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Doctor-patient relationship in the diagnosis and treatment of neoplasmatic diseases

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Abstract

Neoplasmatic diseases, due to their chronic character, as well as the potential threat to life and other important values, are a significant life stressor. An important factor in their treatment is the patients' advantageous psychological adaptation to the disease. This, apart from the patient-centered factors, strongly relies on effective and satisfying communication between a physician and patient. Application of patient-focused approach in the treatment process enables regarding patient's expectations as for information and emotional support, which is essential for obtaining patients' compliance during the treatment course. Evolution of approaches to patient-physician communication, as well as the current understanding of this process, were reviewed and discussed in the paper. Patients' preferences concerning process of communication with oncologist were described. Studies presenting the influence of patient-physician communication on the treatment process, were discussed. The importance of patient's satisfaction with relationship with a physician for successful treatment of a neoplasmatic disease is depicted. Significance of appropriate communication in palliative care was stressed, with special regard to communication of breaking bad news. Factors negatively influencing patient-physician communication in oncology were characterised. Methods of training communication skills in oncology were briefly presented.

Key words: doctor-patient relationship, communication skills, oncology

1. Introduction

The last decades have brought significant changes in the mutual relations between patients and doctors. Many factors contribute to the disappearance of the patient's image as a passive recipient of diagnosis, medical recommendations and other medical services. The development of the movement for patients' rights, education on patient rights and the widespread access to medical information on the Internet is of particular importance (Han, 2005]. In addition, the growing range of diagnostic tests carried out in hospitals and their increasing invasiveness requires the participation of the patient, undertaking a dialogue and establishing closer contact between the doctor and the patient (Freedman, 2002). As the research shows, the quality of doctor's communication with the patient is of great importance in the context of diagnostics and treatment of cancer (Chipidza, et al 2015). The aim of the present work was to describe the current understanding of patient-physician relationship, its evolution and consequences for the treatment of

2. The specificity of oncological patients’ psychological situation.

Understanding the impact of the doctor-patient relationship on the course of the disease and its treatment, requires taking into account the psychological consequences of the disease and the significance of the disease for the patient. The authors dealing with the problems of psychological aspects of somatic diseases put them in the category of stressors and present them in the context of Richard Lazarus' transactional stress theory (Heszen-Niejodek., 2000; Sęk, 2001). An important element of the concept of stress is the so-called primary and secondary assessment of the situation in which the subject found him, or herself. Consequently, the stressful situation (in this case the illness) can be perceived by the patient as a threat, loss or challenge. The subject assesses his coping chances, taking into account his own remedial competence. Both types of assessment depend on the characteristics of the disease itself and a number of subjective determinants of the patient.

The specific features of cancer are its chronicity and the majority of the instances, a threat to life. Specific problems are faced by the patients dealing with situations characterized by an unfavorable or unclear prognosis, causing a sense of loss and helplessness, all these problems being characteristic for cancer. In spite of making efforts to recover, there is a long-lasting, real risk that the disease will have an adverse outcome or even end in death. Each illness is accompanied by emotions, the type and severity of which varies depending on the patient's perceived threat to their own health and life (Heszen-Niejodek, Heszen-Klemens, 1979). Cancer disease and related problems can give rise to strong anxiety, which may be caused by a sense of death threat, loneliness, pain, shame or confrontation with a completely new situation (Gałuszka, 2000). Cognitive evaluation of the disease is closely related to the emotional state of the patient. A negative picture of the disease can lead to depression, resignation and a sense of hopelessness.

Cognitive representation of the disease is largely determined by relatively constant subjective conditions, such as the general personality traits, the style of coping with stress and health habits. Attitude towards the official health care system is another significant factor. It is especially important for patients suffering from cancer, as their visit to the hospital, is often not a form of a one-off hospitalization, and requires multiple visits to the hospital, eg due to the use of chemotherapy or to carry out control tests (Heszen-Niejodek, Heszen-Klemens, 1979). In such situation, the patient may be affected by institutional stressors, in addition to the illness itself.

The factors described above, conditioning the assessment of own ailments, are of considerable importance in the case of cancer, because on this basis the patient creates an image of his own illness and chooses a strategy for dealing with it. The type of strategy that the patient uses in coping with the disease may play an important role in the course of the disease. It is indicated that a longer survival time in good condition, without metastases, is found in those patients who can minimize the impact of the disease on their own lives, actively oppose it and apply the strategy of redefinition. Conversely, strategies based on ruminating the disease experiences, analyzing the disease and focusing on emotions, are particularly unfavourable (Sęk, 2001). The most favourable attitude towards the disease is treating it as a value, applying flexible remedial strategies to it, shaping the attitude towards the disease based on reliable information. The type and quality of the relationship with the doctor have a significant impact on developing an attitude towards the disease.

3. Models of doctor-patient relationship.

Charavel (2001) made a critical analysis of consequent models of doctor-patient relations. The most traditional model of communication is called the paternalistic or "active-passive" model (Hollender, 1956 for: Charavel, 2001). In this model, the doctor autonomously makes all decisions as to the course and method of treatment, while the passive and dependent patient is obliged to adapt to his recommendations. It is the patient's sole responsibility to find and report to a specialist, and then to cooperate with him. However, the doctor provides the patient with information, bearing in mind the patient's motivation to take up and continue the best, according to the doctor, intervention. This model assumes the unity of patient and doctor views on the issue of treatment, thanks to which the patient is able to assess with great probability what is beneficial for him, even in spite of a small self-participation in the diagnostic and therapeutic process.

A completely different model of interaction of both sides of the treatment process is the "informative" model in which the physician remains in the competence to provide the patient with all necessary information so that the patient can choose the preferred treatment method on their own. On this basis, the doctor selects the appropriate method of intervention. This model assumes that the patient is aware of their values and views about treatment, but does not have the most important information for making an independent decision about treatment, hence the source of this data should be a doctor. There is no meaning to the doctor's personal opinion about what is best for the patient or his / her own interpretation of the patient's health attitudes (Charavel, 2001).

The intermediate model is so-called the “interpretive” model, which, although closer to the "informative" than to the paternalistic one, presupposes greater doctor's activity in the process of negotiating the treatment. Here, the main means to determine the treatment method is to jointly identify the expectations and health values, professed by the patient and to help the patient choose the most appropriate method of treatment. The doctor uses his knowledge and experience in order to organize often inconsistent and imprecise expectations of the patient, who, in the end, makes the decision himself.

The "discursive" model is very similar to the one described previously, but here the emphasis is placed on discussing the decisions made by the patient and the doctor's ability to make his own opinion on the most effective, in his opinion, treatment. The last three interaction models are less frequently practiced and tend to occur in private health care, but their use and discussion over them has allowed to create an optimal model of communication between the doctor and the patient. The paternalistic model has been criticized due to the disproportion between the role of the patient and the physician, and due to the false assumption that the views and expectations of both sides of interaction are consistent. The "informative" model has also been criticized because the doctor has a purely technical role and gives the patient complete competence in making decisions about treatment. Leaving a lonely patient in this situation is often a source of understandable fear (Charavel, 2001).

If we assume that the paternalistic and informative models are the opposite ends of the continuum, the other two are in the middle. The integral model, called the "joint decision-making model", is directly derived from them, and its assumptions can be summarized in four points:

1. Both the patient and the doctor are involved in the decision-making process regarding the treatment method;
2. There is a mutual exchange of information between the doctor and the patient;
3. Both the patient and the doctor take steps to select the appropriate treatment method by informing about their preferences;
4. The decision on the treatment method is made when both sides of the interaction agree to its implementation (Charavel, 2001).

Another way of analyzing a patient-doctor relationship takes into account a greater number of factors than just symmetry or asymmetry of interaction and consists in distinguishing a physician-centered approach and a patient-centered approach. The characteristics of these models (Dowsett., 2000) emphasize the role of the doctor and the way in which he communicates with the patient. In a physician-centered approach, the doctor uses verbal rather than non-verbal communication, which, specifically, is characterized by the use of medical vocabulary. This style of communication is also characterized by a high degree of privacy for the physician and a strong control of one's own behavior. The patient-centered attitude is distinguished by the attitudes and behaviors of the physician characterized by greater empathy and emotionality of actions, expressed in greater openness and bigger number of supportive behaviors. The doctor uses a more colloquial, "egalitarian" language, and decision-making about treatment takes place with the patient's cooperation.

4. Patient's relationship with a doctor in the diagnosis and treatment of cancer and patients' preferences

Due to the aforementioned increase in awareness of patients’ rights, the treatment success is now defined not only by the mastering of the disease process, but also by the patient's satisfaction. It seems that the most satisfying models for patients are "joint decision-making" and patient-centered models. They assume the greatest proportionality in the physician-patient relationship, requiring both the doctor's greater competence and greater openness in communication with the patient. When applying these types of approaches in practice, the researchers made a number of interesting observations about the impact of these models on patient satisfaction and the course of treatment. The largest number of studies on the patient-doctor relationship were conducted in the participation of breast cancer patients

(Dowsett, 2000; Han, 2005). They show that effective communication with doctors makes patients respect the recommendations to a greater extent and comply more closely with the requirements of the treatment process. Psychological adaptation to the disease is also better, which is important because, as research has shown, 16% of women suffer distress for two years after hearing a diagnosis, which is an important factor affecting the life expectancy of women with breast cancer (Figueiredo, 2004). It has been shown that one of the main reasons for experiencing stress by patients is ineffective and unsatisfactory communication with a doctor, which led, among others, to to maladjustment to the disease process, mood disorders, and in the short term - feeling anxiety, anger and embarrassment three months after experiencing inappropriate contact with a doctor. However, a satisfactory relationship with the doctor improved the quality of life and satisfaction with the contact experienced by the patients three months after visiting the doctor. When the features of contact with the doctor most preferred by the patients were taken into account, it turned out that they were: active listening to the patients' statements, attaching importance to the patients' knowledge about their illness as well as honesty and partnership attitude. An important factor, increasing the patients’ level of satisfaction with the medical consultation, was the reliability of the information provided by the doctor. Information about treatment options, recognition of relapses, chances for cure and the impact of the disease on other family members was considered particularly valuable. The authors also point out that as the patient's autonomy increases, it is necessary to increase the patient's sense of responsibility for the treatment process (Figueiredo, 2004). Interesting results are also provided by the latest research, which indicates that what information the patient expects from the doctor and what questions he will ask depends on how the patient perceives the doctor. If the patient does not trust that the doctor is providing him with comprehensive information, he asks fewer questions, and consequently, is poorly informed about his own illness (Adamson et al., 2018).

Although the patient's preferences regarding communication with the physician are not homogeneous, they show a clear tendency towards a patient-centered approach. Dowsett et al. (2000) examined breast cancer patients and showed that 36% of them expressed the opinion that the doctor and patient should have the same contribution to treatment decisions, 48% were convinced that the doctor and the patient should make this decision jointly, and 9% were of the opinion that the decision should be taken by the doctor and a family member, without the patient's own participation. Regarding the behavior of the doctor in conversation with the patient, patients showed greater satisfaction with patient-centered contact at the diagnostic stage, while, interestingly, at the stage of the treatment itself, if the prognosis was good, they preferred a physician-centered approach. Preferences regarding the physician's attitude at the diagnostic stage were particularly strong in the case of an unsuccessful diagnosis. This allows us to state that the patients' priorities differ depending on the degree of success of the medical prognosis. However, to maintain hope in patients with both successful and poor prognosis, a factor as important as the empathic attitude of the doctor, is reliable and clear information provided to patients during consultations. It also turned out that a patient-centered approach is more preferable to patients who work as professionals or managers because they are more independent in their work. There was no correlation between the age of the patients and the doctor's preferred attitude. The results of the study indicate that the ideal model of physician's behavior includes not only going beyond providing information, but also empathy, openness and supporting attitudes, as well as allowing the patient to participate in decisions about treatment. The practical application of models of work with patients should be largely tailored to the individual needs of patients, and the ability to sense these needs depends on the knowledge of doctors on how to communicate with the patient, and their experience (Charavel, 2001).

5. Factors impeding the patient-physician relationship

The most frequently described phenomenon hindering the establishment of a good doctor-patient relationship are the so-called iatrogenic errors, defined by Jarosz as "behaviors of a physician or other health care worker (...) which (...) have a detrimental effect on the health of a person". The errors directly affecting the doctor's relationship with the patient include: lack of information or insufficient information, use of incomprehensible terms, neglecting the need for a holistic approach to the patient, creating a distance between the doctor and the patient, aggravating the patient's anxiety, and not preparing the patient mentally for the tests or surgery. The reasons for such errors include the superiority of the egocentric attitudes of the physician, dysfunctional patterns of physician-patient relations in society, incompetence and destructive patterns of behavior prevalent in the medical environment (Jarosz, 1978).

In the case of cancer patients, the factor that makes it difficult to establish a good doctor-patient relationship is the stress and anxiety experienced by the doctor when communicating bad information to the patient. The sources of stress can be both the emotions of the patient, which the doctor is not always able to cope with, and sometimes violent reactions of the patient's family (Maguire, 1999).

An important phenomenon that disrupts doctor-patient relations is also professional burnout (Sęk, 2001).

The factors hindering good doctor-patient relationship can include a number of variables directly related to the disease itself. Han et al. (Han, 2005) refer to Hobfoll's theory of restoration of psychological resources, according to which the loss of psychological and other resources, reduces the individual's ability to cope with a stressful situation. Cancer has been shown to lead to a loss of resources to such an extent that the patient may show significantly more helplessness and passivity when in contact with a doctor. Another factor that may reduce the quality of the patient's interaction with the doctor is the fact that cancer can be a traumatic event for the patient, and the natural reaction of people to this type of injury is to avoid thoughts and situations related to trauma. This can lead to reduced patient activity in the treatment of the disease. An important factor influencing the patient's interaction with the doctor is the patients’ sense of his own emotional competence. The higher it is, the more the patient is inclined to active forms of coping with the disease. Another factor that may affect the willingness to actively participate in the treatment may be social support, received by patients. It turned out that married breast cancer patients were more likely to cooperate with the doctor in making treatment decisions because they perceived the environment as helpful and favorable (Han, 2005).

6. Communication in palliative care: the truth and good of the patient

The reason why the communication in palliative care should be given a separate place is that, more than in the case of previously discussed areas of communication between the doctor and the patient, discussions and controversies concern ethical problems. The scope of concern is the dilemma of doctors, which can be formulated as follows: "If I reveal to the patient that his state of health precludes the validity of therapeutic treatment, will I not take his faith in the meaning of life?". Fallowfield (2002) describes a study conducted by Jenkins et al. (2001) in the United Kingdom, which shows that 87% of the cancer population "expected complete information, both successful and unsuccessful". It is worth noting that the differences between the preferences of patients treated palliative and non-repetitive were slight. The variables that differentiated the preferences of the patients were gender and age.

Women expected more complete information, but these differences have disappeared in relation to essential matters, such as information on the type of disease and prognosis. Patients under 65 years of age expected more complete information than those who exceeded this age, these differences did not concern information about prognosis in treatment. Other authors consider factors differentiating patients in terms of information demand: socio-economic status (people with higher status ask more questions) and strategies for coping with stress (people displaying more anxiety ask more questions than those that cope with stress by denying the disease (De Valck, Van de Voestijne, 1996).

Despite these findings, providing the patient with bad information about his health state should be preceded by assessing how much the patients wants to know. This is one of the elements included in the “SPIKES” tool for communicating the breaking bad news to the patient (Kaplan 2010).

Studies conducted in patients with chronic obstructive pulmonary disease (COPD) in the terminal phase indicate that reaching the level of care postulated by Fallowfield and communication between patients and patients in some areas of palliative medicine, requires a lot of work, especially in the area of increasing the awareness of doctors about the needs of patients. The group of patients with COPD was compared with a control group of patients with lung cancer. It turned out that 30% of patients with lung cancer were included in the specialist palliative care system, while none of the patients with chronic obstructive pulmonary disease received such care. Patients with lung disease showed significantly poorer quality of life. Their level of emotional, social and somatic functioning was lower. Most patients complained about the lack of information in the field of diagnosis, prognosis in treatment and too little social support. As many as 90% of patients in the experimental group and 52% of the control group had anxiety symptoms or symptoms of depression, requiring treatment, while only 4% of people in both groups were subjected to specialist psychiatric and psychological care (Gore et al., 2000).

7. Communication skills training

Awareness of the importance of effective communication between the doctor and the patient in the treatment of neoplastic diseases and the knowledge of factors interfering with the discussed process lead to the conclusion that the skills of the doctor working in the oncological ward should include specific communication skills. Therefore, the role of communication trainings for specialists in health care is emphasized (Travado et al., 2005). Higher communication skills acquired by a doctor not only serve the patient, but also the physician himself, as they protect the specialist against stress and burnout (Back et al., 2005). Training programs for communication and psychological skills consist of four main parts. The first of these is learning the theoretical basis of effective communication with patients. The second one is the analysis and discussion of patients' cases, which gives participants the opportunity to learn about mutual communication strategies and to specify the areas of functioning of individual patients, which are worth investigating during the conversation. Another important element of the training is a workshop consisting in playing scenes, presenting the doctor's or nurse's talks with the patient and his family. The participants of the training have the opportunity to try out the various strategies used in the conversation with the patient and discuss the difficulties they encountered while playing the stage. The last extremely important element of the training is the training of coping with stress created on the basis of contact with the patient. This part includes learning about possible stressors, and learning how to recognize and deal with stress symptoms (Razavi, Delvaux, 1997). The analysis of the effectiveness of communication programs in the last decade indicates the need to work with the emotions and beliefs of the doctor regarding contacts with patients. Training containing elements of the analysis of physicians' own experiences in relation to the patient, awareness of the sources of their own reactions and difficulties, is much more effective than learning technical communication skills (Stiefel, Bourquin, 2016).

8. Summary

The shape of the patient's relationship with the doctor in the process of diagnosing and treating cancer is important for these processes. This is because an important factor taken into account in the assessment of the treatment process is patient satisfaction, which in turn may affect their adaptation to the stressful situation, which is the disease and, consequently, the chances of recovery and survival. The effective application of the latest theoretical models of doctor communication with the patient is possible only when knowing the individual needs and expectations of the patient. These remarks also apply to the issues of palliative care. As research shows, in the case of terminal disease, patients expect full information about their own disease and familiarize them with information on prognosis. Proposing to a patient to start palliative treatment at the right time can improve the quality of life and the way of functioning and management of terminal disease. The most appropriate method of improving the communication skills of palliative care physicians with patients is the psychological trainings of a workshop character.

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