concept of *thenai*, which stated that medicine is both science and art. The science addressed the human generalities and the art referred to human uniqueness. The art implied talent to “know how to ally with the patient’s soul in the healing act. For this, the doctor must not offend the family”, “to accept the consultation from other colleagues” etc. The Hippocratic Oath in itself makes reference to the moral aspect and to the relation of uniqueness in the medical practice (Cornuțiu, 2004).

Aristotle makes a very profound remark: “... and we notice that the doctor in general does not heal even though he possesses the medicine but there is another principle which urges him to act according to science, but not because of science”. The more direct explanation of this statement is to be found in Plato, who says: “I would earn people’s respect but I would sin against the gods” (Plato, 1993). In a different culture, Confucius’, this truth sounds as follows: “The philosopher says: the one who knows the principles of right reason does not equal the one who loves them; the one who likes them does not equal the one who makes them his own pleasures and practices them” (Confucius, 1994). This is the same duality in unity: quant and wave, series generality of nature and uniqueness of phenotype.

The necessity of synthesis and the respect for the harmony between the two aspects of the same unique reality was also noticed by Albert the Great, who wrote: “there seems to be a unique nature of things whose essential act is one” (Albert the Great, 2001). Saint Augustus was also preoccupied by these relations and he emphasized the characteristic of the human uniqueness grained in affectivity. He said: “for those, it is enough to believe, to hope and to love” (St. Augustus, 1992).

The history of science comprises a consistent blend of generality and singular subjectivity. In 1927, the famous science philosopher (Calvin, 2007) Bertrand Russel remarked, bantering in an English manner the psychology and the psychopharmacology laboratory research: “the animals studied by the Americans swoop, hectically almost, with unbelievable agitation and energy, and, in the end, almost by chance, they get the desired result. The animals observed by the Germans sit still and think and, in the end, they develop the solution in their inner conscience”.

All these are connected with understanding diseases and patients and they determine the attitude towards patients. In order to limit the subject, return to the partiality stated in the title is needed. It is remarked what J. Z. Sadler (2005) concluded as historical evolution: “in the western medical practice, the ideal of the doctor-patient relationship has evolved since the second half of the 20th century towards equality as the ethical ideal”. All these are supported by the presence of the informed consent, by the necessity of discussing the therapeutic options with patient, by the recommendation of reaching a therapeutic decision together, etc.

This evolution of the contractual and relational content of the medical act is not merely the translation of the evolution of the general (theoretical) conception in reality, but also an evolution of the collective thought, which differs from geography to another, in spite of the homogeneity imposed by globalization. Thus, this attitude is natural for the Anglo-Saxon population, but in Hispanics it may signify insecurity on behalf of the doctor who emphasizes these aspects, or even incompetence, as they prefer the authoritarian attitude, which they associate with competence and confidence. These are reflexes of the two cultures and are impossible to abolish, the catholic shadowing a strict hierarchical order from God downwards and the protestant

leveling the humans.

The spiritual level of the human being must not be overlooked (the human being is bio-psycho-socio-spiritual, with four levels). According to psychoanalysis, in the western culture, the self is governed by internalized believes. In Asian cultures, the self is determined by social relations and responsibilities.

These cultural differences of the historical state must be pointed out because they determine the degree of inner freedom of a person. Moreover, they ingrain in the collective thought of a group and, as is well known, the placebo or anti-placebo effect is not dependant only on the patient or physician but also on other people's (the patients' social groups) opinion about the treatment. In front of every patient these generalities must be shaded for personal success and the well-being of the patient.

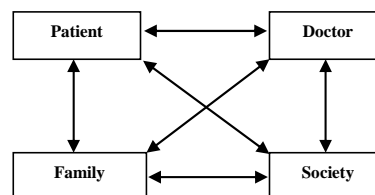
### Medical and Psychological Outlooks

According to O'Brien and Houston (2007) "a big part of what a therapist does could be called research". This fact could also be set in relation to the current medical paradigm: "person centered medicine" (Mezzich, 2008), because each case must be examined (investigated) in its domestic, professional, social and cultural context. Therefore, the patient's truth is expressed by every specialist attending the case, but every specialist notices the part of the truth belonging to his specialty. General medical practice states: "interpersonal relationship and information are inter-twined as essential cornerstones of healthcare" (Tonang, 2006). This is confirmed by daily practice: "Lower use of medication treatment, poorer doctor-patient communication, and depression stigma are key contributors to mental healthcare disparities among Latinos with depression" (Interian, Ang, Gara, Rodriguez, & Vega, 2011). The patient, his convictions and emotions are seen in the center of the relational complex: "Patient trust has an impact on patient satisfaction, adherence to medical prescription, and continued enrollment" (Holbeck, 2011). In this relationship: "Patients seek doctors who can provide treatment and cures to allow them to return to their daily routines. Physicians practice medicine hoping to successfully diagnose and treat people with illnesses" (Rabin, 2010). Family and social settings of the patient-therapist relationship are set. Brought to the gates of reason are the four instances of the therapeutic relational complex: patient, doctor, family and society. By saying society, the overall society framework and everyone else, closer or more distant to the patient is understood.

### The Psychiatric Particularities

From the things mentioned above it can be inferred that the accurate diagnosis and an accurate "technical" approach of the treatment are not enough to maximize the effectiveness of therapy. The maximum of the therapeutic effectiveness regards the entire rational complex of a disease. This complex is a synthetic combination of the relation between four factors: patient, doctor, society and family, each interacting with the others (the relational complex consists of 12 types of relations as seen in **Figure 1**).

As presented in the diagram above the accurate "technical" approach of the treatment regards only the patient and the doctor in the direction doctor-patient and less on the direction patient-doctor, which is already a different relation with a different content.



**Figure 1.**  
The therapeutic relationship system.

The doctor-patient relationship has a consistent and necessary scientific and rational content. It may become a failure unless this is taken into consideration. The patient does not only expect competence from his doctor, but, according to his structure, human sympathy, sometimes peer-like, other times parent-like and affective warmth for his security and comfort and especially for his protection of dignity as a creature "fallen to the ground". From a therapeutic perspective this means patients have unconditional trust in their doctor, which is a primordial premise for the placebo effect, which translates into therapeutic compliance. If the non-compliance rises to 40% - 50% in cardio-vascular diseases, in psychic patients (especially schizophrenics) it rises up to 70%.

In addition, comfort, security, self-esteem and dignity re-statement are the four factors which allow the recovery of the reality function in psychotic patients. This is the long term effect of the seriousness of the relation doctor-patient taken the other way around—patient-doctor.

Therefore, doctors are just one of the factors that influence the therapeutic evolution of a patient. Another rational category is the doctor-family and its other-way-around—family-doctor relationship. The five types of families must be mentioned: harmonious, overprotective, the family of double signal, the cold family and the overemotional family, each type having a specific impact on the emotional evolution of the patient, on his existential and future security, on his comfort and degree of solicitude (Cornuțiu, 2004). All five types of families require a different approach in order to understand the disease and they must be trained specifically for the future relationship with the psychic patient among them. The indirect psycho-therapeutic contribution is essential. It must be mentioned that, for instance, within the same time unit, 15% of schizophrenics decompensate in a harmonious family, while in an overemotional one 50% do so. The counseling and training of these families has a direct effect on the patient-family relationship, harmonizing the patient's primary group affectively. It is pivotal to his social insertion. Without it, the patient's social insertion may be scarce because the family is the barest and the most representative image of the world he lives in. All this means that the patient cannot be approached only as a patient because he has increased affective psychological needs which are different from the needs of a psychologically healthy person, who is self-confident.

As Sadler remarked (Sadler, 2005), "any disease is an ethical public case" which leads to a social redefinition of the person who became ill. The diagnosis therefore establishes a new ratio individual-society. This is extremely important because "not every psychotic crisis evolves into schizophrenia" (Calvin, 2007) and if schizophrenia is tempestuously diagnosed (no matter how right it may seem) it becomes a contribution to the psychotic patient's definitive disconnection from the reality. Schizophrenia is nothing more than an evolving subtype of the

first psychotic episode. This thing does not only depend only on diagnosis but also on the limitation to a set of “bare necessities” of the treatment (according to vulnerabilities). Nothing is more devastating for the patient’s self esteem and his hopes than the diagnosis of schizophrenia. The psychotherapeutic preparation of giving this diagnosis has an immense therapeutic effect as it annihilates self stigma.

This may make the patient understand—through dignity, self-esteem and hope—that his disease is a natural one among other diseases, which all have their “ailments”, and should walk tall in society. If “stigma may spring from lack of understanding” (Radden, 2004), self stigma springs from the same lack of understanding. All these are necessary because “psychic disturbance rarely lead to total and definitive inability of autonomy, most of the times there is only an intermittent inability” (ibidem). Annulling self stigma allows the psychic patient a reasonable social functioning, according to the completeness of the remission, which validates him socially, thus altering his perception of the disease and lowering his stigma.

In this direction, the norms of good medical conduct: the patient’s right to choose his therapist, his right to an explanation of disease and treatment, his right to consent internment and treatment, his right to refuse treatment, etc. all have the purpose not only to protect the patient from a juridical point of view, but also to reduce self stigma with all its consequences previously mentioned.

These are the ribs of an adequate doctor-patient relationship in general and doctor-psychiatric patient in psychiatry in particular, which can be defined as indirect psychotherapy in case of adequate medical practice and as failed psychotherapeutic act in case of neglecting the good practices. They can be given different meanings in psychiatry, considering each type of psychiatric suffering and their enriching connotations, but they do not alter the central topic of the general rules generated on the 12 types of contextual relationships in case of disease, in which the doctor is only one of the four factors in the relation.

### Conclusion

Developing a rating scale for self stigma is needed. It could bring benefits in understanding and optimizing therapeutic steps through evolutionary studies on pathological groups between minimal self stigma groups and maximum self stigma

groups. A third step could be the development of means to fight self stigma.

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