

Considerations on Medical-Patient Relationship in Psychiatry. Anthro-Medical Implications

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Abstract: This article attempts to briefly present aspects of the doctor-patient relationship in practice cases with the unipolar affective disorder, with or without anxiety. It also presents a case study demonstrating how the approach to a friendly relationship between treating physician and depressed patient increases compliance with treatment. The subjective observations can be applied *cum grano salis* in other forms of depression in different disorders (post-schizophrenic depression, depression from bipolar disorder). The therapeutic experience assimilated to the imaginative level considers every person valuable because the mere fact that he/she exists, then finds what makes it unique and respects its idiosyncrasies. The volatility of the depressed patient's state of mind requires a dynamic imagination of medical knowledge and principles, as well as the sliding between the three different instances of the physician-patient relationship during admission or interaction with the patient. In the case of depression, it can be said that each instance of the disorder is unique to every patient, like fingerprints: genetics, neurodevelopment, primary and intermediate irrational beliefs are unique to the affected individual, aspects that are of great interest in medical anthropology.

Keywords: Doctor, Patient, Depression, Medical anthropology.

INTRODUCTION

The Etymology of the Words: Doctor, Medic and Patient

The Indo-European radical **med-* is the one that gave rise to the Latin noun *medicus*. Its meaning implies the idea of "authority," "sovereign decision". *Medicus* is the person who "aids a troubled body", he "brings back to normal a state of disorder". The word *medicus* represents the basis of many derivatives in Latin: *medico* "to treat, to medicate", *medication* "treatment, medication", *medicina* "medicine", *medicamentum* "cure, medicine, drug", and *remedium* "remedy" (*i.e.* the means by which one recovers his normal state of health).

The term *doctor* used today on the same level of meaning with *medic* comes from a different radical and has a different history, up to a point. It comes from the Latin word *doceo* "to teach (something to someone else)", originally from the Indo-European radical **dek-* "to take". The term *doctor* came into use with the founding of medieval universities. Here, the *doctor* received his *licentia docendi* (teaching licence) and he acquired the "right to teach," to teach his disciples, his students.

Patient has its origins in the Latin verb *patior* "to suffer", with the present participle *patiens* "the one who suffers", and in the Greek verb πάσχειν (*paschein*) "to suffer" and the noun πάθος (*pathos*) "suffering". They are all formed from the Proto-Indo-European radical **peh₁-* "to harm, to injure, to inflict pain".

Theories Behind the Doctor-Patient Relationship

Over the past twenty years, the classic model of the doctor-patient relationship, theorized by Talcott Parsons (1951), has the dominant role held by the doctor. He takes all decisions regarding examination and treatment. This classical model was replaced in time by a dynamic model in which the balance between the two is somewhat restored: the patient reaches a level almost equal to that of the physician [2].

Both the physician and the patient must have the ability of introspection and communicate their message so that the patient's state of health is brought back to balance: these capacities depend on the socio-political and intellectual environment of that period in which communication takes place [3].

Thomas Szasz and M.H. Hollender (1956) described three models of the doctor-patient relationship: the *active-passive* model, the *guidance-cooperation* model, and the *mutual participation* model. The first two models have the focus on the doctor who plays a major active role. This is considered to be of a paternal-type situation. The mutual model is focused on

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the patient; he gains more control and the power shift towards him with the help of the conscious will of the doctor [4].

It is widely believed that the first two models functioned in varying degrees during the Ancient Egypt and the Middle Ages, epochs dominated by a magical ideology, and then during the Greek Antiquity and the Roman Empire, when a scientific method was increasingly more necessary. The paternal model gradually evolved, shyly at the same time, towards the patient-focused model, starting with the French Enlightenment to date. Medicine begins to focus on the patient and integrate him into the medical act as a person whose participation must be taken into account starting with Josef Bauer (1842-1925) and Sigmund Freud (1856-1939). The doctor was in active communication with the patient, whose feelings and opinions were taken into account and on which the medical act was centered Michael Balint (1896 - 1970) has theorized that the unique relationship developed between the doctor and the patient is a crucial issue in the diagnosis and treatment process, the physician having to take into account not only signs and symptoms but to look at the patient's state of health as a psychosocial phenomenon and as a biological one at the same time [5].

Nowadays, because of the increased medical accessibility through the media and the Internet, the patient tends to want more and more control over the type of consultation and decision-making of the treatment.

The balanced doctor-patient partnership tends to be imposed nowadays by the ever-increasing prevalence of chronic diseases: monitoring of symptoms, informing the patient of the stages of his illness, the need to change the treatment according to disease progression, etc [6].

Szasz and Hollender described in 1956 three models of the doctor-patient relationship. The first active-passive model was paternal-like and was similar to a parent-child relationship: the patient is considered helpless and relying entirely on the authority and competence of the physician. This applied more in the context of an acute illness when the doctor had to make immediate decisions, and the patient was incapable of other behaviour than obedience. The second, the coordinator-guiding model, applies in transitional situations from acute to chronic disease,

when the patient's mood could be significantly altered; the patient would be asking the doctor for guidance in order to adopt a beneficial behaviour towards the disease. The third, the mutual model, considers that both persons participating in the medical act have social functions and that collaboration is equally advantageous and necessary for a democratic and free society [4]. The patient gains more power, because having independence and equal control, the two instances - physician and patient - will have similar satisfaction. The patient who has a chronic illness will know and will be able to take better care of him self. In this patient-focused model, the physician has to take into account the affective traits of the patient; he must understand the significance of the disease for the patient: the same surgery procedure for the same type of fracture is of different importance to two patients [5].

A patient-focused medical act comprises five main instances: the bio-psycho-social perspective, the patient-like-person, the shared power and responsibility, the therapeutic alliance and the doctor-as-person [6]. The bio-psycho-social perspective means involving the doctor beyond the biomedical aspect that the disease brings inherently to the medical act, so that the doctor must modulate the influence that the condition has on the "biography" of the patient. The patient-as-person situation looks beyond the bio-psycho-social model, with the physician having the ability to dissociate the impact that the same illness has on the different patients.

In the medical act between the doctor and the patient, the authority is shared between the two democratically, and the responsibility to participate in the medical act is equal. In this regard, the patient should be encouraged by the physician to express his/her views on the medical act, offering greater involvement. The therapeutic alliance requires the doctor to have empathy towards the patient and to display a positive attitude in the therapeutic act so that the patient feels the relevance of the diagnosis and treatment. The patient must believe in the goals that the doctor proposes and develop a relationship based on trust and help with the caregiver [6]. The "doctor-as-person" situation is based on the notion of counter transference used predominantly in psychology: the feelings that the doctor has towards the patient and the reactions that the doctor causes in him can be used to improve the medical act and to adapt it to the situation, the physician gaining a greater insight ability.

STUDY CASE

Patient A.M. 41, female, married, of Orthodox religion, checks into a psychiatric hospital from Bucharest Romania, in March 2017. At the time of her arrival, she was on maternity leave, she had a job as a hotel manager, mainly responsible for the management of the restaurant. Her work schedule was usually busy, having to handle a large staff and organizing events for hundreds of people. She had a pregnancy score of Apgar 10, without further obstetric complications. At the time of her arrival at the hospital, her child was three months old.

The patient presented a severe depressive mood ("I do not like my life," "I am not and will never be a good mother," "I feel useless and unable to take care of my baby"). Also, ideas of futility and incapacity with anhedonia, disorganized behaviour ("I run away from my husband in another room and burst into weeping", "Sometimes I walk constantly through the room, sometimes I sit and stare for hours"), anxiety of pre-psychotic intensity ("I'm a bad mother, someone like me should never have to have a baby"). Reduced tolerance to frustration ("If my husband scolds me or tries to encourage me, I burst into weeping, and I cannot stop any more", "I just want to sit alone in a room, me with my suffering"), low appetite ("I am hardly hungry, food does not have a good taste") and mixed insomnia.

The hereditary-collateral history contains the situation of her mother that had surgery for uterine fibroids and her father with primary hypertension and mixed dyslipidemia. As far as the personal physiological history is concerned, menarche at 14 years of age, one birth three months ago and regular menstruation before pregnancy. Personal pathological antecedents are insignificant: it is noted that she has been smoking for 15 years, consumes 2 cups of coffee a day and occasional alcohol.

It is clear from the personal history that the patient lived in a customarily organized family environment, but deprived of maternal support in childhood and numerous episodes of discord between parents. She says she has an older brother that was the favourite of both parents. She is married for three years, and her 57-year-old husband supports her through these difficult moments. They live in a 3-room apartment in the urban area and the financial situation is good, above the average of the population, but money is always a source of intra-family tensions. Regarding her studies,

she finished high school and a post-secondary school specializing in tourism.

Previous psychiatric history is not significant, and the patient has no psychiatric hospitalization to date.

To summarize, the current episode presents a 41-year-old patient with no psychiatric antecedents, severe depressive mood with ideas of futility and incapacity, anhedonia, disorganized behaviour, an anxiety of pre-psychotic intensity, reduced tolerance to frustration, tendency to social withdrawal, low eating instincts and mixed insomnia. Symptoms began insidiously five months ago, two months before pregnancy and with progressive aggravation, for three months after pregnancy, when she came willingly to the hospital. Having this in mind, the patient does not care for her infant child, this responsibility being taken over by her husband, she does not breastfeed, and she cannot perform any maternal duties.

The physical examination was usual; there was only a higher BMI of 29.3 kg/m² indicating overweight, a blood pressure value of 120/80 mmHg with a pulse of 96 beats per minute.

Concerning paraclinical tests, there were normal assays and thyroid function (TSH, fT4), except for mixed dyslipidemia (serum triglycerides = 280 mg/dl, total cholesterol = 239 mg/dl). The electrocardiogram revealed a sinus tachycardia without pathological features. A psychological examination was made, with values for the Hamilton Depression Rating Scale of 28, the Hamilton Anxiety Rating Scale of 26 and a PANSS value of 59).

Psychiatric examination: female patient with a well-kept aspect, conscious and cooperative, good hygiene, time-space self- and allopsychic orientation, anxious visage with relative eye contact, hypo-mobile gestures, intermittent speech, easy-to-understand dialogue maintained throughout the interview. The awareness of the disease is present in a high degree. No productive symptoms (hallucinations, delusions) at the time of examination and anamnestic in the past. There is a spontaneous and voluntary concentrated hypoprosopexia, fixed hypomnesia, thematic hypermnesia, selective, evocative, and centred on family history. The rhythm and flow of ideas are slowed, with a focus on the problems of raising an infant. During the interview, the volume of knowledge is in line with the educational level, the patient easily realizes the similarities and differences, perceives the absurd, the dynamic abstraction processes and dynamic synthesis are

present, and the logical associations are possible. From an affective point of view, there was a background anxiety with paroxysmal exacerbations. A fragile Ego, emotional immaturity, and emotional resonance could be observed during examination. The patient was unable to fulfil her social function, the appetite was low, also mixed sleeping disorders were present. She denies the autolytic ideation, both at the time of the examination and in the past.

Taking into account the exposed facts, the following diagnosis was made:

- Axis I: severe depressive disorder with peri-partum onset and post-partum progression;
- Axis II: personality structure with elements of hyperthymia, demonstration, and hypervigilance;
- Axis III: Overweight, mixed dyslipidemia;
- Axis IV: Problems related to the primary support group (family with many tensions and minimization of the role of women), problems related to social support (negative influence of the family financial situation);
- Axis V: GAF score 61.

Diagnostic support was performed according to the DSM V criteria for peri-partum onset unipolar affective disorder.

CONSIDERATIONS ON THE DOCTOR-PATIENT RELATIONSHIP BASED ON THE PRESENTED CASE

In psychiatry, it seems the majority of physicians apply a non-reflexive behaviour to the physician-patient relationship that tends to turn to the physician's importance and exercise his undefeatable authority. It can be stated from the very beginning that depression with psychotic symptoms, where the patient has delusional ideas or hallucinations, by the nature of the disease, the pattern of the relationship tends to an authoritarian one because the patient has a low or absent insight/critique of the disease. The degree of urgency, the acute condition, prevents the establishment of an equal or patient-centred model in such a situation; but this can change with the disappearance of psychotic symptoms.

In depression without psychotic symptoms, the patient-doctor relationship is bankrupt if it remains only in the physician's power pole. While the patient feels

overwhelmed by his affection, the fact that he has no say whatsoever to the treating physician can accentuate his state of helplessness and make him incompetent and uncooperative, with poor results in the evolution of the disorder under medication. Personally, we have often been stopped by other medical patients who were asking me to help or explain the nature of the disease or the types of medication they were taking because their own doctor did not explain it to them. This has discouraged them, and often, after hospital discharge, they did not continue to take the medication while at home.

Despite activated knowledge level and insight of a patient, we had noticed that almost all of the patients we treated responded better when we tried to offer them a measure of equality. We practiced benevolent neutrality without involvement in the patient's life and practiced empathy with participation in the patient's life through techniques of cognitive-behavioural therapy. In the latter case, these methods convey a different degree of validity to the physician's understanding because the patient perceives not only warmth and friendship, but also the science with which he is groomed with the increase of his insight. The use of layman terms as frequently as possible, the variable transfer from one pole to the other between the doctor-patient relationship, depending on the circumstances, leads to the observance of the patient's treatment and the increase of his courage to face the illness.

Dealing with a psychiatric disorder such as that of the unipolar type, applying a single model of the doctor-patient relationship is often impossible. From our experience, the key seems to be the permanent evolution between the three models of connection depending on the personality of the patient, his symptoms, his level of knowledge, the response to treatment, etc. The variables are multiple, which means that the physician's experience is vital in knowing how to relate to each patient. Although it may seem a role play, this role takes place in a medical setting according to medical ethics. Friendship does not have the usual day to day meaning, because it does not transgress medical norms and takes place within therapeutic empathy. In psychiatry, highly effective involvement in the patient's life leads to an attachment from the two instances involved in the medical act that will later prove to be of no benefit to the patient, if not harmful.

What is the moral competence of the psychiatrist to deal with the problems faced by patients? If the doctor treats a post-partum depression when he does not

have children, can empathy be a therapeutic tool? All the more so, since the doctor does not have the patient's life experience, the patient-focused model can be beneficial in two directions: on the one hand, the doctor can extract from the patient's experience and assimilate those things that enrich his own experience, even if at an imaginative level. The imaginative level of assimilation creates the possibility of mimesis with that patient and with future patients in similar situations. By focusing on the patient in the doctor-patient relationship, the medic manages to blur his public persona but to augment the values of his intimate reality, his subjective forum. The experiences the doctor assimilates are more precious in the situation where the pole of power is at the patient rather than at the doctor. If the doctor applies the paternal model, he applies his usual medical science and runs the same ideas on a machine-organism from which he does not get opinions that can fit into the imaginative-with-possibility-mimesis. Medical science is, in fact, a mixture of objective, diagnostic, clinical and therapeutic principles, and the personal, mental atmosphere of the doctor. These are mixed, indiscernible and in a continuous dynamics of evolution: they cannot evolve without one another.

CONCLUSIONS

Applying a type of doctor-patient relationship, in which the doctor has a dominant role, does not have

good results in psychiatric patients. This work, through the clinical aspects presented, attempts to demonstrate that a patient-centred cooperative relationship that also takes into account the personality traits, the environment of the depressed patient can have better results in recovering from illness. Thus, the vast field of medical anthropology proves its importance in establishing a kind of doctor-patient relationship, favourable to the patient and especially to the non-psychotic patients suffering from depression.

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